Research and Engagement into NHS System Recovery

Integrated Insights Report (Interim)

1   Background

1.1   Over the last 6 months the NHS has introduced a range of measures to help manage the impact of Covid-19 on the population and on local services. This includes making radical changes not only to the way in which services are delivered, but what is delivered where. These changes, along with the wider impact of the range of Government measures introduced over this period, have had an impact on our population's health and wellbeing and the way they use NHS services.

1.2   In addition to changes to services we have also seen changes in patient behaviour, both positive and concerning. For example, we have seen a greater use of 111 and 111 online and a reduced number of inappropriate A&E attendances. We have also seen fewer presentations in primary care for genuine health concerns that should be investigated. In particular we have seen a reduction in presentations for concerns that may be related to cancer and for low to moderate mental health issues.

1.3   To support the local NHS system recovery work, the CCG has undertaken an extensive programme of research and engagement with the Nottingham and Nottinghamshire population to objectively evaluate the impact of the changes we have made in response to Covid-19 and the changes we have seen in patient behaviour.

2   Approach to research and engagement

2.1   The programme of research and engagement has five core objectives:
   i.   Understand people's views of the changes made, even if they are not directly affected
   ii.   Understand the tolerance of the population for keeping the changes made
   iii.   Understand the impact of changes on the people directly affected
   iv.   Understand the impact of keeping changes on the people directly affected
   v.   Understand the impact of changes on groups who are vulnerable and face barriers   to accessing services as a result of Covid-19.

2.2   The programme sought to gather insight from the following:
   i.   A representative sample of the Nottingham and Nottinghamshire population
   ii.   Specific patient cohorts affected by the service changes made in response to Covid-19
   iii.   Vulnerable groups who are likely to have faced greater barriers to accessing services as a result of Covid-19.

2.3   The programme incorporated four strands to provide a rounded set of insights:

Quantitative research	• Agency commissioned to develop questionnaire and survey a representative sample of the population • Focused on impact of service changes and tolerance for keeping changes e.g. remote consultations • Representative sample of the Nottingham and Nottinghamshire population, based on 2,000 responses online and via telephone.

Qualitative research	• Agency commissioned to recruit sample for focus groups and in-depth interviews
	• Drilling down into perceptions of service changes to inform barriers to transformation and potential behavioural nudges
	• Focus groups and interviews split by:
	    o Light/infrequent service users
	    o Moderate service users
	    o Heavy service users,

Targeted engagement	• Engagement by the CCG Engagement Team and through the CCG's contracted engagement service with the CVS Alliance • Engagement sought to understand the particular barriers and challenges faced by different groups and communities as a result of Covid-19 and service changes • A mapping exercise was undertaken with CVS colleagues to identify the cohorts and communities that should be targeted • VCS organisations were asked to respond directly on behalf of their service users, providing a collective voice on behalf of some of our most vulnerable communities • Over 100 organisations, working with our most vulnerable and marginalised communities, responded • A survey was also distributed, generating 550 responses.
Desktop research	• A review of findings from national research and research and engagement in other areas was undertaken • Findings relating to impact of Covid-19 and related service changes were reviewed • A total of 30 sources were reviewed including national social research (e.g. Ipsos Mori); other Integrated Care Systems, Local Authorities and NHS bodies; national and local charities.

3   Summary of findings

3.1   The main findings from across the programme are summarised below.
- Many people have put off accessing healthcare during the pandemic, either because of concerns about overwhelming the NHS or through fear of contracting Covid-19.
- The majority of our population are satisfied with how we have kept them informed and with the alternative access points that we have used in response to Covid-19.

