

# The art of the abstract

Crafting compelling conference submissions

Big Conversation, 22 April 2026

# Housekeeping



Please keep your mic muted unless you are asking a question



Please note that the presentation (excluding the Q&A) is being recorded



The recording and slides will be on the Big Conversation website after the event



Please use the Chat function to ask any questions as we go along



AI bots are not permitted in these meetings and will be removed

# Agenda

11:00 – 11:10

Welcome & Introductions

11:10 – 11:25

Writing effective abstracts

11:25 – 11:40

Putting the tips into practice: breakout rooms

11:40 – 11:45

Our mentoring scheme

11:45 – 11:50

Creating effective posters

11:50 – 12:00

Conference update and any other questions

12:00

Close

# Introducing Dr Jed Jerwood



Clinical academic Art Psychotherapist working in adult mental health services.

Honorary Clinical Associate Professor at the University of Birmingham with research interests in health inequalities, death, dying and bereavement and the use of arts-based methods in health research.

Co-founder of the award-winning 'No Barriers Here' programme, an arts-based, equity-oriented approach to advance care planning for people underserved in healthcare.

# CALL FOR PAPERS TEAM



MELANIE



ELLA

# What we'll cover



What makes for a good abstract



The importance of structure



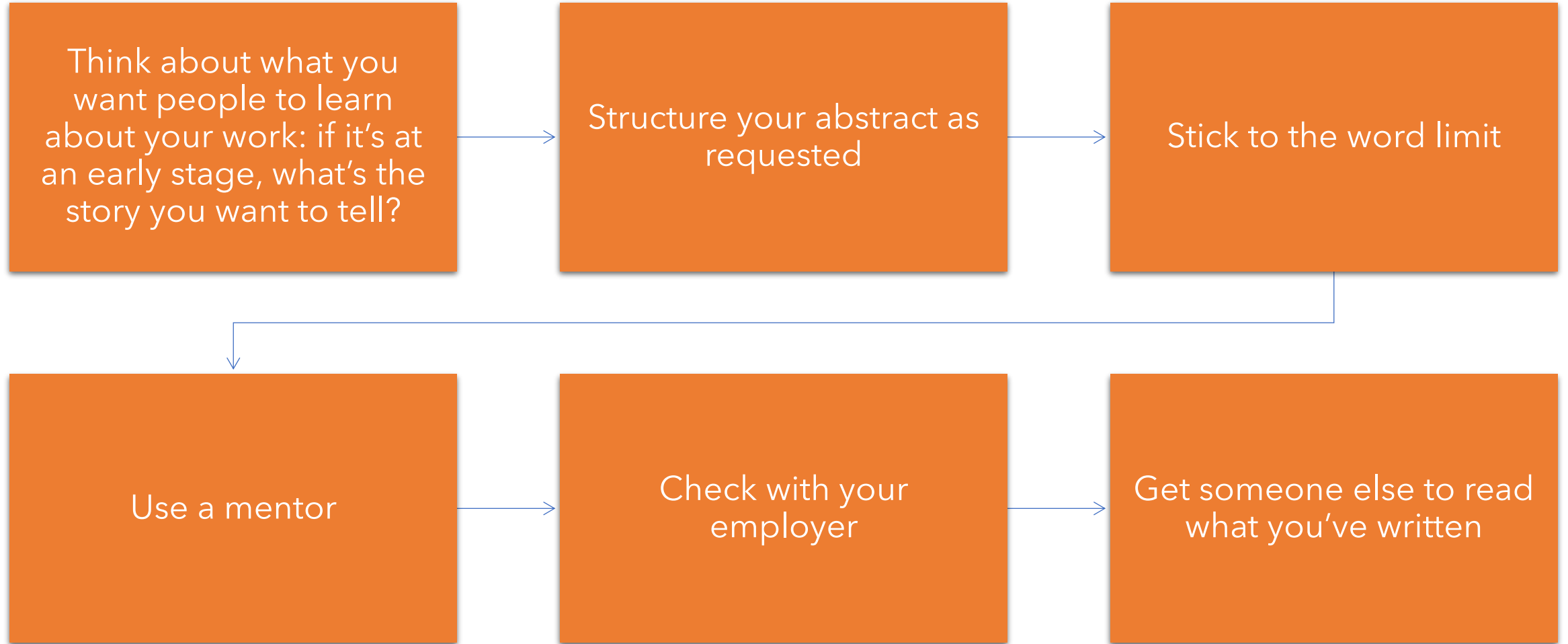
Tips to share on writing for success and great posters



