

# Experiences of accessing healthcare services during Covid-19.



January 2021.



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# Executive Summary

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Over 100 groups representing the most vulnerable communities across Nottingham and Nottinghamshire participated in this programme of work that was undertaken to understand the impact of changes made to the way health services were delivered during the Covid-19 pandemic.

A range of changes were made to help the NHS cope with the impact of Covid-19 and to keep our patients and staff safe. The changes were already part of a planned strategy to improve the delivery and efficiency of services, but their early implementation arose from the Covid-19 pandemic and included;

- An increase in the use of telephone and online consultations with health care professionals
- Reduced attendances at the Accident & Emergency Department
- An increase in the use of NHS111 or 111 online
- A new discharge assessment to speed up hospital discharges.

The specific objectives of this programme of work aimed to;

1. Understand people's views of the changes made, even if they were not directly affected
2. Understand the tolerance of the population for keeping the changes made
3. Understand the impact of changes on the people directly affected
4. Understand the impact of keeping changes on the people directly affected
5. Understand the impact of changes on groups who are vulnerable and face barriers to accessing services as a result of Covid-19.

The key messages may be distilled into the following;

- Many of the positives and the challenges experienced by the wider population were also experienced by the groups that were engaged with. But the challenges often exacerbated existing health inequalities and vice-versa.
- Changes to access to services needs to be carefully considered for all these groups – but real opportunities as well as pitfalls of remote access
- One size does not fit all – a universal approach to the delivery of services often excludes vulnerable patient groups.
- Language, literacy and access to the use of technology were significant barriers to some communities, when accessing telephone and online platforms for medical appointments. Privacy issues arose for the most vulnerable due to the sharing of mobile phones.
- Digital inclusion is key to improving access.
- Adjustments to services are needed if barriers to access are to be reduced, for example, access to interpretation services absolute priority to enable those people for whom English is not their first language to successfully navigate or access healthcare services.
- Accessible and tailored information needs to be effectively cascaded into communities.
- Isolation and increased vulnerability seen in many groups, both because of the pandemic, the government's changes and our changes

- Poverty and disadvantage are factors in accessing healthcare and whilst these are wider social issues, measures can be put in place to mitigate the extent of their impact.

As a next step it is expected that the CCG and system partners provide a response to the findings detailed in this report and develop a dedicated strategy to improve access to services and more effectively meet the needs of vulnerable patient groups to reduce health inequalities that were in existence prior to Covid-19 but have been exacerbated by the pandemic.

Whilst many of the groups who participated appreciated the opportunity to have their voice heard and be involved, the importance of communicating the outcomes of this piece of work to these communities cannot be overstated.

# Introduction

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The Recovery Engagement focused on understanding how changes in the delivery of services in response to Covid-19 impacted the patient population of Nottingham City and County . The CCG wanted to gauge patient perspective relating to adjustments to health and social care during the pandemic, and specifically gain feedback in relation to the changes listed below:

- An increase in the use of telephone and online consultations with health care professionals.
- Reduced attendances at the Accident & Emergency Department.
- An increase in the use of NHS111 or 111 online.
- A new discharge assessment to speed up hospital discharges.

These scheduled changes were already part of a planned strategy to improve the delivery and efficiency of services, but their early implementation arose from the Covid-19 pandemic.

The work was divided into three distinct elements:

1. Surveys conducted with a demographically representative section of the patient population.
2. Targeted and deeper dive engagement by CCG with specific patient cohorts.
3. Additional in-depth engagement by voluntary sector partners with vulnerable and harder to reach cohorts.

This report relates to the work undertaken by the CCG Engagement Team and the Voluntary Sector Alliance. The Voluntary Sector Alliance comprises a partnership of the following organisations;

- Ashfield Voluntary Action
- Mansfield CVS
- Newark & Sherwood CVS
- Nottingham CVS
- Rushcliffe CVS

## Methodology

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The CCG Engagement Team and Voluntary Sector Alliance (VSA) worked together to gather rich insight into the experience of patients and the wider community across Nottingham City and Nottinghamshire County.

Identification of the patient cohorts was informed by the demographic profile of Nottingham and Nottinghamshire and focused on the most vulnerable groups likely to experience additional barriers when accessing services. In addition, input from statutory services was sought where necessary to ensure a thorough and in-depth understanding. Details of the groups engaged with by patient cohort may be found in Appendix 1.

