



INNOVATION UNCOVERED

SHINING A LIGHT ON INNOVATION AND
CREATIVITY IN HEALTHCARE COMMS

**WHY WE SHOULD USE POETRY IN HEALTHCARE
COMMUNICATIONS**

CASE STUDY: BLOOD EQUALITY

**DRIVING HEALTH LITERACY THROUGH
GENUINE CUSTOMISATION**

**IGNITING WORKING-CLASS REPRESENTATION
IN HEALTHCARE ADVERTISING**

HEALTH SYSTEM TRANSFORMATION

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INTRODUCTION TO IMPROVING DIVERSITY REPRESENTATION IN

HEALTHCARE COMMUNICATIONS



WELCOME EVERYONE.

Perhaps that didn't need saying, but across the healthcare communications industry there is a continuing crisis of representation. Of course, much ink has been spilt over diversity. We don't intend to get political. Suffice to say this edition of Innovation Uncovered aims to be as diverse as we can make it.

As a natural blonde, I've never needed to worry about my roots. But for many people a working-class background is a barrier to their prospects in communications, and even worse, damages our ability to reach vitally important audiences. Emma Marie Lea tells us what it's like to be an outsider, and what we can do better. Ben Finlay's complementary piece discusses how a digital health solution could help prevent the development of frailty in over 55 year olds in Northern England.

I spoke to my Difference Collective colleague Sally Snow, who really was the smartest person in the room. She tells us about the power of health literacy and the equity it gives to all, regardless of ethnicity, background or gender. This is a subject so important we asked Tim Gomersall of GiG to contribute too, which he does with a brilliant piece on how personalisation can bolster health literacy.

We welcome a new voice from across the pond too: Jessica Spano of FCB Health in NYC outlines a case study of a project to stop discrimination against gay and bisexual men and give everyone an equal opportunity to donate blood in the US.

Two professional practice pieces round out this edition: Our very own Rick Evans of 90TEN spells out the impact of social media guidance and regulation on creativity, while Dominic Marchant of Open Health crunches the numbers on data-driven creativity.

Finally, turning from the prosaic to the poetic: Charlotte Shyllon of Transforming Words turns in some purple prose on the power of poetry to healthcare communications. Which allows me to leave you with three lines from An Arundel Tomb, by one of the finest poets of the 20th century, Philip Larkin. It encapsulates a universal human wish, which even the cynical Larkin didn't dare dismiss. Our desire to be remembered shows no matter how different we appear, there's more we share:

**Their final blazon, and to prove
Our almost-instinct almost true:
What will survive of us is love.**

Take care of yourselves.

STUART MAYELL
DIFFERENCE COLLECTIVE

You can send articles, ideas or comments to the editorial team using: innovation@the-hca.org

Share on social media using:
#InnovationUncovered
And please tag the HCA



IGNITING WORKING-CLASS REPRESENTATION IN HEALTHCARE ADVERTISING

EMMA MARIE LEA //
SENIOR PLANNER, VCCP HEALTH

How often do the experiences of working-class people influence creative campaigns for your healthcare brand or client?

Probably not that often. The working-class are often overlooked in DEI (diversity, equity and inclusion) efforts or worse, stereotypically portrayed in healthcare communications. Yet, for someone like me, their representation is a top priority in campaign development.

Before we move on, though, what even is “working-class”? The dictionary definition may simplify it as a socioeconomic term used to describe people employed in low-paid, low-skilled manual labour. But, in reality, it is far more complex and ever-evolving, so it’s essential to consider class as having three core aspects: social, cultural and economic. For example, I am no longer considered economically working-class, yet I still identify with many of the social and cultural traits of the working-class community

I grew up in a Leicestershire town called Coalville (coal town, you cannot get more working-class, and no, I am not making this up). As a child, our struggles weren’t apparent, but as I reflect on this now, I see the strain on my parents. Maybe we were eligible for free school meals after all, but Dad’s pride wouldn’t allow that. Cucumber sandwiches and a flask of squash every day it was then.

I was lucky to enjoy a tuition fee-free university education at the Labour Party’s peak. But I still needed to max out the student loan to get by (which I finally paid off this year). The debt lasted throughout my 20s, which meant skipping lots of nights out or facing the anxiety of splitting the bill. My university education

didn’t shield me from discrimination in the advertising agency world either, courtesy of my unmistakable working-class Midlands accent.

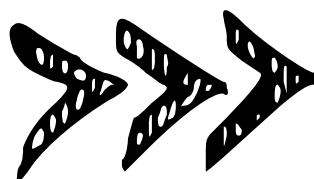
I’m not alone. It’s a running joke that Adland is dominated by middle-class culture, and according to the latest Advertising Association All In Census, **only 20% of the workforce is from a working-class background compared to 40% of the UK population.**¹ This likely extends into healthcare brands and agencies too, because it certainly applies to our HCP customers. Another study found that only 6% of doctors are from working-class backgrounds.²

Do you not think this should be a cause for concern for our industry? How can we create meaningful healthcare campaigns and communications, if we under represent the people we serve?

Whilst on paper working-class people in the UK technically make up 40% of your audience, the reality is that there’s an inherent need to speak to the working-class more about health. Health disparities amongst the social classes are widely documented. From the adverse effects on many aspects of health (including life expectancy, healthy life expectancy, infant mortality, cancer and chronic disease outcomes, and pregnancy complications) to reduced access to care, along with higher rates of detrimental health factors such as smoking, obesity, poor diet, and drug misuse.³

The literature will tell you statistics like:

“On average, a 60-year-old woman in the poorest area of England, has a diagnosed illness equivalent to that of a 76-year-old woman in the wealthiest area. She will spend more than half (43.6 years) of her life in ill health compared with 46% (41 years) for a woman in the wealthiest areas⁴.”



Or you'll be given a few generalised challenges that working-class people face in healthcare; language barriers, limited health literacy, institutional barriers, wait times, etc.

Yet, these statistics don't capture the human truths of the challenges faced by the working-class in healthcare.

At age 11, I lost my dad to a rare form of leukaemia. His work as a miner put his health at a considerable amount of risk. Too much. I vividly remember his final days and my mum's struggle to communicate her concerns to our family GP. His complex diagnosis left us without guidance and we coped alone. Today my mum faces health issues common among the working-class, like heart conditions and physical pain from her labour-intensive job, with little motivation to improve her overall health.

These experiences (not mere statistics), get to the heart of the matter and serve as the source for a more compassionate, authentic and effective approach to creativity in healthcare communications.

So, where do you start when it comes to building working-class representation in healthcare campaigns?

Here are some actionable ideas:

01

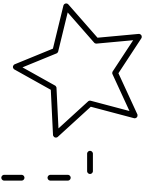
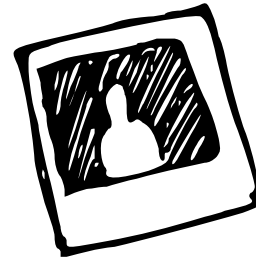
START WITH YOUR WORKFORCE

Is your agency or company actively recruiting people from working-class communities and do you even know how to reach them?

Working with an organisation like Commercial Break could be a good starting point. It's a business focused on increasing working-class representation in the creative and marketing industries. And they can help your business find, train and mentor working class talent.

<https://www.commercialbreak.org.uk/>

02

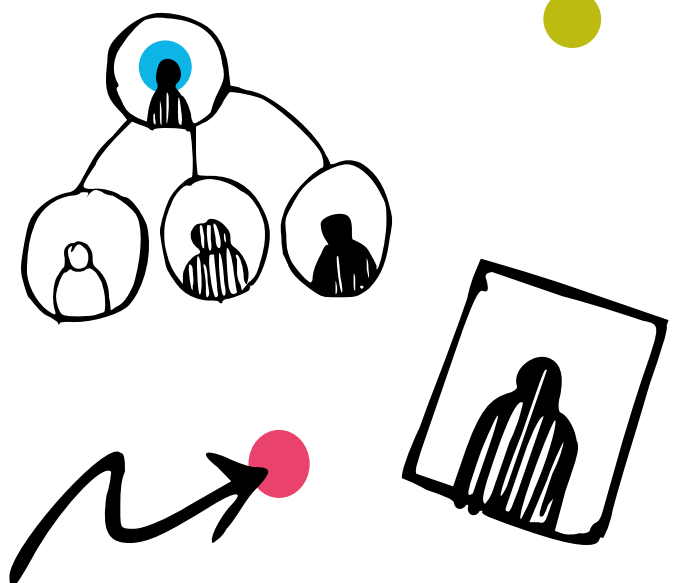


ENSURE DEI POLICIES ARE INCLUSIVE FOR WORKING-CLASS EMPLOYEES

You need to do more than put boots on the ground. You need to ensure that your working-class people feel like they belong in your organisation. It's not as straightforward as it sounds. Accents, clothing, after-work drinks, client entertainment (and more) can all be a source of anxiety and stigma for common people like me.

To get to grips with the in-role experiences of working-class individuals and for advice on how you can create an inclusive environment, I would recommend taking a look at Common People. It's a network of people in the creative industries who just happen to be from working-class backgrounds. Its mission is to make common people more common in the creative industries and instil a sense of pride and ownership in coming from a different class.

<https://www.commonpeoplelike.me/>





03

REMOVE BARRIERS FOR UP-AND-COMING TALENT

Does your organisation have internships and work experience programmes in place? If so, are they actually accessible for working-class people? Because a lot of these opportunities aren't. Take it from someone who lived off packets of Cup a Soup and bread during three weeks of unpaid work experience in London.

In a national survey of 2,000 individuals aged 16-24, conducted by VCCP Group, it found that around a fifth of respondents feel that being unable to afford a move to London stops them from considering creative careers. For some regions, such as the West Midlands, this increases to a quarter of young people⁵.

It's great to be a part of an agency that recognises it takes more than an internship programme to mobilise diverse talent. Through VCCP Stoke Academy, the goal is to inspire, identify and unlock the creative talent in Stoke, enabling young people to pursue successful careers in our industry without needing to relocate to London. We want to make the advertising and creative industries more accessible and socially diverse through valuable work experience opportunities, skills training and career guidance.

<https://vccpstoke.com/>

04

INCLUSIVE MARKET RESEARCH

When you conduct research, are you forcing yourself outside of your bubble? It's easy to send an all-staffer email to get a few opinions. It's also easy to reduce screening criteria in healthcare research to condense field time. But what are you losing in return? The valuable opinions and experiences of real patients that you won't find within your company or on any research panel.

Why not use a specialist market research agency that goes the extra mile to find diverse, hard-to-reach audiences and patients. Two brilliant organisations that spring to mind are The Outsiders and The Diversity Standards Collective and I encourage you to reach out to them next time an opportunity comes forward.

<https://outsidersinsight.com/>
<https://thedsc.org.uk/>



05

COLLABORATE WITH PATIENTS

Sometimes the best ideas can come from the patients themselves. Working alongside patient advocacy groups and charities can be a great way of unlocking opportunities to support working-class patients effectively. They can give you a window into their life, the realities of their condition and thoughts on the things that could make a real difference in their day-to-day.

You have the opportunity to actively address the underrepresentation of the working-class in healthcare campaigns. Whether you're in an agency or healthcare company, it's crucial to examine your processes, seek out working-class perspectives and promote diversity within your teams. The right support is out there to help you fulfil this, so there's no excuse. Together we can help bridge the gap in health disparities through more inclusive and representative education and materials.

By walking in the shoes of those we serve, driven by compassion, we can let their experiences fuel the creativity needed to make a tangible difference, leaving no one behind.

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AN INTERVIEW WITH...

SALLY SNOW //
DIFFERENCE COLLECTIVE

MORE THAN WORDS - THE SIMPLE SCIENCE OF HEALTH LITERACY

“No flipping footnotes.”

It’s the politest rallying cry I’ve ever heard, but it encapsulates a vital truth according to Sally Snow, scientist, healthcare communicator and a health literacy expert at The Difference Collective.

“If it needs to be included, take the time and space to explain it properly” Sally tells me.

“The desire might be to give further detail, but footnotes impede understanding.”

I’m chatting to Sally about her work helping healthcare organisations across the globe to equip and empower people to make better health decisions. It’s clear that even though the discipline is having its moment in the sun, there’s still confusion and misconceptions amongst even professional communicators, which ultimately might be doing more harm than good.