How reviewers score abstracts

# Poll question

# The makings of a good abstract



# Top tips on writing an abstract

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Be concise

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Be clear; use plain English, explain abbreviations

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Write a clear and captivating title

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Add references if allowed

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Anonymise the text

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Add content for every headed section in the abstract template

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Schedule adequate time to draft

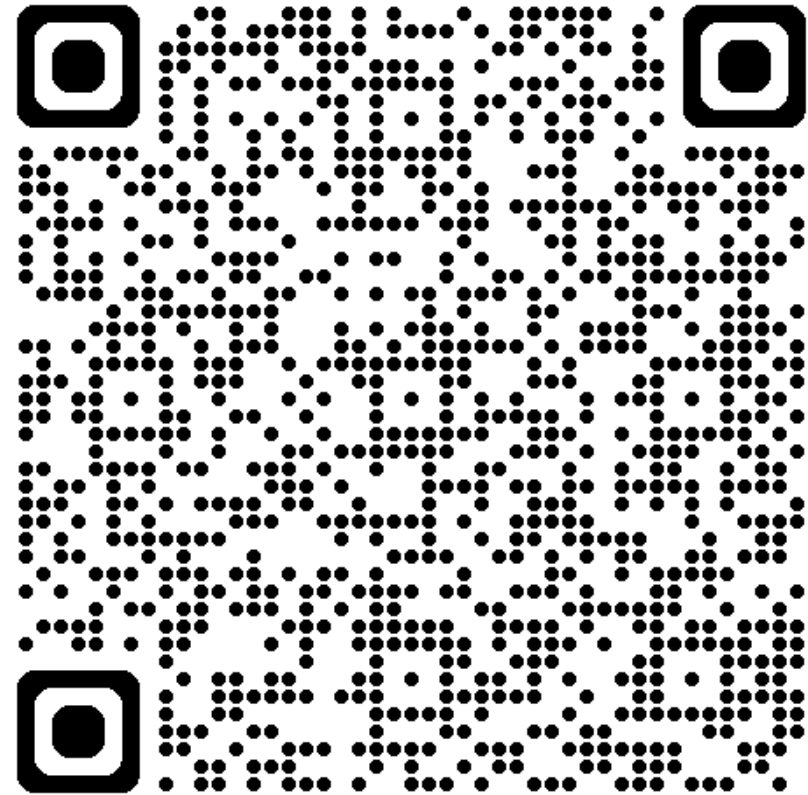
# Reviewers scoring sheet

Considers status of project

Shows marking schedule according to abstract's structure (Background, Aims, etc.,)

