

Using technology in the NHS and producing better information for patients

Findings from Group Discussion at Annual Open
Meeting

July 2019



Introduction

Healthwatch is the champion for users of health and social care in Coventry. We give local people a voice - making sure that patients, service users, carers and public views and experiences are heard.

We are independent of NHS and care services and decide our own programme of work. We work to influence the planning and delivery of NHS and social care services based on what local people tell us.

Our annual open meeting was held on 16 July 2019 and was attended by 55 people.

We held discussions on tables to focus on key points within the NHS Long Term Plan that are aimed at patients and to help our work to improve patient information in Coventry:

1. Digital - or using IT technology more in how patient and the public interact with NHS services and to support services
2. Reducing outpatient appointments by 30%
3. Patient information leaflets used when patients are discharged from hospital

This report gives the findings of these discussions and identifies further priorities for action.

Part one: 'Digitally enabled' NHS services

We posed four questions related to priorities within the NHS Long Term Plan to use technology more to support access to NHS services for patients.

1.1 What does the term 'digitally enabled' mean to you? What does it cover do you think?

We found that people had a mixed understanding of the term and therefore this is not the best terminology to use to talk to patients and the public about new ways of accessing services or information. For some their understanding was mixed up with how they felt about this approach and their perceptions that this would not be positive for them:

- Does it mean the person is digitally enabled or the service is digital?
- Automated systems - bookings
- Assisted technology
- Websites
- Access to various devices - smart phones, IPad, tablets, computers
- Web search
- Alexa - symptom checker (GDPR nightmare)
- Online booking - eg for blood tests
- Skype appointments
- Apps - my GP
- Equality of access - could create isolation, less interaction with people
- Booking service - not first come first served
- Digital decision making?
- Access to knowledge
- Tension between technology and human face of care
- Access to information but issues re. trusting sources
- Means of information sharing to improve care
- Will the NHS connect up between organisations?
- Paperless
- Can use your fingers
- Social media
- Information BUT accountability / ownership / responsibility
- Impersonal
- Generation gap

One person associated this as a dependency and confining you to your house as it takes away the reasons to go out. It was described as:

"If you have a telephone or a computer you don't get out of your chair, it doesn't encourage people to be active. Being active is important, it keeps you well. Planning your day, planning to get off the bus one stop before you need to, keeps you well. Being digital sadly will isolate you. When we get old we need help to keep us moving not do things that keep us in our chairs"

1.2 How can health services support and remove the barriers for people to use digital health services?

Barriers identified

- Cost
 - Poverty prevents access. Not everyone can afford this technology (cost of internet access at home or by phone; cost of devices)
 - Could be more expensive to provide both services
- Computer literacy/IT literacy
- Trust
- Language/culture (eg newly settled communities)
- Accessibility of mobile signal
- Physical barriers - physical disability, Learning disabilities, Visual impairment

One participant who felt very uneasy about technology said “You’ve got to believe in it to be a part of it. I do not like it. It’s not private and confidential. There might be a breach. I’d like to turn the clock back. It’s difficult to accommodate modern day. I feel like I left childhood and went straight to old womanhood”

Solutions suggested

- Have community based resources to use to access services, libraries, pharmacy and GP practice - Welcoming environment plus staff to assist
- Find out how people want/need to use services
- Provide NHS leaflets to let people know what their options/preferences are and how they can express this
- Training and education
- Range of options - keep face to face for those who need it
- Difference of: can opt-in to assuming opt-in
- Consistent deployment between GP practices
- Helpline number at the bottom of appointment letter and correspondence

- Languages training staff/carers
- Consult with different groups about how this can work- but actually listen
- Backup system
- Access to records - records - got to be good quality
- Most people have access to a phone for phone calls

1.3 How can the NHS ensure equality in access with the introduction of digital services for patients (between those who can and want to use digital services and those who don't want to or are not able to)?

Give people choice - right method for individual

- For people who are known to services, they can be communicated with and asked their preferred method of communication.
- For first point of contact through primary care, people should be asked to complete a questionnaire to express their preferred method of communication. This creates 'a profile' that should be shared NHS wide (maybe attached to an individual's hospital number, so that all services know the communication preferences of each patient).
- Do not reduce analogue access- not limiting other points of access to services to focus on digital - still have face to face/telephone access

Support

- Libraries, pharmacy and family centres - digital hubs with trained staff
- Training education campaigns

Approach

- Monitor the system
- Enforce continuity of care
- Ensure affordability
- Address availability in different languages
- It is always seen as an add on rather than digital first

1.4 How could outpatient appointments be done differently to benefit patients:

- a. Location (eg what service could be delivered in a community setting)
- b. Amount/frequently of follow up (eg is there a different way that patients could be signed off from consultancy led services other than a face to face appointment?)
- c. How might technology help with to reduce the amount of times a patient might have to attend hospital for a consultant appointment?

Groups made the following points:

Method

- Phone or skype could be used to discharge and for 6 monthly reviews for long term health conditions where a physical examination is not required.
- Important that the patient is given a final opportunity to ask any questions so text or letter wouldn't provide that.
- The patient's communication profile should play a role in this.