But before we get to the sharp points on those pesky asterisks, I start by asking Sally about what’s in it for pharma.

Why should they care?

Sally Snow: “Supporting health literacy is about improved engagement with healthcare right from the start. You get more diagnoses because you have more people turning up for screening tests; more prescriptions because people get the right meds; more people taking their drugs more effectively and therefore staying on them longer-term.^{1,2} Ultimately, it’s a win-win for everyone.”

What’s standing in the way then?

Sally Snow: “Put very simply, health literacy is not solely about the ability to read. Yes, readability is one component of health literacy, and an easy one to measure, but to focus solely on that is to miss the point. Health literacy is being able to act in your own health interests. For many if not most people that’s as much about financial literacy and numeracy as it is about your reading ability.”

What is health literacy then? How should we properly define it?

Sally Snow: “Health literacy is the skills, knowledge and capacity required to find, understand, critically appraise and use information to make better decisions about health.”

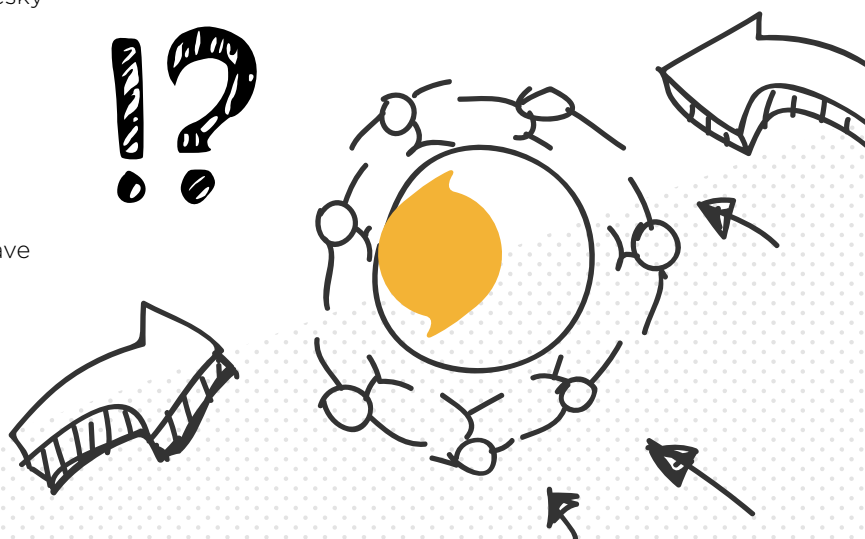
Extremely succinct, but I hear a “but” coming...

Sally Snow: “There is no universally accepted definition across the industry. It’s also not as straightforward as it might appear on first glance.”

Uh-oh.

Sally Snow: “Health literacy is context dependent – it’s as much about the health system as it is about the individual. For example, the standard of comprehension required to fully participate in the US healthcare system, getting your head round insurance, co-pays, and providers may be higher than that needed for the same person living in the UK.”

The statistics back this up. The US Centers for Disease Control estimate that up to nine out of ten people struggle with health literacy.³ In Europe the figure is lower (though still too high): on average four out of ten adults struggle with health literacy.⁴ It is all about the dollar bills, it seems.



So, geography and health systems matter. That isn't the end though.

Sally Snow: "Health literacy isn't static either. A person who is stressed or tired may have lower health literacy than the same person who is well-rested and calm."

Surely though, someone who has just received a diagnosis will be literally desperate to learn more? Not for the last time Sally disabuses me of my preconceived notions. I'm asked to imagine someone who has just been given a cancer diagnosis. They're frightened. They've a million questions and an internet's worth of "answers". Quite frankly they are in no fit state to process the information they are receiving. In other words, their personal health literacy is impaired – even if it's temporary – they may need additional support to comprehend and make the decisions they need to make in that moment.

OK, let's try and find some firm ground. What can we do about health literacy?

Sally Snow: "It's not rocket science – there is a lot that we can do. For a start, we can stop bombarding people with information. It's a common mistake to think that a patient must need all the knowledge. They may want it, but as communicators our job is to make the information easy to access, easy to understand, and easy to act upon. Not to dump everything all at once. This is one of the reasons why artificial intelligence (AI) could be so powerful for supporting health literacy. AI has the ability to synthesise a large amount of data and present it in an easily understandable way. Though this needs to be balanced against the challenge of validating the information presented."

The mention of AI's proficiency leaves me with a sinking feeling. Creatives pride themselves on finding ways to say things simply and impactfully; to reach the parts others can't. Are we doing it wrong? Thankfully, according to Sally, not entirely: "Understandable doesn't mean boring. You've still got to grab and hold people's attention. Just don't do it with holograms or unnecessarily fancy design."

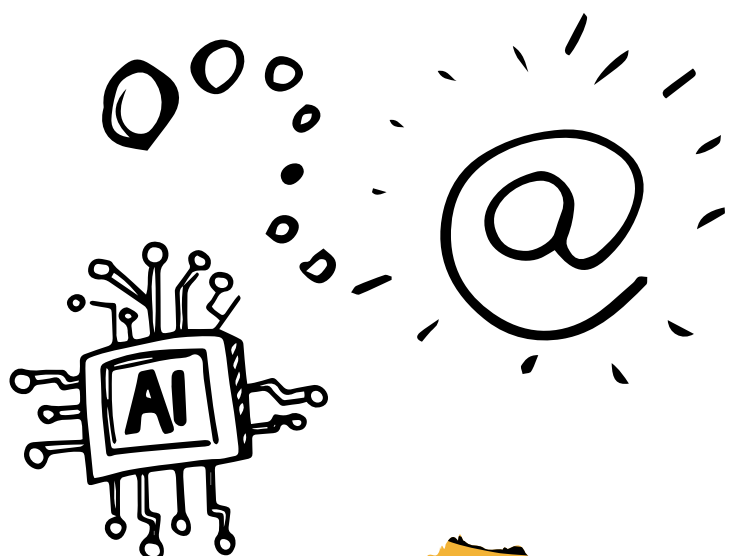
That's the copy. What about the art, the graphic design? It's clear that Sally feels there is room for improvement there too: "We spend a lot of time creating health information for trials and for disease awareness campaigns. Focus groups are a fascinating opportunity to see things through the eyes of your audience. You get such interesting insights into how people interpret icons and the instructions they are supposed to represent."

We discuss examples. The most obvious idea is using icons to illustrate the parts of the body. It seems so simple at first glance, but can we really be sure the image of a lung is understood? Do people even know what lungs look like? Anatomical not romantic hearts? And that's before you try to convey more abstract concepts like fatigue or pain. Health literacy principles challenge all of us to be more thoughtful, and yes, creative.

Now I'm properly enthusiastic. What should we be doing? How can we all get more on board?

Sally says: "Learning about health literacy is a really good start. The Patient Information Forum (PIF) has some fabulous materials. Try to consider different aspects of health literacy too, not just words and pictures. Increasingly, our primary means of engaging with our health and healthcare is through digital tools like apps and websites. Are they accessible? Are they built with digital and health literacy in mind?"

"The single best thing anyone can do is to ensure users have a voice in the testing process. When materials, concepts, protocols, whatever are being assessed with patients, consider health literacy."



USER TESTING FOR HEALTH LITERACY

The **Patient Information Forum (PIF)** has produced a brand-new guide to involving users in creating health information, which includes tips for how user testing can support health literacy:

- Screen for participants with limited health literacy skills using proxy measures, such as low household income
- Develop consent forms, and facilitator guides in plain language
- Limit the number of questions and tasks
- Pre-test your protocol with at least one participant with limited literacy skills, from your target audience
- Help participants feel comfortable during testing
- Choose a facilitator with experience of conducting research with your target participants
- Conduct user research throughout the project lifespan using multiple methods
- <https://pifonline.org.uk/>

<https://www.vizhealth.org/>

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3. 2021. <https://www.cdc.gov/healthliteracy/shareinteract/tellothers.html>. Accessed February 2024.
4. The Economist Intelligence Unit. Health literacy around the world. 2021 <https://impact.economist.com/perspectives/health/health-literacy-around-world-policy-approaches-wellbeing-through-knowledge-and-empowerment>

Testing takes time, of course. Time that pharma can claim to have too little of. Testing isn't the only casualty of timings. Here we have to confront the infernal footnote. Sally takes up the cudgels: "It's really important to get medical and legal buy-in really early in the development process. We all respect the law and the relevant industry codes of practice, but there is a balance to be struck. Diluting patient information with legal jargon, acronyms or footnotes often happens when reviewers are involved too late in the process."

No flippin' footnotes it is then. But how to banish them for good, Sally?

"User testing is vital here too. It gives medical and legal reviewers the confidence to act, to make the judgement of risk/benefit. If we are able to demonstrate that presenting information in a certain way isn't understood by the target audience, this could be detrimental to the safe use of medicines. Testing can provide the evidence to change minds!"

It may seem strange and counter-productive at first, flying in the face of perceived wisdom about communicating with patients, but health literacy has never seemed more vital. With ever more information from a diverse range of providers, separating what is important (Sally calls them 'actionable messages') from what is unhelpful, inaccurate or downright harmful can be harder than ever.

Pharma owes it to all its audiences to embrace the concept. And creatives can be confident that far from shutting down innovation, it provides a powerful new way to get inside the minds of patients.

MORE RESOURCES

<https://visualisinghealth.com/design-guidelines/>

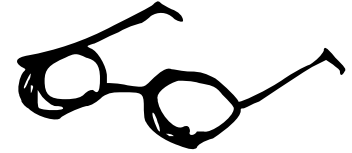
<http://www.vizhealth.org/>

<https://realrisk.wintoncentre.uk/>

<https://www.plainenglish.co.uk/medical-information.html>

WHY WE SHOULD USE POETRY IN HEALTHCARE COMMUNICATIONS

CHARLOTTE SHYLLON //
CHIEF CREATIVE OFFICER, BLACK IN WHITE



Poetry may not be one of our go-to tools in healthcare communications but perhaps it is one that we should consider using more often, because it is a proven and powerful way to drive change.

Charlotte Shyllon, Director of Transforming Words and Founder & Chief Creative Officer of Black in White, explains why.

I have always loved the written word. As a former pharmacist and pharmacy journalist, I made the shift into healthcare communications where my writing skills helped me find the job satisfaction that I had sought. But there was a part of my creative psyche that wasn't completely fulfilled in my new profession.

That's because most of the writing we do is constrained by the need to be mindful of the pharmaceutical industry regulations that govern to whom, what, how, why and when communications can occur. As a result, we sometimes fail to take the opportunity to get truly creative, conscious perhaps of those critical Medical, Legal and Regulatory reviews. One form of creativity that should be considered more often in a healthcare communications context is poetry.

When I went freelance in 2016 I started writing poetry in my spare time. This was mainly for my own consumption, and covered an eclectic mix of topics including love, health and family. Then following the killing of George Floyd in 2020, I was moved to write poems about some of my experiences of racism and unconscious bias. I set up Black in White as a social enterprise to 'share poems and open minds', and continue to elicit poems about other people's experiences via an annual poetry competition and publish them in poetry anthologies.

I'm a firm believer in the power of poetry to capture and communicate messages in an emotive manner, making it a brilliant medium to transform lives and situations. Poetry has been widely acknowledged as a form of emotional and intellectual therapy, and this is backed up by numerous research studies. Poetry can be cathartic, it encourages critical thinking, it helps to provide insights into different perspectives, it can build empathy, and when it's shared it can help forge connections.

Sam Illingworth, an Australian poet and geoscientist, says:

“POETRY IS A GREAT TOOL FOR INTERROGATING AND QUESTIONING THE WORLD.”

Illingworth believes that science communication initiatives too often comprise lectures and PowerPoint slides. On the other hand, poems build on a more common set of experiences. “Poetry levels hierarchies of intellect,” Illingworth says. When science communication involves writing and sharing poems, it invites a two-way dialogue between experts and non-experts.



THE PEOPLE'S POEM

Illingworth's point is beautifully illustrated in a project I participated in a few months ago after a former colleague, Edel McCaffrey, shared a LinkedIn post with me about a Sanofi initiative called the What If? People's Poem. I was immediately drawn in.