Recommendation for oral or poster presentation

Comments - may be used for feedback



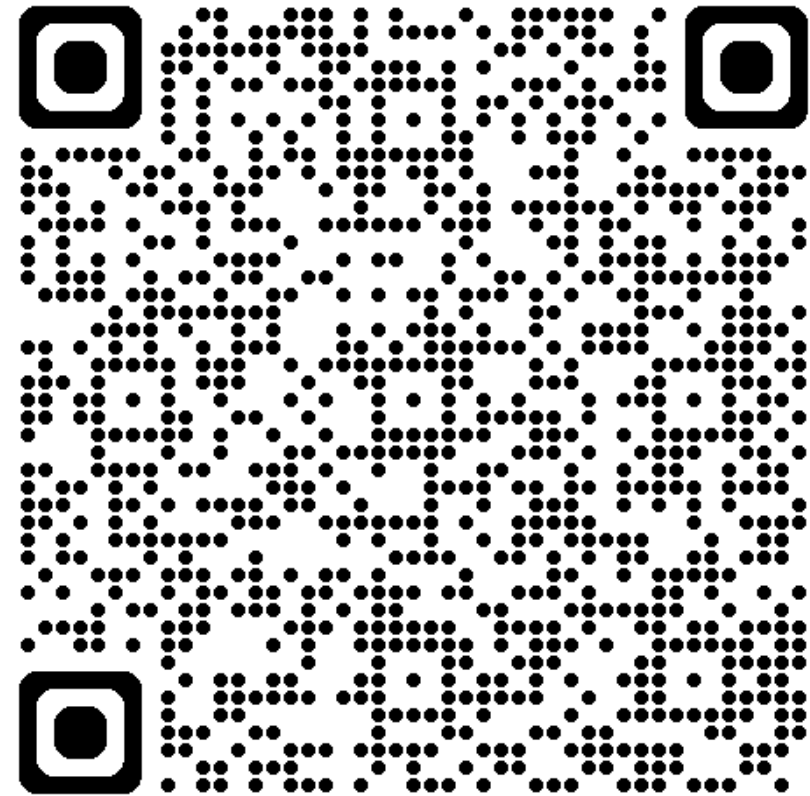
# Scoring template

References included (Yes or No)				
<b>Section 1: Abstract content</b> - score each section below				
<i>Not at all described = 0</i>		<i>Not much described = 1</i>		
<i>Well described = 2</i>		<i>Very well described = 3</i>		
<b>Background</b> <i>E.g. what is the rationale or gap in knowledge/practice that the work is based upon?</i>				
<b>Aim(s)</b> <i>E.g. what does the work/project aim to achieve and for whom?</i>				
<b>Methods</b> <i>E.g. what are/were the methods used to deliver or evaluate the work / project?</i>				
<b>Results</b> <i>E.g. what are/were the anticipated results and how will they make a difference? Note, for 'Work in progress' abstracts there may be no results to report in which case, score zero.</i>				
<b>Conclusions</b> <i>E.g. do the conclusions and recommendations seem logical from the completed or anticipated results? Note; if work is still in progress there may be no conclusion if so, score zero and make a note in the Additional Comment section.</i>				
<b>Section 2: How innovative or of interest do you think this abstract is?</b> (max 3 points)				
<i>Very = 3</i>	<i>Quite = 2</i>	<i>Not much = 1</i>	<i>Not at all = 0</i>	
<b>Comment</b>				

# Sample abstracts

Examples of work likely to be declined, through to work likely to be accepted.

Explanations to help understand reasons why work may or may not be accepted.



# Breakout room activity



WHAT MAKES AN ABSTRACT  
WORK?



PUTTING YOUR KNOWLEDGE  
INTO PRACTICE.

# (1) Title: ACP

There are many nursing care homes in our hospice neighbourhood. We had been informed that one was requesting support from the hospice community palliative care team with ACP. They were undertaking the GSFCH Programme, and ACP was an element of the programme. We contacted the care home manager and arranged to visit them. At this visit we explored how we could work with them and support them with the residents they had living in the home. All of the residents had dementia. Our support was welcomed. In our presentation we will report on the support we provided.

97 words

# Example 1: Cold

“ Acknowledged as topic of interest.

📄 Does not follow the suggested format headings.

✎ Activity is not well described.

⚙️ Use headings, add description.

✚ Use the full word count.

📋 Score: 4/18

## (2) Title: Advance Care Planning (ACP)

Background: Our hospice has many nursing care homes in the neighbourhood. We were aware that all those living in these care homes had a palliative care diagnosis. Our community palliative care team was asked to support one of these with implementing Advanced Care Planning [ACP]. The home had asked for support because they were undertaking the GSFCH programme. All the residents in the nursing care home had dementia.

Aims: To support the nursing care home with undertaking Advance Care Planning with their residents and to show the impact.

Methods: The community palliative care team undertook an audit and then delivered training sessions for the nursing care home staff on ACP. Following this they supported the staff in the nursing care home to undertake and document Advance Care Plans. They recorded the impact of the plans.

Results: An audit was undertaken. All nursing care home staff then received training on ACP. Following this training the community palliative care team role modelled ACP discussions with the nursing care home staff. After six months most residents had an ACP put in place and the care, they received was according to their preference.

Conclusion: Staff recognised it is important to have a plan in place for when a resident deteriorate.

206 words

# Example 2: Chilly



Lacks detail. E.g. no mention of residents living with dementia and impact of ACP on this.



Does not follow the suggested format headings.



Add descriptions and figures.



Add references.



Full word count not utilised (206/300).



Score: 7/18

# (3) Title: Advance Care Planning (ACP)

Background: A nursing care home, implementing the Gold Standards Framework for Care Homes [GSFCH] programme<sup>1</sup>, approached their local hospice community palliative care team for Advance Care Planning [ACP] support. All the residents in the nursing home had dementia. They were requesting assistance with ACP conversations as undertaking these was a key component of the GSFCH programme they were implementing.

Aim: To enable all residents living in the nursing care home to have a documented individualised personalised care plan and evaluate the impact of these plans.

Method: The palliative care team reviewed the literature. An audit was co-created and undertaken with the nursing care home staff, and other professionals, supporting them. Staff in the care home also attended an education session on audit and ACP which included information on mental capacity and best interest decisions<sup>2</sup>. ACP was role modelled. Data was collected monthly, for six months, on ACP documentation, including the residents preferred place of care [PPC] and death [PPD].