Location

- Library or GP services could be used to provide the facility for skype if people don't have this available to them. Or identify community assets that are already in place, maybe another service for pharmacy to offer.
- Home visits - more information than a phone call
- Locate in community area
- Could be done at GP surgery/ Appointments with GP/Nurse instead
- Specialists see people at the health centre rather than in hospital
- Transport, Group practice, pharmacy, schools, triage for bloods, ecgs, paediatricians, ophthalmology, respiratory, OT/Physio
- Keeping hospital setting but seeing multiple specialists on the same day if patient has more than one condition
- Mobile or temporary clinics

Who with

- Allowing GPs more prescribing power to deal with mental health
- Frequency - Advanced Nurse Practitioners, dependent on condition/operation, dependant on individual
- Follow up with different staff
- Issue specific - dependent on condition / complexity

Other

- Outreach/telephone clinics
- Prompt response good but not at expense of quality
- Group appointments
- Phone calls
- Needs based service, telephone/skype
- Shared database

Part 2: Better information

We discussed how information for patients being discharged into ‘discharge to assess’ and ‘reablement pathways’ after a stay in hospital could be improved. This is support for up to 6 weeks so that people can get better or have their support needs identified.

2.1 What I need to know

There was a consensus on the following:

- Clear information on what is going to happen
- What can I expect? What will they do? How often? Who?
- Who to call if you need help: central support contact (named)/contacts
- What happens if I need more care?
- Expectations
- Ref. number on leaflet
- Transportation
- Likely cost implications
- Reassurance

I need to know I'll be safe and looked after “who will turn my heating on for me so that my home will be warm when I get there?” who will be delivering my care

A call for person centred information too:

- Tailored section/specific information, personalised plan
- Person centred messages for carer/family
- Check list, what will be provided and when
- Service provider
- Review periods
- Duration/term
- What to expect as recovery - Milestones/ How you should progress/feel
- Medication
- Cultural needs; appropriate care

2.2 Terminology

We asked people what 3 terms that are often used in written material meant to them and even though our audience was more informed than most it was clear from the responses that different things were associated with these terms by different people and therefore they are not clear enough for general public use:

“Health and social care”

- Some people might not fully understand the breadth of what the term *“health and social care”* covers.
- Social can have negative connotations, social worker etc
- Social - not in hospital, may have to pay for it
- Physical health, local teams, not sure how the two are linked
- Local authority, social services, society, family members
- Generic, Daily living,

“Social Care needs”

- Carers needs, my choice, how little someone can do, outcome of assessment, local authority resources
- Individual care needs
- Ability to live, independence with appropriate care

“Assessments”

- Lack of understanding, can be scary - What will they do?
- Care, money
- Benefits
- Formal assessment/test, review of need/progress

2.3 Guiding principles for information leaflets

1. Plain English and jargon free

Eg ‘short term ‘doesn’t mean the same thing to all people. It should state ‘for a period of up to? Weeks dependent on your circumstance’.

2. Patient centric:

Talk about what “you” will get, what “you” will not get, what “you” can expect - outlines the quality offer.

3. Clear expectations

Clear messages give clear expectations for patients and family/carer

4. Focus:

People were not interested in service design, or how it’s delivered to the wider community. People only want to know what’s in it for them

Information leaflets should not be confused with a care/support plan

5. Understood and agreed:

Part of discharge process to show that patient has received/had leaflet discussed and understood

Correct person delivers the information

6. Not only route:

Effective and appropriate face to face communication is needed too, have leaflet as a back-up/reminder

7. Personalised information:

A strong desire for information to be personalised where it can be

8. Accessible:

Use all good practice in terms of format eg easy read pictures; digital for software to read.

Address challenges of languages spoken

People will require differing levels of information

There could be a link to a place on a website where fuller information along the same lines is available. If people do not have internet access, then maybe they could be directed to a community resource.

Creative idea for a new approach

Technology - send a pre-recorded voice note in the required language if people have the appropriate means to listen to the voice note. This should also accommodate disabilities around communication. This should be determined by the individual's communication profile.

Conclusions

There was unease about the introduction of new mechanisms using technology for patients to interact with NHS services and health professionals amongst participants in our discussions and barriers to use were identified. How people felt and the issue of trust were clearly flagged.

Our discussions began to identify some potential ways to overcome some of the barriers, but more conversations and work is needed to ensure that a focus on 'digital' will be meaningful for the population of Coventry by supporting better access to NHS services rather than adding complexity and inequality for people who are not equipped to deal with this.

Our discussion regarding information leaflets sets out some clear principles to be taken forward in work to improve paper information for patients at key points of transition in care such as discharge from hospital

Recommendations

1. Coventry and Rugby Clinical Commissioning Group to take account of the findings in this report and the suggestions for overcoming barriers to use of digital technology
2. Coventry and Rugby Clinical Commissioning Group and other organisations which develop services to undertake more consultation/engagement with different population groups to ensure all future 'digital' offers meet needs
3. NHS organisations adopt the good practice identified within this report as guiding principles when producing patient information leaflets

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Healthwatch Coventry

27-29 Trinity Street

Coventry

CV1 1FJ

024 7622 0381

Email: healthwatch@vacoventry.org.uk

www.healthwatchcoventry.co.uk

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Voluntary Action Coventry