This project was part of a wider What if? programme that Sanofi is running centred around curiosity. They believe that "curiosity can be an extremely powerful tool, which can help us all to thrive by exploring new ideas and ways of doing things"; this is what delivers innovation within medical research. By harnessing the same curiosity to ask the big questions about health policy, in partnership with other healthcare stakeholders, Sanofi hopes to challenge the status quo, drive solutions-focused thinking and ultimately benefit patients.

Of course, Sanofi is not the only pharmaceutical company to have a vision to drive change in healthcare policy. What I love about Sanofi's approach is the creative way in which they have expressed and are delivering this. I would venture to suggest that the leap from healthcare policy to poetry is not one that many in the industry would make.

The People's Poem was one of the first ways in which Sanofi have moved forward on their What if? journey. Their nationwide project called for members of the public to "find their power in poetry" Entries were open to people of all ages who had a health-related story to share. Once the submitted entries had been reviewed, a selection of poems would be chosen for display or performance at a celebratory event on 5 October, National Poetry Day, with an opportunity to attend a workshop with the award-winning poet, Jaspreet Kaur. Kaur would also create the People's Poem, a piece inspired by the submitted poems.

I excitedly penned a few poems and duly submitted them. A few weeks later, I was delighted to learn that one of my pieces had been selected as one of the top 30 entries from the pool submitted by 149 poets. Titled 'What if diseases didn't destroy destinies?', it is written only with words beginning with the letter D. Verse 1 acknowledges the pain and suffering diseases inflict on people, while verse 2 highlights the need for more drugs to be discovered and prioritised, so more

people can fulfil their destinies. Short, simple and with a clear message.

All of the selected poems were powerful explorations of the What If? theme. Some spoke of personal health experiences, the emotions these evoked and, sometimes, the sad endings. Some dealt with specific health conditions or challenges in a hopeful and inspiring manner. Some were written by carers who told stories of a loved one's health issues from their perspectives. Whatever the content, form or style of poetry used, the idea was to challenge people to be curious and creative, and to give them a chance to be heard.

The resulting People's Poem is a beautifully and expertly crafted piece that pulls together the voices of the people who shared their stories, in the hope that we can "break down barriers that exist within health and come together as a community to drive change". This poem, as well as all of the top 30 entries that were displayed at the Battersea Arts Centre, can be read on the [Sanofi UK website](#).

As well as the direct benefits to those who were a part of the What If? poetry project, the People's Poem has armed Sanofi with a credible and compelling 'door opener' to initiate conversations with other healthcare stakeholders. The potential for dialogue and cooperation is immense.



POETRY AND HEALTH INEQUITIES

The beneficial link between poetry and health equity is well-established and is increasingly visible. The People's Poem is just one example of how engagement with the arts, including poetry, can help to reduce health inequities.

In January last year, the Journal of the American Medical Association (JAMA) launched a new commentary section designed to increase the visibility of the poems it publishes in Poetry and Medicine from scientists, clinicians, patients and carers. These poems explore a variety of themes and topics, including health inequities, and the journal reported that the number of submissions it received rose during the COVID-19 pandemic. Announcing this new commentary section, the article's author Rafael Campo invited readers' responses through an online commenting function "as we consider together the healing power of human expression, that we reckon through science and feel through art makes possible a healthier world."

The [Good Listening Project](#), a US-based initiative, also utilise poetry in their operations. They have Listener Poets who connect with individuals in healthcare organisations in one-on-one listening sessions and then write a bespoke poem for them. They use the poems to facilitate meaningful conversations among the organisation's staff, with the aim of "strengthening the social fabric within healthcare systems and contributing to a culture where people care about each other's wellbeing".

In April last year, they ran an event called Just Poetry, a live fundraiser and online poetry reading themed around actions for transformation. This included stories of courage in the face of inequities designed to spark systemic change, fuelling an "equal care world where feeling heard, safe and seen is the norm".



The People's Poem highlights video includes Charlotte Shyllon (L) and Jillian Shields (R), two of the poets whose poems were featured at the Sanofi event.

See <https://www.sanofi.co.uk/what-if/Peoples-poem>

In an article published in *Annals of Family Medicine* in May 2023 about the use of arts and poetry as a novel approach to enhance patient care and job satisfaction, the authors explain that some of their most meaningful and beneficial activities include times when they invite patients to tell their stories through art, poetry and music. They find that most patients agree to participate, and regardless of race, gender, language and socioeconomic status, patients who value holistic care find these activities valuable. Sharing poems with patients gives them an opportunity to express submerged emotions that are often directly relevant to their care.



INTEGRATING POETRY INTO WHAT WE DO

The few examples I have shared provide some insights into how effectively poetry can be used in a healthcare context to deliver positive outcomes for patients, carers, healthcare professionals as well as other science, medicine and health policy stakeholders. I have felt and seen its benefits directly through the poems I write and elicit to curate into anthologies, giving people an opportunity to share their experiences and be heard.

I believe poetry should be considered for integration into healthcare communications activities where possible and appropriate. As healthcare communicators, we have a role to play in encouraging our organisations, clients and partners to step outside of the tried-and-tested norms and embrace new ways of thinking and doing what we do.

Why not think poetically?

Charlotte Shyllon has worked in healthcare communications for over 25 years including, for the last seven years, as a senior freelance consultant. She is also a poet, and set up a social enterprise called Black in White in 2020 to share books of poems about experiences of racism and unconscious in the workplace and in childhood. She believes in using the transformative power of words to bring insight and illumination to important issues.



Charlotte Shyllon's poem, 'What if disease didn't destroy destinies?'

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WHAT IF DISEASES DIDN'T DESTROY DESTINIES?

By Charlotte Shyllon

Despite doctors doing due diligence,
Difficult diseases depress, distress, dismay.

Dangerous diseases destroy, decimate,
devastate.

Deadly diseases deliver doom, despair,
death.

Discover different drugs.

Don't delay decisions.

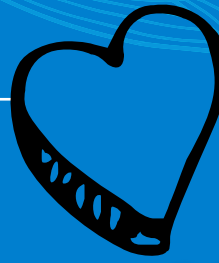
Dose diligently.

Diminish diseases.

Deliver destinies.



US CASE STUDY: BLOOD EQUALITY



JESSICA SPANO //
FCB HEALTH,
NEW YORK

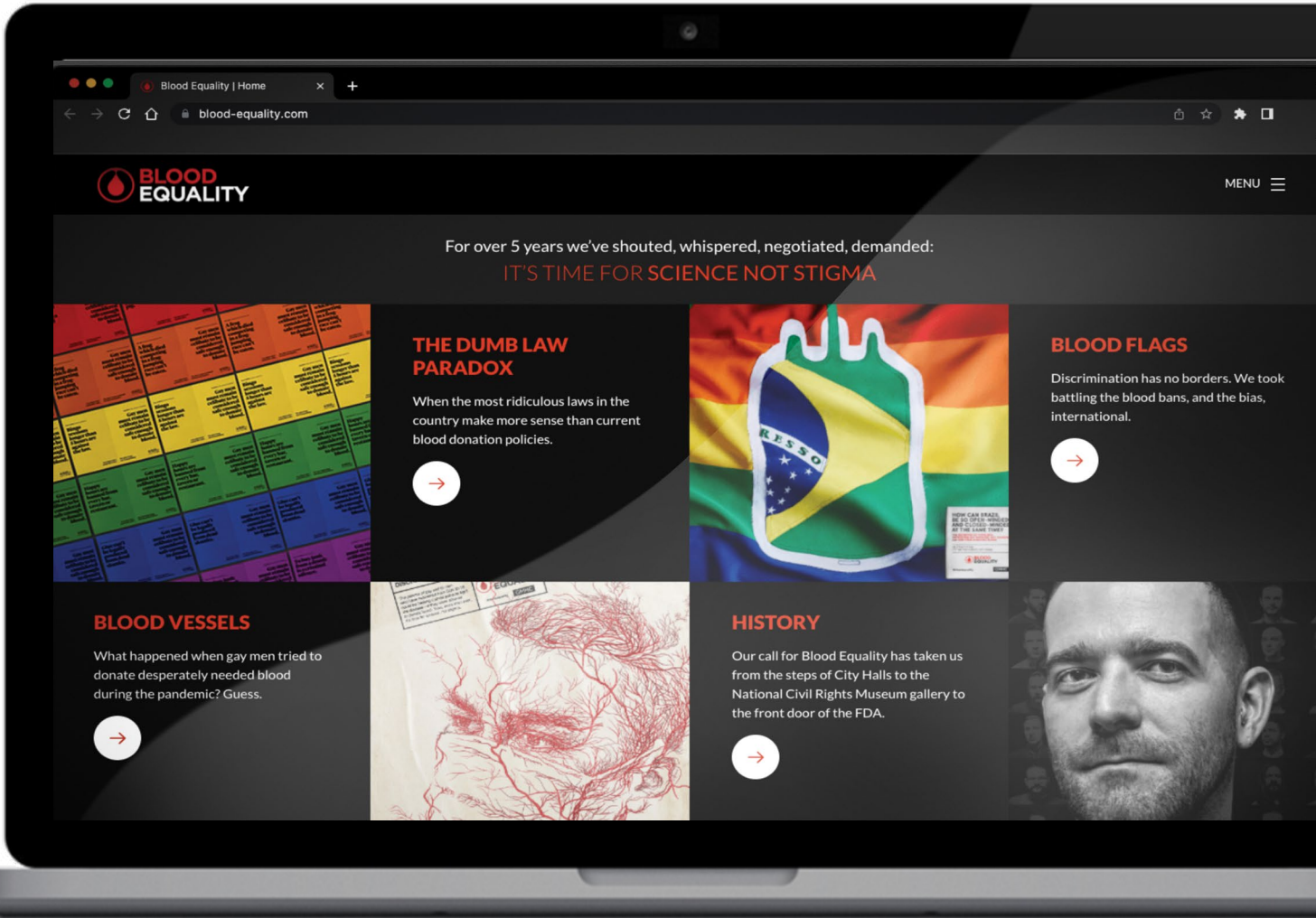
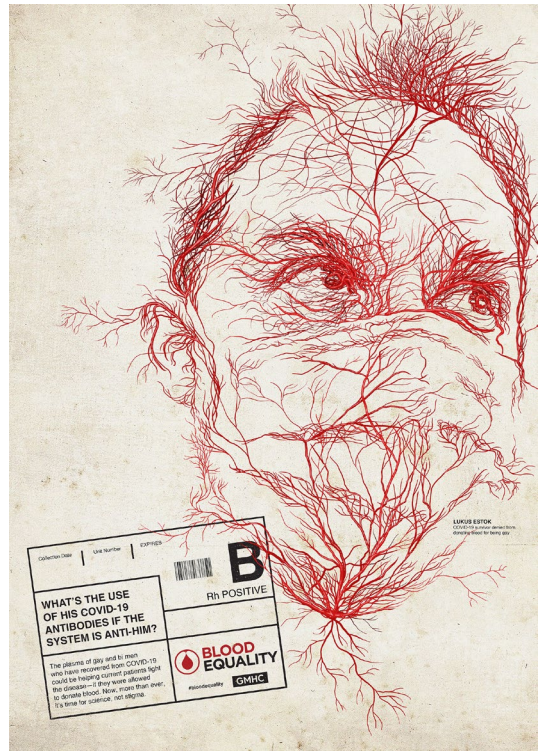
“ A 7+ Year Commitment between FCB Health New York, An IPG Health Company and Gay Men’s Health Crisis (GMHC) to stop the discrimination against gay and bisexual men and give everyone an equal opportunity to donate blood in the US. ”

All blood is not created equal. That’s the message that gay and bisexual men receive when they attempt to donate their blood.

That’s not to say we have not seen tremendous progress - when we launched our Blood Equality effort, a complete ban on “gay blood” was still in place in the US. We continue to fight, and saw the rules change to a 1-year and then 3-month celibacy requirement, to today’s risk-based assessments for all donors. Progress.



However, today many gay men are still prevented from donating blood – if they're on PrEP (pre-exposure prophylaxis) therapy, or engage in anal sex. Stigma at any level begets discrimination, and cannot be accepted. The science here is more complex, and while we are pleased that Blood Equality played a role in helping to advance the policies, we're still looking for the day where all blood is truly created equal.



BLOOD EQUALITY: HIGHLIGHTS

Our initiative has sparked massive media attention, action on the floor of the United States Senate and Congress, and awareness across the LGBT community and beyond.