Results: Following the review of the literature as all residents had dementia, Future Care Planning [FCP] was undertaken not ACP. Care home staff attended training. During the six months FCP was completed for n=22/30 residents. Throughout the audit admissions to the hospital had occurred [n=15] as had deaths in the hospital [n=10]. Known FCP preferences guided these decisions. The audit showed preferences regarding PPC and PPD were met.

Conclusion: ACP made a difference to the residents living in the nursing care home as staff knew their preferences and could act on them.

251 words

References:

1. Gold Standards Framework Care Home Training Programme <https://www.goldstandardsframework.org.uk/care-homes-training-programme> accessed 21st February 2024.
2. Froggatt K. (2000) Palliative care education in nursing homes. Macmillan Cancer Relief, London.

# Example 3: Getting warmer



The abstract is well structured.



Benefit from more detail in the Methods and Results - e.g. the number of staff attending training, and were all residents' preferences on ACP met or just some?



Word allowance not used fully.



Attention to detail. FCP is recognised to be important not ACP. The heading and conclusion still say ACP.



Score: 13/18

#### (4) Title: Future care planning (FCP) 299 words

Background: In England the delivery of individualised personalised care is a national priority<sup>1</sup>. A nursing care home, implementing the Gold Standards Framework for Care Homes [GSFCH] programme<sup>2</sup>, approached their local hospice community palliative care team for Advance Care Planning [ACP] support. All the residents had dementia. ACP was a key component of the GSFCH programme they were implementing, but they had limited experience, so sought external assistance.

Aim: To enable all residents living in the nursing care home to have a documented individualised personalised care plan that is acted upon.

Method: The palliative care team reviewed published literature. They formed a working group with the care home staff, the GP, and the local hospital Geriatrician. An audit was cocreated and undertaken. All staff in the care home then attended an education session on audit and ACP which included information on mental capacity and best interest decisions<sup>3</sup>. ACP was role modelled by all working group members<sup>4</sup>. Data was collected monthly, for six months, on ACP documentation, including the residents preferred place of care [PPC] and death [PPD].

Results: Following the literature review as all residents had dementia, Future Care Planning [FCP] was undertaken not ACP<sup>5</sup>. All care home staff attended training. Prior to the ACP training n=2/30 residents had a FCP in process. During the six months this was completed for n=22/30 residents. Throughout the audit admissions to the hospital had occurred [n=15] as had deaths in the hospital [n=10]. Known FCP preferences guided these decisions. The audit showed all preferences regarding PPC and PPD were met. Prior to the audit preferences were unknown.

Conclusion: ACP was not possible in this care setting, but FCP was. Having such plans in place enabled the delivery of personalised care to the residents living here. Achieving was only possible with an integrated approach.

# (4) References accompanying abstract

1. NHS (2019) Universal Personalised Care: Implementing the Comprehensive model <https://www.england.nhs.uk/wp-content/uploads/2019/01/universalpersonalisedcare.pdf> (accessed 21st February 2024).
2. Gold Standards Framework Care Home Training Programme (<https://www.goldstandardsframework.org.uk/care-homes-training-programme> (accessed 21st February 2024)).
3. Froggatt K. (2000) Palliative care education in nursing homes. Macmillan Cancer Relief, London.
4. Stone L. Kinley J. and Hockley J (2013) Advance care planning in care homes: the experience of staff, residents, and family members. *International Journal of Palliative Nursing* 19 (11) 550-557.
5. Kinley J. Denton L. and Levy J. (2018) Improving the approach to future care planning in care homes. *International Journal of Palliative Nursing* 24 (12) 576-583.

# Example 4: Warm



The abstract is well structured.



Good detail. Something else to say about why FCP not completed for all?



Word allowance utilised.