Conversations comprised a mixture of focus groups, telephone/email/text conversations, virtual meetings and workshops and later in the engagement a few socially distanced face-to-face meetings. Conversations were guided through a template discussion document

linked to the main survey to ensure a consistency of approach, whilst also facilitating the capture of valuable in-depth feedback.

Members of the CCG's Patient and Public Engagement Committee, practice based Patient Participation Groups and Patient Leaders participated in this programme of work and their experiences and feedback are incorporated within the relevant patient cohort they represent.

Whilst feedback was elicited in relation to all of the cohorts it also became apparent that many VCS organisations, particularly smaller groups, were unable to deliver their services due to reduced staff and volunteer numbers, or the inability to operate safely. This did impact on the number of organisations who were able to feedback on the impact of changes to services on the people that they support.

# Key Findings by Patient Cohort

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## Asylum Seekers and Refugees

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A series of telephone interviews were used to obtain feedback about the experiences of asylum seekers and refugees (AS&Rs) during Covid-19.

### Experience of accessing healthcare services

#### Telephone or Video Consultations

Many AS&R's experienced difficulties accessing telephone or video consultations because they did not have access to mobile phones and had insufficient credit or privacy (particularly when sharing phones or accommodation). The sharing of mobile phones was a barrier for female AS&R's when wanting to access sensitive services such as support for domestic abuse or a termination of an unwanted pregnancy etc., because their history of calls and messaging could be visible to others in terms of their digital footprint.

When AS&R's did attempt to access telephone consultations many were not provided an interpreter (most AS&R's do not speak English). This language barrier also meant that they could not understand any text messages sent by the NHS relating to medical appointments etc. Where telephone or video consultations happened, often these were enabled by the internal interpreters provided by a supporting agency (i.e. a charity). One organisation felt it had to remain visible and accessible during the lockdown period so continued with some face to face appointments because they recognised the communication barriers and the safeguarding risks that the AS&R community face. Another organisation (supporting a more settled Syrian AS&R community) relied on the 'What's App' resource to communicate with their service users because this was what they preferred. The organisation translated any healthcare advice into both English and Arabic and sent this via 'What's App'.

#### Increased use of NHS 11 and 111 on line

There was an increased use of 111 (and in some cases 999) where AS&R's were not able to access a face to face consultation or where they were not registered with a GP. Access to healthcare services was particularly problematic for approximately 291 AS&R's temporarily accommodated in two Nottingham City Covid-19 contingency sites where there was no primary care pathway in place. This cohort had many complex needs; many were new to the country and had with limited levels of English so their support staff had no option other than recourse to 111 services.

In all, language, literacy and access to the use of technology were significant barriers to the AS&R communities accessing telephone and online platforms for medical appointments.

In order to mitigate the digital exclusion experienced by the AS&R community, suggestions from stakeholders included restoring face to face consultations for those patients whose needs cannot be met remotely; more targeted Public Health information and in particular for non-English speaking women and more overall help to access primary health services.

#### Access to services during the pandemic Information provision

The AS&R community felt that there was a lack of information provision in the public arena. Stakeholders reported that any information that was available did not appear to be tailored to AS&R needs i.e. their circumstances, culture and language. One organization acquired information from the Nottingham & Nottinghamshire Refugee Forum and circulated this around. AS&R women were particularly impacted as they lost their face to face interpreters (many of these were from the BAMER community themselves and had legitimate concerns

about their heightened vulnerabilities in relation to Covid 19). Similarly where interpreters were available, many were male interpreters which women weren't always comfortable with. One organisation had to rely on Language Line and Big Word to provide interpretation for them.

### **Behaviours regarding accessing services**

Overall AS&R's were reluctant to access NHS services as they became increasingly aware of the additional risks posed to the BAMER communities and some felt stigmatised as a result of their ethnicity. The AS&R's reported not being understood in terms of receiving a culturally sensitive service, and as a consequence tended to close up. Pregnant AS&R women found attending hospital for scans etc. difficult and daunting as they had to attend unaccompanied (without a partner) due Covid restrictions. In addition, the lack of interpretation services provided meant many pregnant women were only staying for part of their hospital ante-natal appointments because they did not understand that they had to stay for other important tests.