Blood Equality and One In Our Blood exhibits were featured at the National Civil Rights Institute in Birmingham, Alabama, the Birmingham Public Library, University of Alabama Birmingham and more.

Our efforts caught the attention of the one organisation empowered to change things: the Food & Drug Administration (FDA). Blood Equality helped influence the FDA's decision to open up a public docket, and played some small part in the FDA's change from a lifetime ban to the current policy. Most important, perhaps, is that the FDA personally attended our Blood Equality Medical Advisory Board meetings, where we assembled thought leaders from blood safety, infectious disease and advocacy groups to discuss and debate a path forward.

THE BLOOD EQUALITY CAMPAIGN

included television and cinema public service announcement; print ads, posters and installations; BloodEquality.com with a robust social media effort (Facebook, Instagram, Twitter); FCB Health Artist in Residence: Jordan Eagles (BloodMirror.com) whose vision helped define the overall aesthetic; Blood "Selfie" Tool allowed people to "become" part of the campaign and spread the word to their social networks; World Blood Donor Day Art installations, global "Flags" campaign, Jordan's Blood Illuminations on the High Line and "Blood Dumpster" in Chelsea for NY Pride; Political push: helped spark members of the U.S. Senate and Congress directly asking the FDA Commissioner to lift the ban; 21 men, 21 days from World AIDS Day - December 21 - the anniversary of the FDA's policy change; One In Our Blood and Blood Equality efforts featured across Birmingham, Alabama, including being featured at the National Civil Rights Institute.



CONCLUSION:

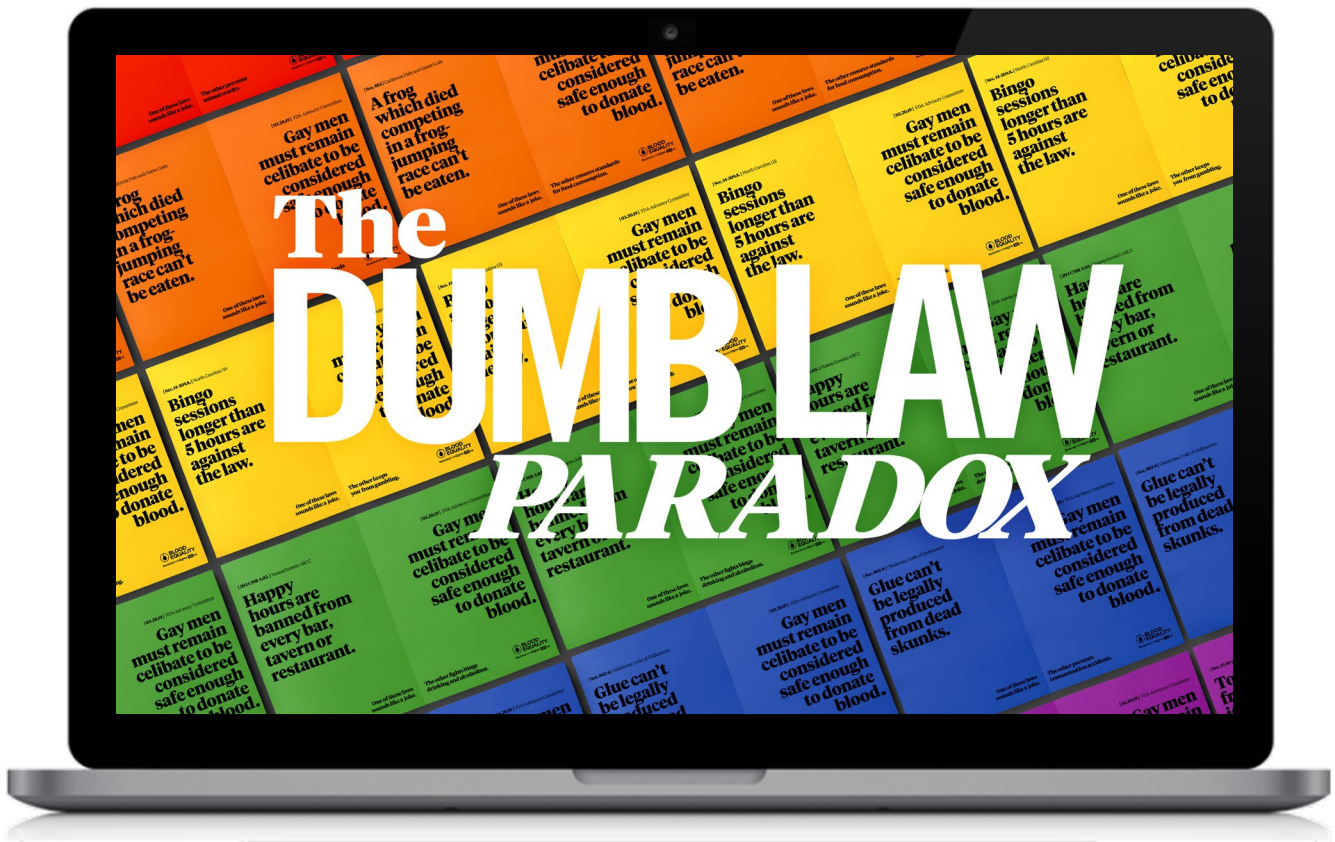
We achieved our primary goal: The FDA joined our Medical Advisory Board, which helped advance the policy over the past few years to today's risk-based assessments.

The campaign generated massive media attention, including The NY Times, The Guardian, PBS, Business Insider, Bloomberg, Forbes, Mashable, The Hill, CNBC, Daily Beast, Newsweek, Vice, WINS, WOR, NY1, ABC, NBC, HuffPost, Univision Noticias, Observer, Brooklyn Patch, NY Daily News, AdForum, Advocate, Metro, International Business Times and dozens more.

- Art Installations and art events reached millions: "Dumpster Art Project at NYC Pride (2.1 million attendees)
- Jordan Eagles Blood Mirror events in Washington DC and New York City drew hundreds of attendees and massive media attention

- ESI Media: 1 million impressions for Guardian/Independent (500+ placements)
- MedScape, MedPage Today, MDLinx, Body Pro and American Family Physician covered the BLOOD EQUALITY campaign and the push for an end to the stigma
- Medical Journals: Medical Economics, Journal of Family Practice, Clinician Reviews covered the BLOOD EQUALITY campaign and the push for an end to the stigma
- Screen Vision Media: 2,900 movie screens in 623 theatres in the US, 2.45 million impressions

Our protest + science approach struck a chord. But the fight continues until every pint of blood is treated equally. Until there is Science, Not Stigma.



DATA-DRIVEN CREATIVITY: WHO CARES?

DOMINIC MARCHANT //
CHIEF CREATIVE OFFICER AT OPEN X HEALTH



I read a Ricky Gervais interview last year and he compared his two main genres of work: written and recorded work; and stand-up. The writer, producer, director, and lead actor of several award-winning TV series has also made a name performing in stand-up comedy tours over the years. And he says that live performance is fundamentally different to recorded work. With recorded material, you put your best thinking, writing, producing, acting into several hours of “baked” content and release it out to the world

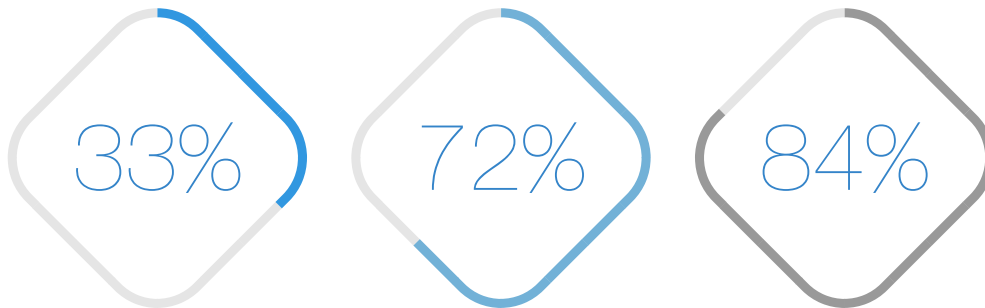
with your fingers crossed. With stand-up, you get to learn and course correct - constantly - and it feels “less like an art form and more of a science”. If the audience laugh, you keep the material. If they don’t, you change it or kill it.

And it struck me that the above is core to what we mean by data-driven creativity. The data are simply there to course correct your message/campaign.

Let me take you through the five steps of data-driven creativity in action with a charity campaign:

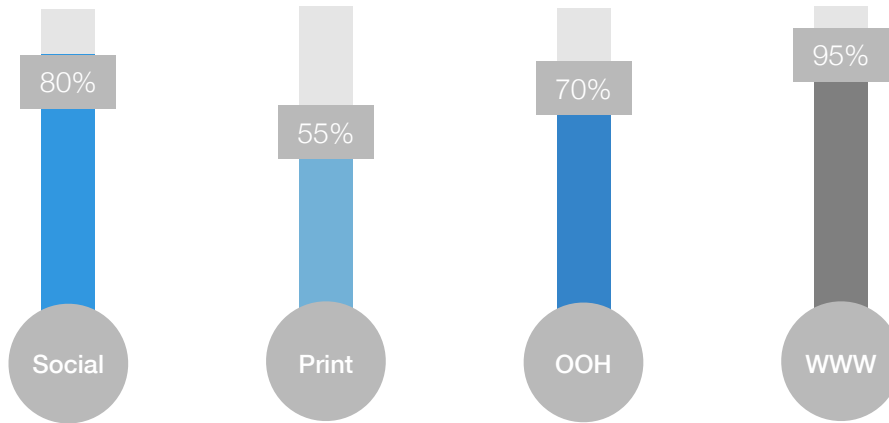
The Process

1. Evaluate core campaign messages with control groups to **predict** which concept will generate maximum donations

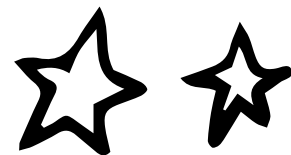


With a large group of friendly faces, we tested 3 different creative “territories” - three sets of messages/creative that look like the beginnings of a campaign - to evaluate which route will do two things best: generate clicks to a website; and then, for those clicks to convert into donations.

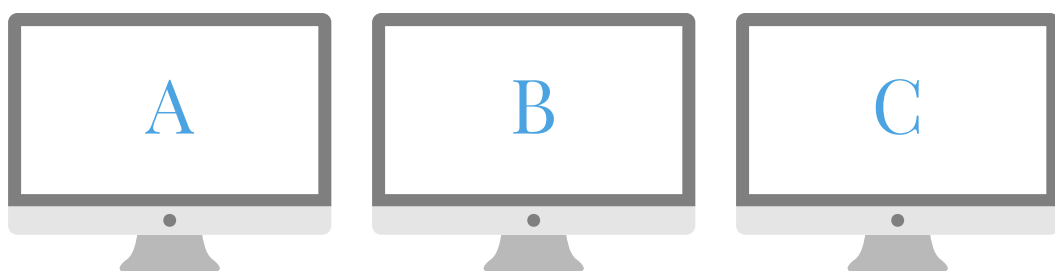
2. Find the **optimal channel** mix based on customer data



Working with a media partner, we work out which channels are going to work best for us (considering budget, previous campaign performance, locations, etc.) to deliver maximum visibility and click-through for our campaign.

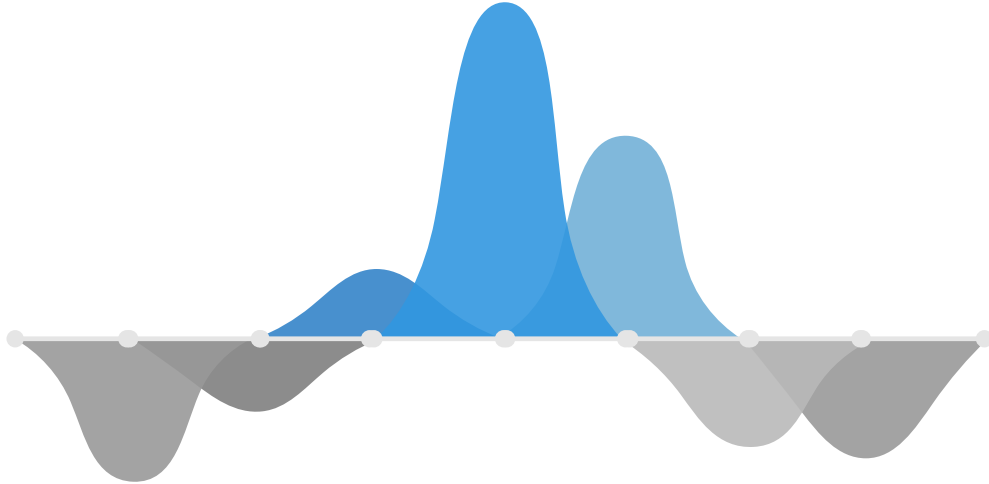


3. Develop campaign creative assets - theme and variation (**multiple versions**)



Having worked out what the campaign message and creative looks like, and where it will all live, we now develop theme and variation of all assets. In short, we develop a campaign with A/B testing at the heart.