- Some of our population have experienced the reverse and have struggled to access information about Covid-19 and local service changes and have faced significant barriers to accessing services. These tend to be our most vulnerable communities and those who face the greatest barriers to accessing healthcare.
- Some of the changes we have made in response to Covid-19 out of necessity have exacerbated existing inequalities in service access for our most marginalised and vulnerable communities.
- Some of the barriers identified are shared across many communities, and some are very specific to particular communities.
- Use of community pharmacy has been a success – satisfaction among our population with pharmacy services has remained high throughout the pandemic.
- Remote consultations are broadly supported, although the level of support for increasing their use depends on the care setting and what is being discussed within the appointment.
- There is little correlation between age of respondents and level of support for remote consultations.
- For some communities there are significant barriers to accessing remote consultations. Some of these are shared across a number of communities and some are very specific.
- Socio-economic factors are significant – digital access, access to a phone and access to information all have a socio-economic element. This needs exploring in more detail as we analyse the data.
- There may also be a geographic significance within the data – again this needs exploring in more detail.

4   Key insights

<u>Findings from desktop research</u>

4.1   The pandemic and related service changes have disproportionately affected some groups more than others, and have exacerbated existing health inequalities and barriers to access. The research we reviewed highlighted the following.

- People who experience barriers to accessing information have been unable to identify how to access services and have been unable to access information on the virus and how to protect themselves, In particular people who do not speak English and people who are disabled or have a learning disability have been further marginalised.
- There has been some confusion among the public as to what services are available and how to access them. This has been due to a lack of clarity in communication.
- The most common reasons people have avoided using healthcare services even if they have felt they needed to have been fear of contracting Covid-19 and not wanting to put additional pressure on NHS services.
- People have been most comfortable accessing pharmacy services. This is reflected in local and national data on service usage, with an increase in the use of community pharmacy and 111 and a high level of satisfaction among our local population with pharmacy services during the pandemic.

- The use of remote consultations, mainly in primary care, has been well received. However, many groups have faced significant barriers to accessing remote consultations. This has also been a key theme across our local engagement.

4.2 Our desktop research also explored the impact on a number of groups. This highlighted the following:
- The disproportionate impact of Covid-19 on BAME communities has been well documented. Public Health England's research highlighted that further work is needed, in partnership with BAME communities, to properly understand and address these impacts.
- Local and national research on the impact of Covid-19 on Asylum Seekers and refugees has highlighted a number of issues, including difficulty accessing information in translated formats; lack of understanding about Covid-19 in general and a distrust of local services.
- People with disabilities have had issues accessing information about Covid-19 and related service changes in ways that they can understand.
- Lockdown has impacted existing carers and created 'new' carers. Those already caring for someone have found that the number of hours they spend caring have increased and a number of people are now caring for someone for the first time. Lockdown has also increased carers' feelings of loneliness and isolation.
- Covid-19 has heightened existing mental health issues for some people. People with mental health problems have also found it more difficult to access support.

Findings from quantitative research

4.3 The quantitative research was delivered by DJS Research, a social research agency. The sample of 2,000 responses was controlled to ensure it is properly representative of the Nottingham and Nottinghamshire (ICS) population. The findings can therefore said to be representative of our population. Further analysis is currently being undertaken to drill down into the findings. The headlines at this stage are as follows:
- Many people have put off accessing healthcare during the pandemic, either because of concerns about overwhelming the NHS or through fear of catching Covid-19.
- We identified satisfaction with the information provided by the local and national NHS (70% and 78% satisfied respectively) and support for continuation of remote consultations among a majority of the population.
- Pharmacy as an access point has been a success during the pandemic, with 90% finding it easy to access. This compares to 78% who found their GP easy to access.
- Reported ease of access to services varied by demographic factors. This needs further analysis.
- Support for continuing remote consultations varies by care setting with people being most supportive of their use for GP appointments (64%). Support for continuing the use of remote consultations is lower for routine hospital appointments (56%) and lower still for mental health services (46%).
- The 'what' of the appointment is hugely important to people in whether they support the use of remote consultations or not. For example, 69% would be happy discussing a

minor physical illness or injury remotely while 26% would be happy hearing bad news for the first time remotely.