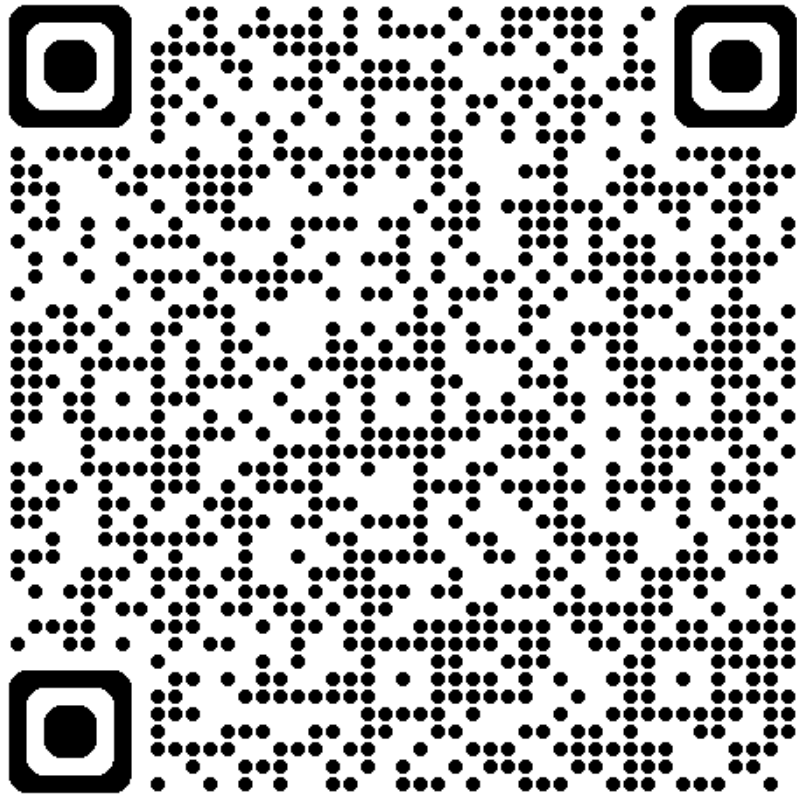


Appropriate referencing.



Score: 17/18

# Support for new authors



Volunteer mentors share their knowledge and experience in writing abstracts

Mentor provides one-time feedback on the writing and format of an abstract

Help with questions about the formal requirements of abstract writing

Guidance on points relating to clarity of writing, data presentation etc

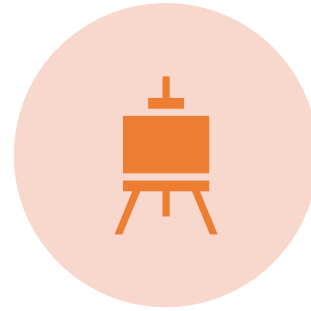
# Designing a poster



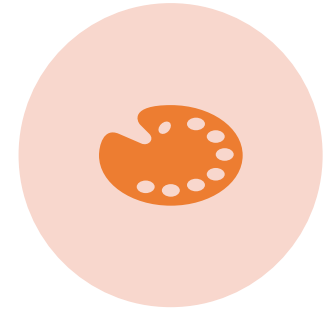
THE TITLE HAS TO WORK  
SUPER HARD: 'LEGITBAIT'  
NOT 'CLICKBAIT'



PURPOSE IS TO START  
CONVERSATIONS



POSTERS ARE VISUAL  
TOOLS



USE COLOUR WILDLY!

# Recent examples

## Living matters now

Improving transitional care for young people with complex and life-limiting conditions

**Background**

- An increasing number of children and young people in the UK are living with life-limiting or life-threatening conditions<sup>1</sup>
- These young people are living longer than in the past
- Needs and preferences change over time
- Young people face a process of transition from children's to adult hospices<sup>2</sup>
- This process can be difficult and concerning

**Methods**

- Adopted a quality improvement approach to implementation, with a focus on continuous learning
- Engaged with professionals and young people with lived experience of transition
- Led and developed a national network for Transition Co-ordinators using ECHO methodology
- Supported three regional ECHO hubs
- Produced online resources for professionals supporting young peoples' transition

**Recommendations**

1. Harness the expert voice of experience to improve transitional care
2. Encourage and support adult hospices to do more to support young people through transition
3. Discover more about who is missing out on care so that we can tackle unequal access
4. Continue the work of the Transition ECHO hubs and National Transition Network to realise their full potential
5. Make sure that local health and care systems consider the needs of young people in transition to adult services

## I just want to be me

### End of Life Care for Trans and Gender Diverse People

**Trans** - umbrella term used to describe people whose gender is not the same as the sex they were assigned at birth.<sup>1</sup>

**Gender diverse** - umbrella term used to describe people whose gender identity does not conform to socially defined gender norms, and/or do not place themselves in the male/female binary.<sup>2</sup>

**Background**

Trans and gender diverse people have inequitable access to healthcare.<sup>3</sup> The research on LGBTQ+ experiences of end of life care often does not address specific barriers faced by trans and gender diverse communities and rarely involves trans people.

This work sought to platform trans communities' perspectives of palliative and end of life care to inform policy and practice, and highlight specific care needs.