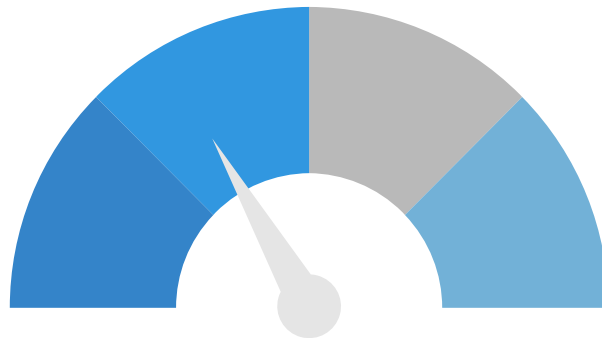
4. Assess performance of all creative assets in all formats/channels



So, we've got a campaign with many small variants in the collateral - often tiny changes in the headline, the call-to-action, the key visual - but, most importantly, all the creative looks fundamentally the same. This is about testing small variations on a theme to see what

works best. And, using a simple dashboard, we can see what works well, where, and with whom. (We can see a heck of a lot more but we need to focus on meaningful data to drive decision making.)

5. Redeploy creative assets based on results of above



Having assessed the performance of our collateral, we can course correct - make small changes to the media inventory, the channel choice, the messages even - to ensure we are constantly dialling up or down

based on what our target audience are doing. This is performance marketing, all with the intent to maximise the effectiveness of our campaign.

And here's the top performers in the inventory. Four different ads but all clearly part of the same campaign.



This was a 7 day campaign. At day four, the data showed that we were on course to make £1.25m in donations. But the dashboard also showed that if we changed the inventory to just include the top left creative, we would increase our total to nearer £1.5m. And, in fact, this was the result:

In summary, we've used data to show which of our proposed creative routes will probably work best. We've used data to find out which media is best suited to our budget and target audience. And we've then used data to assess the performance of our A/B testing and fine tune the effectiveness with tangible results.

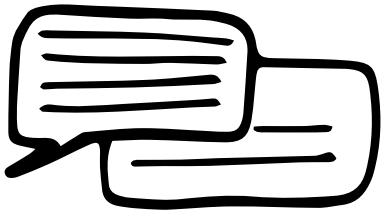


So data are useful. But they are still, ultimately, measuring a campaign and at the heart of the campaign is the creative. At the very beginning of this process, we tested three creative territories and these informed which route we would adopt. Each of these routes had to be good otherwise you are simply measuring which is the least "bad" of the

options. Similarly, the A/B testing had to include creative that elicited a response (all of the 4 ads above had above average click-through rates). In simple terms, you need strong theme and variation options in your campaign and you need to assess which is the strongest to suit your KPIs. In this instance, the KPIs were simple: number of click throughs; and donations.

Keeping the metrics simple and easy-to-measure is paramount as otherwise you can end up measuring everything at the expense of capturing only what you need to know to make quick and informed decisions.

Now, whilst this is a simple and (hopefully) effective example to demonstrate the principle of data-driven creativity, it is not an example from the pharma space. There will be many folk quick to note that medical, legal, and regulatory requirements make getting even one piece of work signed off is hard enough let alone 3 (or more) variations on a theme, that measuring effectiveness of a campaign to raise money is easier than the more nuanced KPIs of a brand awareness campaign (for example), that pharma clients dashboards or CLM platforms are, ahem, sometimes more complicated than I've illustrated in the above example.



BUT

The fact remains that this approach can and has worked in the industry. At global and local levels. Market research is nothing new within the brand promotion space in pharma. However, testing creative routes online as opposed to via face-to-face focus/steering groups ensures that we can get larger numbers in our data. Many large global campaign testing phases include large group sizes from each market within the campaign roll-out so our global brand managers can produce empirical evidence suggesting that each market's target audience's

feedback has been incorporated. We also get cleaner data as, when testing online as opposed to within meetings where often the loudest voice dominates the room, we are gathering feedback without herd bias. All of this testing is typically the same cost or even less expensive than conventional market research and often much, much quicker. When deploying content, the A/B testing is cemented into the roll-out (with guidance via the playbook) and global assets are often produced with multiple variations, although local markets/agencies are encouraged to develop yet further variants based on market needs. The data collated (assessing performance) are used to course correct and, in many situations, the results are readily shared across markets in the form of best practice sharing.

None of this is rocket science. And the devil is in the detail - what data are you using? How good is the creative that you put into the mix? How do you recruit your testing audience? What dashboards do you need to ensure the results are robust and meaningful?

But the most surprising result I have noticed about this approach is that it actually encourages braver creative output. For example, when testing 5 different creative routes in a recent campaign we had the safe option at one end and the "the client will never sign off on that" at the other. After testing with over 200 dermatologists, the "bravest" route was chosen by our target audience - and there was a significant gap between 1st and 2nd choice.

As we say in our pitches, it actually doesn't matter what we (agency) think, what you (client) think, but what your target audience thinks. So, to the question in the title of this article: who cares about data-driven creativity? At a time when the industry is questioning every dollar spent on communication, perhaps we should care about utilising data more in our evaluation of creativity to ensure it is as effective as it possibly could be.

IT'S EVERYTHING PERSONAL

DRIVING HEALTH LITERACY THROUGH GENUINE CUSTOMISATION

TIM GOMERSALL // MANAGING DIRECTOR,
THE GOOD IDEAS GROUP.



01

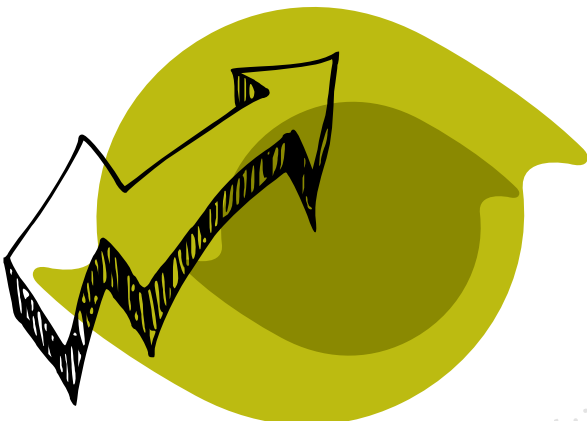
INERTIA CREEPS

You can tell someone a story, but you can't make them listen.

Nobody understands this better than healthcare marketers. If only we sold smartphones, right? Just tell people how many lenses it has and watch the queues form.

But we don't sell smartphones, and we're proud not to. But we're often selling the app on that smartphone. The one that might be telling people to lose a little weight, or to see a GP about that persistent cough. Things that are difficult, perhaps even frightening, to hear. Things they don't want to queue for. Much easier to defer, deflect, decline.

And when people are looking for any reason not to listen, we need to do everything we can to reduce the exit ramps between them and the action they need to take.



02

US AND THEM

That starts with recognising that 'them' is a fiction; a collective term that fails to capture the million 'me's it usually encompasses.

Maybe our campaign has a median patient somewhere, but everyone else sits off-centre. If we build an online - or any other - campaign around that median patient, then everyone else is going to feel a degree of distance right from the start. We're giving them that exit-ramp. A reason not to listen.

If a COPD awareness site's banner-image features an elderly male smoker on it, it won't connect with a young woman who's never touched a cigarette but has COPD anyway; and she's the one most likely to fall through the cracks precisely because her GP isn't looking for COPD in her.

The same applies to professional audiences. Delivering a clinical narrative with enough deep-cut detail to satisfy seasoned secondary care specialists risks overlooking all the primary care rookies who need the 101 version, and vice versa.

Deep down, we know this. In a perfect world we'd have suites of materials for every audience subset, rather than delivering a singular experience to myriad demographics. Historically, budget and time have prevented this.

Happily, that's changing.

03

IT'S ALL ABOUT YOU

We're entering an era of truly personalised digital experiences. It's begun with social media, where Zuckerberg et al have made it a breeze to target people courtesy of the massive amounts of just-about-consensual data they hold.

So... our young woman with COPD sees something on Instagram encouraging her to visit a site. But then we're back to the same problem. What's the point of a targeted social campaign if the site it leads to doesn't similarly reflect her singular "experience"?

That's where things are changing. A website, app or game that knows who you are and creates an experience around you, is invariably going to keep your attention more than one that doesn't. So that should be our goal, and it's already achievable. Smart use of readily-available or readily-attainable user data allow us to present the same messages completely differently, depending on who's looking.

We can ensure:

- The story is structured to reflect their experience
- The imagery is selected to reflect their identity
- The content is arranged to reflect their priorities

Consider how we've been putting drop-down country menus on our sites since forever, allowing people to choose the language. But that's never been enough. We can, and should, be tailoring everything else.

It's not only possible, it's sensible.



04

THANKS FOR THE INFORMATION

So how does it work?

Starting at the shallow end, most people coming to a website arrive with a public IP address that immediately signals what country (and region) they're logging in from. Healthcare platforms (and everyone else's) are already using this information to trigger different language states. A person from Barcelona goes to the site's Spanish-language mirror; this is already standard practice. And there's no reason to stop there when you can have a banner visual with the Sagrada Familia out the window (I know, but you get my point).

It's a good start. But there's a couple of reasons IP tracing isn't enough. For one thing, there's still massive diversity within national populations. Plus, a growing number of people are using VPNs to hide their public IP address – for privacy, yes, and also because it's an excellent way to access Netflix when you're travelling.

So yes, effective personalisation does require data actively provided by the user. A quick on-arrival form which asks for key information, cookies that information, and signals the platform what to display.

Wait, come back! An upfront form doesn't automatically mean you're bouncing everyone away, for a couple of reasons.

01

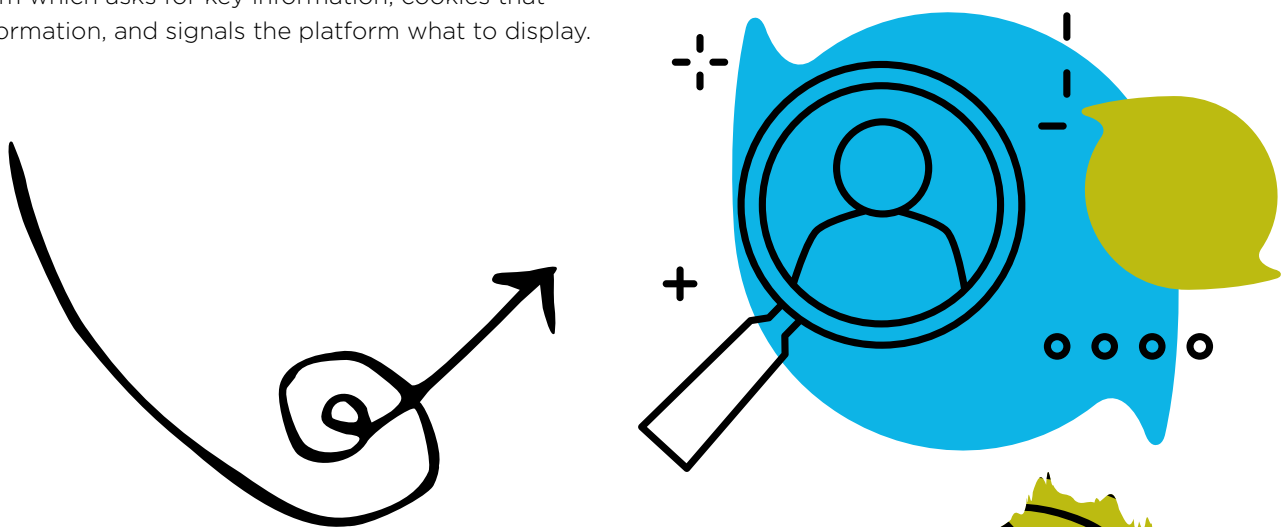
For one thing, a little judicious UX and design expertise can make the data-capture experience as pleasant as it is compliant.