- The factors that would encourage people to use remote consultations are similar to those that people value in face-to-face appointments – convenience and continuity of care. Having appointments at a time to suit the patient (59%) and seeing the same healthcare professional (57%) were the factors most people felt would be helpful.
- Satisfaction with remote consultations for those that accessed them was high across all age groups, indicating age is not the determining factor on likelihood to embrace remote consultations.
- Of those that had experienced the new integrated discharge process, either directly or as a relative, most found the experience positive.
- Just over half of respondents (56%) support a continuation of the discharge process and a small number (14%) oppose this. The large number of neutral responses reflects that many are uncertain what this means.

Findings from qualitative research

4.4 To date two focus groups have taken place, with light service users and frequent service users respectively. While these have yet to be analysed, the agency delivering the work have provided the following early summary.

- Light service users (mostly healthy) were highly satisfied with the way the NHS has responded to the crisis. They displayed a strong sense of protection toward the NHS, meaning both that they are advocates but also that they are likely to put off seeking treatment if they feel it would put unnecessary pressure on services.
- This group were very supportive of expanding the use of remote consultations, to the point that they felt the choice should not always be the patient's own. The expected age divide in this area has not played out in the focus groups, as it does not in the quantitative data.
- Participants felt that *they* understood how to choose the right service to use, but that *others* may misuse the system.
- Heavy service users (people with multiple long-term conditions) displayed very different views and were sceptical about increased use of remote consultations. They were also more likely to have experienced delays, cancellations and other problems with appointments and were therefore less likely to agree that the NHS has adapted well to the pandemic.

Findings from targeted engagement

4.5 Our targeted engagement spanned a broad range of groups and communities. A mapping exercise undertaken with the Community Voluntary Service (CVS) Alliance partnering the CCG in this work identified those most likely to be vulnerable as a result of Covid-19 and related service changes. These were the groups we specifically approached, working through the local Voluntary and Community Sector (VCS) organisations that support them. Working in this way, through organisations that are trusted in communities, allowed us to reach people who we often find it difficult to engage with.

The core findings from this work are:

- Many of the positive impacts and the challenges experienced by the wider population were also experienced by the groups that were engaged with. However, challenges and negative impacts arising from the pandemic, Government restrictions and NHS service changes have exacerbated existing health inequalities.
- Changes to the way in which services are accessed have created additional barriers for some groups, particularly remote consultations. There are opportunities to support different communities to use alternative access points (e.g. remote consultations) that would allow us to lock in the benefits without marginalising people who face barriers to access.
- For remote consultations, there a number of barriers that are specific to different communities and barriers that are common across all the groups we engaged with. These are detailed in appendix 3 and should be reviewed to support any wider roll out of remote consultations. In particular, the CCG should note the barriers faced by people whose first language is not English and for people who are Deaf.
- Adjustments to services are needed if barriers to access are to be reduced for remote consultations. In particular, access to interpretation services are essential given the high proportion of people across Nottingham and Nottinghamshire for whom English is not a first language.
- Language, literacy and access to technology are significant barriers to some communities in accessing telephone and online platforms for medical appointments.
- Some of our most vulnerable communities share mobile phones with others, and so face significant privacy issues in accessing appointments by telephone or online (using a smartphone).
- Many of the people we engaged experience digital exclusion. Many also do not have access to a phone, or have sporadic access (e.g. share a phone or often do not have mobile phone credit).
- Accessible and tailored information needs to be produced and then properly cascaded to communities through channels that they use and trust. Core messages on Covid-19 risks and local service access are not getting through to some groups.
- Feelings of isolation and vulnerability have been exacerbated by Covid-19, Government restrictions and NHS service changes.

5   Next steps

5.1   Further analysis of the quantitative data is being undertaken, with a drill down into the factors driving responses e.g. who supports/opposes particular changes. This interim report will be presented to Governing Body and the CCG's Patient and Public Engagement Committee (PPEC), as well as a range of other local system forums. These discussions will inform the development of a set of recommendations for action to be presented to the Governing Body, along with the final reports, in December.

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