**Findings**

Many trans and gender diverse people expressed anxiety over approaching care providers. Trans and gender diverse people are frequently discriminated against, misgendered and do not have their identity and expression respected and supported. Many health professionals lack understanding of trans people's needs but often were passionate about improving this.

Collectively, we must act to improve end of life care for trans and gender diverse people. The report includes tips and recommendations to support this, such as,

- End of life care providers display a visible commitment to inclusion to empower people to hold services to account.
- Professional bodies should produce up to date guidance on providing medical and clinical end of life care to trans and gender diverse people, and guidance on advance care planning should be updated to include consideration of gender affirmation and continuing transition at end of life.
- Palliative and end of life care services should ensure that intake and referral forms capture preferred name and pronouns.

**Full report**

# Inspiration: Better posters



Blog from biologist Dr Zen Faulkes  
on creating great posters

## Better Posters

IMPROVING POSTER PRESENTATIONS SINCE 2009!



04 MARCH 2026

### Prime blogiversary: Seventeen years of Better Posters

One of the wild things as you get older is that you find yourself thinking, "Hey, when did that movie /song / TV show come out? Must be, like, five years ago now." And you look it up and it's over twenty years ago...

We're not quite at that point yet, but it's a little surprising that this is the **seventeenth** blogiversary for Better Posters!

The blog is certainly in its cranky teenage years, and is admittedly not as communicative as I would like it to be. But it is still very much an ongoing project that I intend to keep going as best I can.

This blog is creeping towards a big milestone: five million views! This is, I think, an incredibly good number for a niche academic blog, and I can only say, "Thank you" to all of you visitors and readers who have contributed to that number.



GALLERY AND LIBRARY

A collection of notable posters (and a few presenters) and every known book devoted to academic conference posters.

BETTER POSTERS BLOG AND BOOK

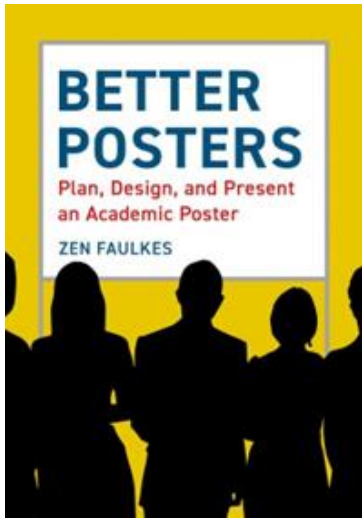
Academic conference posters are often ugly, with tiny text, confusing layouts, and dubious colour schemes. This blog and book is about making posters informative *and* beautiful.

This blog usually updates on Thursdays.

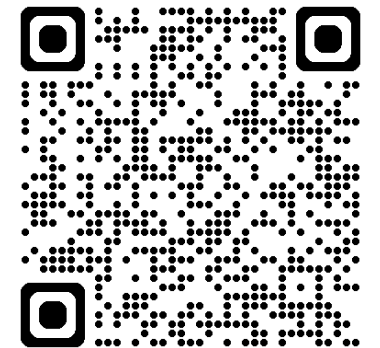
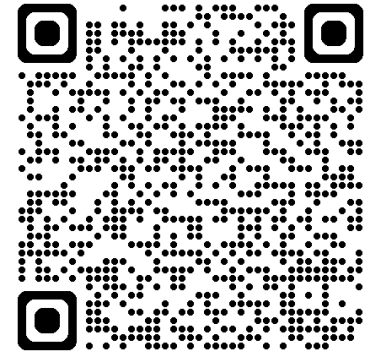
Not the viral video. That's #BetterPoster (singular) on social media.

BETTER POSTERS BOOK

# Inspiration: further reading



- How to design an award-winning conference poster. Tullio Rossi contributes to the LSE Impact Blog with advice
- Faulkes Z. Better posters: plan, design and present an academic poster. Exeter: Pelagic Press; 2021
- Sousa BJ & Clark AM. Six insights to make better academic conference posters. Int J Qualitative Methods. 2019; 18:1-4



# Poll question

# Call for papers



Opens 23 March



Closes midday 11 May



Mentorship scheme available until 5 May

# Contacting the team

Email: [conference@hospiceuk.org](mailto:conference@hospiceuk.org)



# Feedback Survey

Please consider sparing a few minutes to answer this survey, so that we can continue to improve future Big Conversation events:

<https://www.surveymonkey.com/r/QBXZG2D>



**Thank you for joining us today**