02

More importantly, this is where we humble healthcarers have one over on those ritzy smartphone-sellers. Healthcare platforms inherently request information. When a visitor to our theoretical COPD site asks about smoking, they'll understand the question comes from a desire to offer help, rather than to judge.

So within thirty seconds we know our user is a 50-something Caucasian female non-smoker, and the site that loads for them is wall-to-wall relevant to her. The imagery reflects her. The newsfeed is focused on events near her. The blog leads with an interview with a chef at the top: "Years of cooking with oil gave me COPD".

And now... she's listening. And listening leads to literacy.



05

GET THE PARTY STARTED

There are other ways to skin this cat. For professional audiences, for example, building a full login system and plugging a CRM into it allows you to create expert-level and entry-level versions of your platform, with recommended content aligned to their interests. Just like Deliveroo remembering what you ordered last time, except with more advocacy and less avocado.

And yes, a login can do great things for the personalisation of public awareness platforms too, but I'd humbly suggest that - when compared with a less intrusive arrival form - it adds a lot of admin for relatively little return. Find us on LinkedIn for a full-nerd debate on that; if we're proven wrong it'll be because enough exploration has been done for us to know better, and that will be absolutely fine.

But however we do it, the underlying principle is the same. Personalised paid media works. So why not personalise the destination?

Hubspot, who admittedly have a (very) vested interest, ran a study that found personalised calls to action had a 202% better conversion rate. But that was across all sectors and focused on commercial transactions. In healthcare, more research is needed on the balance of benefit; is the increased quantity of bounces worth the increased quality of visits? Answering that requires data, and the only way to get data is to set goals, then stick our necks out and try it.

To sign off that pilot and see what happens.
To learn from failures and build on successes.
To get better at it, and get used to it. To lead the way for others.

To innovate.

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1. 15 Call-to-Action Statistics You Need to Know About to Increase Your Conversion Rate. Available at: <https://blog.hubspot.com/marketing/personalized-calls-to-action-convert-better-data>



Be
Brave





**FEAR
OF FAILURE**

RICK EVANS //
SOCIAL STRATEGY DIRECTOR, 90TEN,
PART OF ENVISION PHARMA GROUP

FEAR OF FAILURE: THE PERILS OF NAVIGATING PHARMA SOCIAL MEDIA IN THE UK

Pharma communications have been traditionally siloed into different content streams for different audiences. Primarily, this includes content for healthcare professionals, content for prescribed patients and content for the general public.

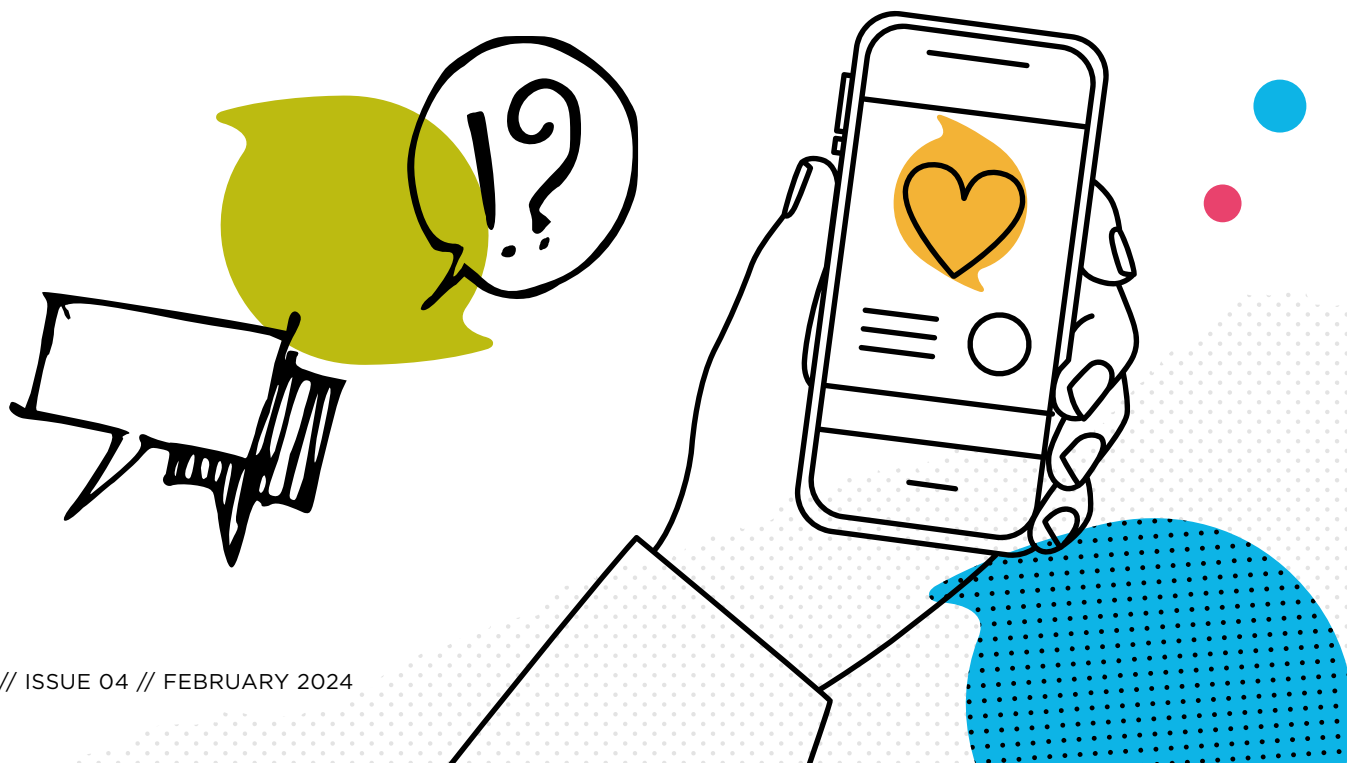
This is hardly a surprise. We work in a highly regulated industry where the penalties for communicating the wrong message to the wrong person can be severe to say the least. Many of the fundamental rules that dictate these siloes have been around for years, and countless refreshes of the ABPI Code of Practice, the iron fist which rules, and sometimes beguiles, those at its mercy.

Over the past 10-12 years, social media has thrown a massive spanner into the works of this machine.

In an environment where we had separate websites for healthcare professionals and patients, where professional content was firewalled and password protected, where conference exhibition centres were forbidden environments for the general public, suddenly we had a new medium in which everything was for everyone, all in one shiny newsfeed.

In the early days of the social media revolution, these channels were all seen as the preserve of the young. They were faddish, not something to take seriously, and hardly an environment in which we could expect serious, time pressured professionals like doctors to frequent. And that was not even factoring in the unpredictable ways in which, powered by mysterious Silicon Valley forces, these platforms appeared to mutate and evolve overnight, bringing new features and functions with alarming rapidity. With the parallel emergence of the smartphone, the social media world went into hyperspeed. Increasingly it looked like this was a space that would leave the sometimes lumbering world of pharma communications far behind. But again, this was hardly a surprise. Social media was dangerous, unpredictable and questions about the user demographics aside, lacked the necessary safeguards and controls that would make it a suitable communication vessel for such a strictly regulated industry.

Of course, in that, some would say, halcyon period, the social networks were not properly monetised; there were no ads on the newsfeed, and the channel owners had not built back-end business platforms that allowed marketers to target or 'dark post' content to specific audiences based on demographics, job titles, and subject matter interest. Yet, these developments have also given content creators greater powers of moderation, the ability to include community guidelines that dictate what can and cannot be discussed on a specific social media page, along with the power to remove unsuitable comments in a timely manner. All factors that allow for better regulation of content.



During the past decade the demographics in the workplace have shifted, and now millennials make up the largest segment of the UK workforce.¹ This has brought about a huge cultural shift. In my experience developing social media strategies for pharma clients, in the early and most cautious days we would never have even thought about using these channels to reach healthcare professionals. Aside from the aforementioned youth-focused air about this new medium, there was also a perceived lack of seriousness. An environment in which one might share pictures of a night out, or comment on celebrity headlines, was hardly the domain of serious conversations about health.

But it quickly became clear that this was indeed a great environment for patient organisations to connect with their memberships, to share messages of prevention, to call for action and to provide a safe space for discussion, bringing together many people who would not typically be able to interact with people going through similar experiences on a day-to-day basis.

But still, this did not really feel like a place to engage with healthcare professionals. For starters, there was a lot of misinformation out there, and in the early days the channel owners had not built technology to counteract this. Arguably, this is an even bigger issue today, where false information is rife, but there is a greater understanding and dialogue about its influence. Then, there was the issue of demographics. Were healthcare professionals really using these platforms? And if by some chance they were signed up social media users, then did they really use them for professional purposes? The answer to this question in the early days was almost certainly a resounding no. But over time, with the rise of Twitter (now known as X) and LinkedIn we started to see more serious topics entering into the social media conversation. I remember spending a lot of time in those days, looking for data to support this shift, and



prove to clients that healthcare professionals were really starting to connect on these public platforms. It was hard work. For every project we would be looking to find out if specific professional specialty was using social media, and we would need to provide hard evidence to convince our clients that any communications exercise on the channels was worthwhile.

Would neurologists be more interested in tweeting than cardiologists? Did Spanish immunologists like to use LinkedIn? Data, where it could be found was expensive, and would not always manage to convince.

But somewhere along the line something shifted. Social media was becoming so ubiquitous, so much a part of the broader cultural conversation, that it became inescapable. Pharma companies were building in-house social media teams and starting to take the channels seriously. In my job as a social media strategist, I was no longer trying to convince clients to use social media platforms to reach healthcare professionals as well as patients. Social listening exercises we carried out revealed that there was a real growth in healthcare professional social media discussion, especially around congress. It became tacitly acknowledged that these communities were growing, and the question was no longer should we use these channels, and more likely to be how do we use them?



But amongst the many smaller challenges and pitfalls, there was and remains a primary barrier to the pharma industry's adoption of social media: the breakdown of the siloed communication model. Suddenly companies were using one newsfeed to post content to multiple audiences whether those be patients and the general public, the media, investors or indeed healthcare professionals. It's true to say that some companies have opted to create specific pages for different audiences, for example, at a regional or professional specialism level. But due to limited geo-blocking facilities, there is very little an organisation can do on most social channels to prevent the general public from seeing all of the content it posts.

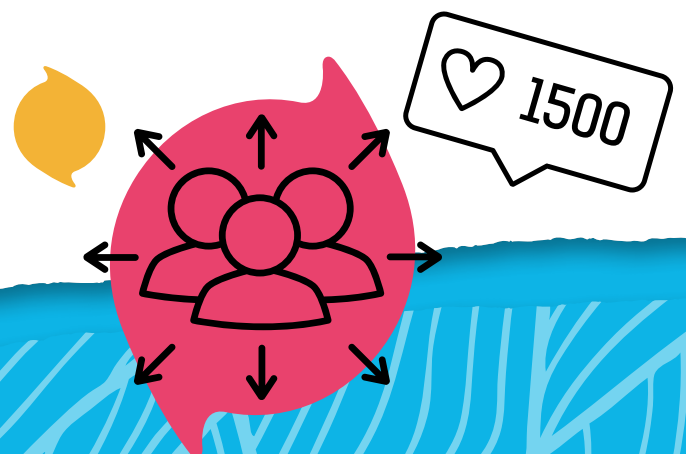
Over time this has created a larger and knottier problem. These are now channels used widely by healthcare professionals and the general public alike, but the targeting capabilities have been designed to help content reach a relevant audience and not to block an inappropriate one. Although the pharma industry can reach healthcare professionals on these channels, in most countries it cannot talk about prescription only medicines or any subjects that it would be unsuitable or even illegal for a pharma company to communicate to the general public. So despite the wide use of these channels, they do not always present the greatest opportunity for candid dialogue between pharma and its professional audiences.

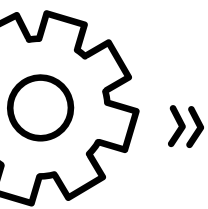
Although for many years the ABPI in the UK did not provide specific social media guidance, the general principles of the code were expected to apply to this newer medium. Broadly this means, do not communicate the wrong message to the wrong audience and you will be safe from rebuke. But in practice this has proved problematic. The algorithms that underpin the social channels and provide an optimised user experience, are capable of weird and wonderful things. Just 'liking' a post by another user can make content on one's own social newsfeed be shown to another user, as UK pharma employees have occasionally discovered to their detriment, when engaging with a post by a US colleague mentioning

a brand name has inadvertently meant the post was then shared with members of their own personal network, including non-healthcare professionals. And the penalties for this type of misdemeanour can be severe. Indeed, a breach of this nature has resulted in a pharmaceutical company receiving the most serious verdict: the dreaded Clause 2 breach which is "likely to bring discredit on, or reduce confidence in, the pharmaceutical industry."²

In the past few years, there have been more of these stories, as pharma companies and their employees have made mistakes that have put them in foul of the code. The fact that it is easy for a small error to have large ramifications has seen a greater focus towards in-house social media compliance training, and thankfully earlier this year, to the arrival of specific social media guidance from the PMCPA (Prescription Medicines Code of Practice Authority).

I was one of the first eager readers of this new guidance when it was published in January last year, and I was gratified at how thoroughly the document explored different aspects of social media, from working with influencers to tagging. Although there was nothing particularly shocking in the guidance, or divergent from the central tenets of the ABPI Code of Practice, it was such a relief to have proper wording around specific social media functionalities that had sometimes felt quite hard to align with documented regulations. I also found it very encouraging in that it did not close off social media or discourage it in my eyes; merely advocating for caution, whilst providing examples of cases that were challenged and sometimes exonerated by the PMCPA.





I was keen to find out how the new guidance would be received in practice. And I was quite surprised when I heard from the teams I was working with that rather than providing reassurance there was an increased fear around using social media. 'We're not allowed to use hashtags any more,' said one social manager to my team. This surprised me, as the guidance does not say hashtags cannot be used, but to exercise caution around their use, as a hashtag is in effect a link, and the pharma company cannot be responsible for the content at the link's destination.

This is true, as the hashtag link takes the user to a newsfeed of the most recent or popular uses of that hashtag. But the real purpose of the hashtag is primarily discoverability. Users follow hashtags to learn more about a topic. It's a way for the pharma company's content to be more visible to the audiences that matter. Granted there are situations where the hashtag could be more likely to lead to inappropriate content. If a pharma company posted on social media using #bcsm (a popular hashtag for breast cancer related topics) in the same week it had a new product launching on the market, it could certainly be perceived as problematic. But on a quieter week there would be a very small chance that this widely used hashtag would bring up related content. It would also be possible for a company to document what content appeared at the link at the time of posting in order to be able to demonstrate, should the challenge arise, that there were no branded mentions at that moment.

In an excellent article for Pharmaphorum, Wendy Lloyd-Goodwin wrote about some of the difficulties with the new guidance including both the subjective nature of interpretation of the document, as well as the fact that there is a conservative approach to the behaviour of third parties, for example influencers, over which they have little control.³

Indeed, such is the level of personal responsibility that lies with individual signatories, that it feels like there has been a more conservative approach taken to the use of social media than there was before the guidance existed. From my own experience I have seen a withdrawal of social media activity in the UK pharma environment over the past year. Indeed, a communications and patient affairs manager for the UK affiliate of an international pharma company told me:

"The new guidance published by the PMCPA earlier this year does seem to have made it more difficult to gain approval on projects that have social media elements. While the guidance gives some more clarity, how it is interpreted is still quite subjective, and can leave review teams hesitant to take any risks that may fall within this grey area. The guidance creates a barrier to developing content that is both engaging and that reaches the intended audience. Non-promotional disease awareness content that is otherwise in scope of the ABPI code is now often coming into question, and pharmaceutical companies feel they must put huge disclaimers on everything to ensure they aren't liable. Content becomes unsightly, distracting and likely disengages the intended audience. Getting your review teams on board early can alleviate some of this and help to navigate some of the lack of clarity, but there is definitely a hesitance across the industry on social media at this moment."

Despite some of these concerns, I am really proud that we now have social media guidance to help pharma companies in the UK navigate these waters. And I absolutely commend the PMCPA for covering so many different areas, in what must have been a very challenging document to pull together. But these channels are here to stay, misinformation is on the rise and as a communicator in this area, I feel we have to help the industry find its voice again.



HERE ARE FOUR THINGS THAT I BELIEVE COULD TRANSFORM UK PHARMA'S RELATIONSHIP WITH SOCIAL MEDIA.

01

SHOWCASING STORIES OF SUCCESS:

There are many ways in which social media can provide a positive benefit to patients and healthcare professionals. And indeed, there are many great case studies in which pharma companies have overcome the barriers and challenges posed by social media in order to build communities, challenge misinformation and contribute to scientific understanding. We need to find more places and forums to share positive examples of how social media can work well in these contexts rather than just code and regulation fails.

02

WIDENING WORKING GROUP PARTICIPATION:

Although a PMCPA working group was set up with the MHRA and pharmaceutical companies, it would be good to see communications agency representation increased. These teams are often at the coal face of social media development and deployment, have a deeper knowledge of how the platforms are evolving and are well poised to advise on creative solutions to many of the challenges posed.

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03

STANDARDISED TRAINING:

Many companies offer their own internal training on social media, but it would be useful to have some standardised training across UK pharma. This would not just touch on the PMCPA guidance but also encourage teams to feel more positive and confident about the benefits of using social media in their communications plans.

04

CLEARER WORDING IN THE NEXT GUIDANCE:

Although the first PMCPA social media guidance has provided a great base for healthcare communications in the UK, it would be useful if the next edition (currently no date announced or planned) provides further clarity based on feedback to date. For example, better guidance on when or when not to use hashtags, so pharma teams can be more reassured in making their content more discoverable without fear of recrimination.

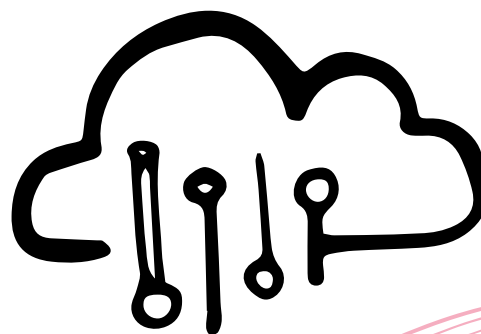


AN INTRODUCTION TO HEALTH SYSTEM TRANSFORMATION

BEN FINLAY // CONSULTANT



The evermore competitive health industry demands that we translate personal stories into measurable experiences along the healthcare value chain. To achieve health system transformation we must involve the entire cross-sectional audience: we need to act without bias, prejudice or preconceptions; so that people, systems and services are equally represented in the design process — enabling equal access to care for all.



IDENTIFYING NEW OPPORTUNITIES FOR HEALTHCARE TRANSFORMATION

For the past six years, we have been leading an all-new innovation co-venture between the NHS, leading nutrition experts, and key industry partners. Teams began researching perspectives across the nutrition and wellness landscape, facilitating immersion sessions with business leaders, and crafting hypothetical opportunities powered by open dialogue and curiosity. What follows is the story of how collaborative design can lead to new services that assist people in maintaining independence in their health journey, whilst delivering measurable value across the health system.

EARLY FINDINGS

Initial research efforts were geared towards understanding market share, competitor strategies and ideating ways to overcome the highly competitive contractual marketplace. Common challenges that were compounding the race to the bottom on price. There were clear business needs to differentiate beyond traditional brand and marketing.

Teams conducted rapid primary research across the UK (later expanded to EU & US) that quickly revealed inconsistencies in how nutrition and associated health matters are discussed and managed across community settings, primary care and secondary care hospitals.



THREE PROBLEM STATEMENTS WERE QUICKLY IDENTIFIED:

01

The absence of patient experience data (collection/usage of step count, mood, food intake) limits our ability to orchestrate future care services

02

Qualified dieticians are the only health stakeholders able to prescribe nutrition, GPs cannot, which poses point of care and care continuity challenges

03

There's no universal care pathway for nutrition; it's often a secondary or tertiary thought in the treatment of any given condition



IDENTIFYING A FOCUS AREA

Research teams analysed treatment areas such as oncology, renal care, neurology and general ward care. Initial conclusions suggested that less competition may sit upstream in the care continuum, i.e., prevention and support, rather than involvement in existing complex treatment regimens. Moving upstream (known in the UK as 'care closer to home') also avoided the highly competitive bidding scene in secondary care, and offered the chance for genuine service differentiation. Further desk research supported our emerging hypothesis regarding the ageing population and the mounting costs of care for the elderly.

“CO-CREATION WILL HELP TEAMS CONNECT WITH A PREVIOUSLY OVERLOOKED AUDIENCE (PEOPLE AGED 65+), ALLOWING NOVEL SOLUTIONS THAT WILL OFFER MORE TIMELY CARE, AND SAVE MONEY BY AVOIDING UNNECESSARY HOSPITALISATION”



A NEW FOCUS: SUPPORTING OUR AGEING POPULATION

By the year 2030 there will be as many eighty year olds as [children under five](#) and as we live longer, more diverse lives, we become exposed to a greater variety of life events including illness. By [2043 one quarter of the UK population will be aged 65+](#) with [47% aged 65+ considered mild or moderately frail](#); [doubling the risk of mortality](#) and increasing health system burden. By [2050 there will be 3.7 million centenarians](#) compared to just 95,000 back in 1990. Attitudes and beliefs in ageing continue to evolve as we integrate the notion of longevity into the very fabric of our daily lives. The way we measure, learn and adjust our health routines will become more prevalent in younger populations as we stretch the possibilities of life expectancy. Our populations and our health systems are slowly but surely adjusting to a more contextual evaluation lens called

[health span](#). Alongside evolving public awareness, policy change and state support, there are significant opportunities for active and passive design systems to support healthy living without adding burden to existing operations and workforce. The UK has managed relatively successfully with [elective care](#), as well as developing [RightCare](#) government initiatives that positively impact population health. System-level change is only made possible once general populations understand the impact of their own health choices — so health departments, industry partners, and community organisations must unite and design age-appropriate experiences. The term [frailty](#) describes someone's overall resilience and how this relates to their chance to recover quickly following health problems. Frailty is a clinically recognised condition and, once diagnosed, it is managed according to a Frailty spectrum. This spectrum (and the associated impact of someone improving or worsening) gave us the platform on which to develop a new multi-sided business model that would support the case for investment.

THE CASE FOR CHANGE

On January 7th, 2019, the NHS launched the “Long Term Plan” highlighting three priorities: getting the best start in life, providing world-class services for major health problems and supporting people to age well. How might we design intervention help slow the effects of frailty ([clinical classification of ageing](#))? Teams quickly developed commercial hypotheses linked to preventative interventions within the ageing population. The UK spends [in excess of £1bn annually on hip fractures](#), the leading cause of [death and](#)

[disability in the elderly](#). Then there's the relationship between age and socioeconomic determinants of health; observing the relationships between the quality of access to (and utilisation of) basic health knowledge, digital literacy and improving quality of life.



METHODS

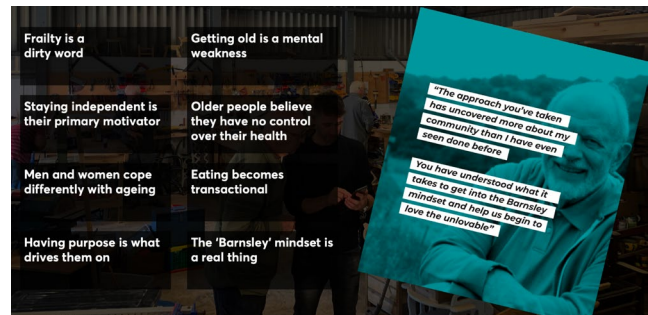
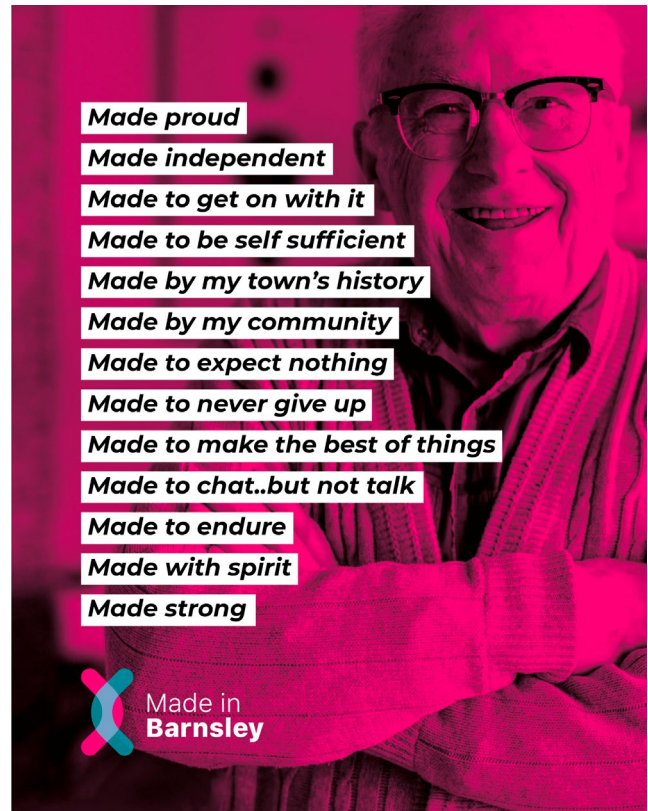
To develop a comprehensive understanding of ageing and **frailty**, we engaged with volunteers from a local community in Yorkshire - observing their home routines and community interactions. We spent nine months in semi-rural settings, specifically in regions with below average health knowledge and higher levels of food insecurity. This involved riding with local taxi drivers, accompanying people whilst they shopped for food, visiting community initiatives, church groups, walking clubs and various other social endeavours such as [Men in Sheds](#).

We began to develop a deep understanding of people that historically haven't asked for help (unless they became seriously unwell). Understanding the lifestyle dimensions of people - outside of the clinical setting - provides the substrate on which we can begin to design interventions to support healthier decisions. We unpacked widespread systematic opportunities to improve people's daily lives, anchored in unmet needs, with contemporary views on how to avoid additional burden to NHS care teams.

INSIGHTS

It turns out that when we age, the term **frailty** becomes a dirty word. Nobody wants to be labelled as frail. We acknowledged the need to empower people to 'work together for a strong and independent future'. Findings were shared, and concepts were developed - with the views of over one hundred people contributing to the development of new service concepts. We facilitated highly participatory workshop exercises: completing ordinary tasks whilst wearing thick winter gloves to simulate arthritic symptoms, or walking up and down stairs whilst breathing through straws to simulate respiratory co-morbidities. We helped people immerse and empathise with an audience profile that is seldom asked when it comes to digital initiatives.

Driving new levels of empathy - a key stage of stakeholders onboarding - came in the form of a multi-stakeholder immersion workshop. We gathered 40+ people across NHS systems, local council teams, voluntary and business sectors. Interactive exercises led to unique perspectives being included in the design process, and informed new digital interactions for those in need.



PHASES

A gated approach to any healthcare innovation is usually well-received by internal and external audiences. Chunking efforts into manageable phases offers reassurance and the chance to continually validate emerging ideas. So far we've run three pilot development phases: Alpha, Beta and Beta+.

During **Alpha** we ran a mock service with people being formally invited via their GP or local healthcare professional. People received a letter, attended a clinic and had face-to-face onboarding to a new 'special service'. This was run with less than 20 people so we could stay close to each main interaction and monitor progress.

Beta involved public outreach, GP SMS recruitment, and local engagement in community settings. This phase included population health data strategies and demonstrated ways we needed to evolve our demo service - in order to support greater scale.

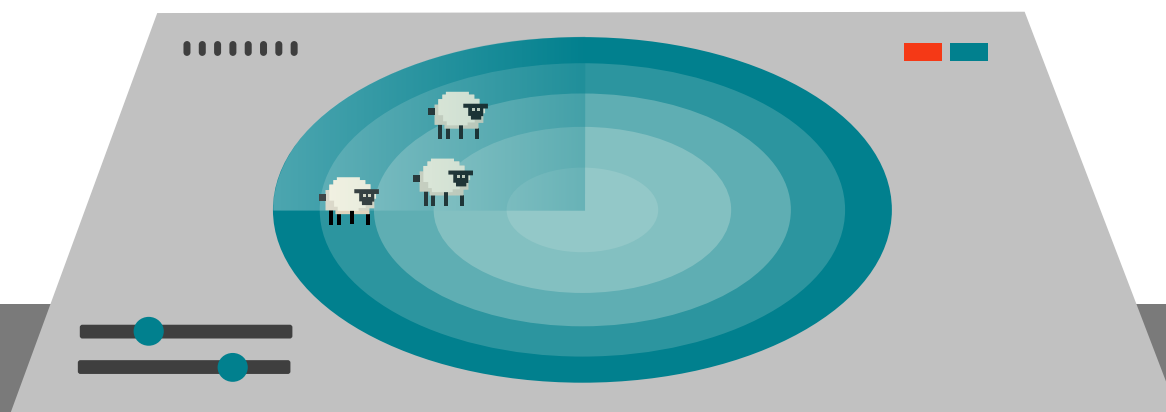
For **Beta+** we tested scaled elements of the service with much greater patient numbers. This most recent phase included reporting of health metrics, and the correlation to commercial models to support the case for continued investment.



Discrete co-creation cohort and 'fake' frailty service pre-scale refinements

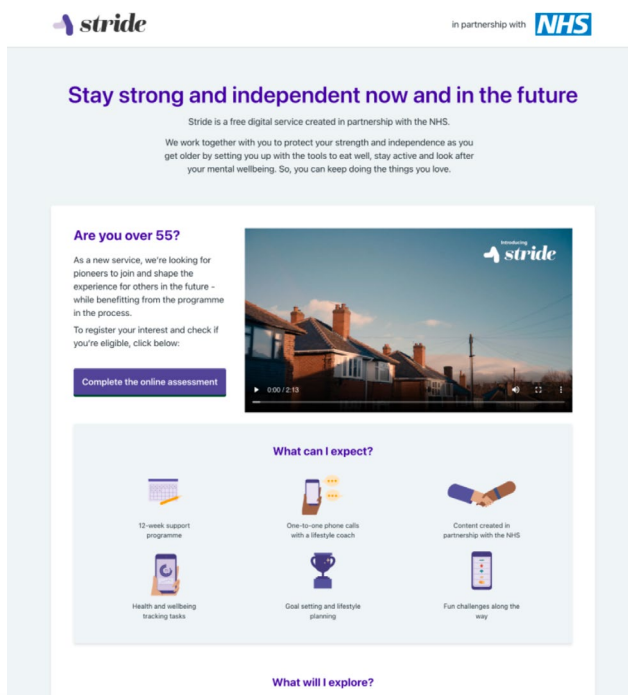
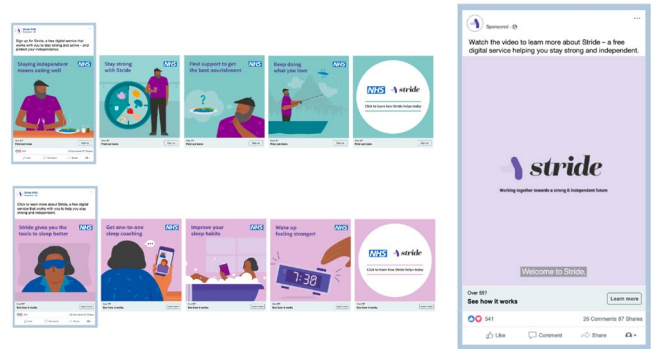
Semi-scaled version with public outreach and live integrations pre-scale refinements

Pre-scale refinements to ensure integrity of systems + processes



RESULTS

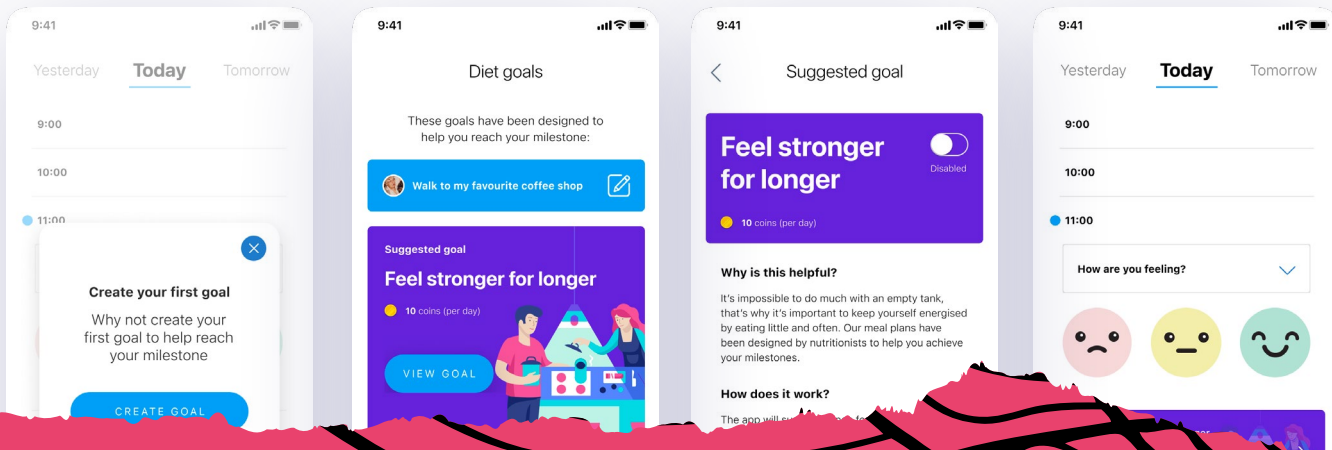
After years of iterative creation, rigorous testing and quite a few more train journeys up to Yorkshire, we finally branded our new service and launched Stride. Stride is a program that helps people work together for a strong and independent future. It's a digital service that addresses unmet needs from a wide range of people in a real-world settings. It's designed not simply for the patients, but also for the people that surround them (family, close friends, neighbours). The Stride platform provides personal behavioural assistance, supported by goal setting, activity measures and access to real human 1-2-1 well-being coaching. It features appropriate content, nudging and interventions. Designed by, and for, the ageing population.



Demonstrating system benefits

- 76% of users improved leading indicators of physical and mental well-being (weight management, grip strength and self-reported mood)
- 80% of users set, then completed, lifestyle goals within the platform
- 85% of service users began and concluded the 90-day Alpha pilot
- 75% of people who raised their hand to participate were eligible (i.e., they fit the clinical frailty criteria)

(Reported via qualitative, semi-quantitative and quantitative participant survey data collected daily, weekly and monthly – including semi-structured face-to-face interviews across the 90-day Alpha service evaluation).





OUTCOMES

To address the realities of an ageing body we must treat the whole person. This means discrete nudges and support mechanisms to help people keep active, consider appropriate nutritional intake and maintain strong social connections.

01 speed to value is made possible by integrating existing services in new/better ways

02 signposting is key to reduce the chances of exclusion through a lack of digital literacy

03 some people may only need a reminder of the basics (physical activity, nutritional intake and good social connections)

04 inclusive design is as much about backstage actors (caregivers, IT, operations, data, systems) as it is about the front stage experience (family caregivers, patients, loved ones)

05 good design intervention is getting ahead of major illnesses through appropriate nudging

06 diverse team thinking begets diverse outcomes: homogenous teams deliver inclusive results

Designing new preventative health services requires dedicated and transparent industry sponsorship. It requires impartial and Inclusive research with health systems, practitioners - with patients and

family caregivers at the centre of human design processes. Over the coming years we will see the gradual evolution of data science (and loosening of regulations) and acceptance of design as an enabler. But to achieve these types of transformation the health industry needs more committed design thinkers who are prepared for the many challenges across health and social care provision.

HELP YOUR TEAMS DEVELOP THEIR INNOVATION POTENTIAL

When looking to design and run healthcare transformations it's important to align early - use design hypotheses linked to business challenges that get everyone engaged. Be sure to focus on quality inputs from well-structured service research - engage with real people to understand how your service will address unmet needs in new ways. And, last but not least, new interactions must be given the right space and time to evolve within the intended audience groups - allowing for discrete iteration enables new services to scale with utility.

Innovation in healthcare is made possible through industry partnerships, health system collaborations and involving people from wide-ranging backgrounds. When cross-functional teams are given the freedom to experiment with research and design methods (whilst recognising and addressing bias), we elevate human needs in ways that deliver positive and lasting change.