### **Choice of services and appetite to continue to use same services going forward**

A minority of homeless AS&R's had more positive experiences- those accommodated in a shelter were supported by the Health Homeless Team who facilitated access to other services e.g. the Health bus, Let's Talk Wellbeing and the Crisis Team. There were accounts of AS&R's using community pharmacies when enabled through a third part such as a housing provider who provided their own internal translation services. Whilst there was some uptake of the 111 service, on the whole, it did not appear that the service changes made during the pandemic would meet the majority of the AS&R's needs going forward. Where these services were accessed it was usually by dint of the advocacy and commitment provided by the support agencies that the AS&R's were linked in with.

### **Reduced Attendances at the Accident & Emergency Department**

There were examples where some AS&R's should have accessed emergency hospital provision but elected to not attend or had to be strongly encouraged by support agencies. These included a young male who had been knocked down by a car from a bike was reluctant to go to A&E and an adult female pregnant and bleeding with a potential miscarriage. Some stakeholders provided examples of very sick AS&R's requiring hospital outpatient treatment including second tier mental health support.

In all, many of the wider Asylum Seeker and Refugee community did not actively engage with both primary and secondary healthcare support when needing this due to the material barriers they faced and their perceived BAMER risk in terms of Covid.

### **Discharge from hospital**

No experiences relating to discharge from hospital were offered.

In order to mitigate some of the choices offered to access services during Covid 19 it was felt that better engagement with trusted third sector organisations would be helpful. Others suggested more visibility of NHS services in the community – such as attending events, community focused campaigns and other creative and innovative ways that help people feel part of NHS on an on-going manner, such as media and partnership programmes that inform and sustain interest and tackle fake news.

### **Additional Comments Received**

It was felt that interpretation services for those individuals for whom English is not their first language was an absolute priority. Without this AS&R's cannot successfully navigate or access healthcare services. Stakeholders wanted it acknowledging that many AS&R's do not possess the necessary resources to enable telephone calls. Many do not have access to free WIFI to take part in on-line consultations (especially when public places with open WIFI like libraries were closed). It was suggested that providing free WIFI for service users living



in designated R&AS accommodation would be helpful so that they could use this and have some privacy during an on-line consultation.

Stakeholders commented that the pandemic raised the importance of good, flexible, partnership working. Pre-existing relationships with other services helped reduce the amount of stress & anxiety AS&R's felt. Overall many indicated that Healthcare staff could make better use of agencies involved in the support of vulnerable AS&R communities to enable them to access health services effectively and help prevent their health needs escalating. Without this it was felt there needs would largely continue to go unmet in future circumstances.

## **Black, Asian and Minority Ethnic (BAME) Communities**

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The health of the younger Asian population may be suffering because they live with elders who are at high risk of Covid 19 so they do not want to leave the house to go to appointments in case they carry the infection.

Some people (particularly the older Pakistani community) are rationing medication because the messages about access to pharmacies have not reached them.

BAME communities are particularly anxious because they have been told that they are at high risk of Covid-19 but this has not been fully explained so they do not know what support they should access.

BAME communities are not getting all of the key Covid messages and may not understand what lockdown means or where to go for information and support.

### **Key Messages**

- When English is not your first language, appointments by phone or email are impossible and it is hard for patients to explain their symptoms and needs.
- The health of the younger Asian population may be suffering because they live with elders who are at high risk of Covid 19 - they do not want to leave the house to go to appointments in case they carry the infection.
- Interpreters have not been allowed to attend appointments with their clients, so the client has been unable to seek medical attention.
- Some people (particularly the older Pakistani community) are rationing medication because the messages about access to pharmacies have not reached them.
- Communication and resources have not reached migrant communities.
- BAME communities have been told that they are at high risk of Covid 19, but this has not been fully explained, so they do not know what support they should access.
- BAME communities are not getting all of the key Covid messages and may not understand what lockdown means, or where to go for information and support.

## **Carers**

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### **Experience of accessing healthcare services**

Carers provided mixed feedback with some reporting no issues accessing services such as Primary Care and they praised the Ambulance and Pharmacy services. Some carers found medicine management easier and really appreciated volunteers delivering medication to their homes, free of cost. However, some carers reported greater difficulty in accessing healthcare services and medication, despite ordering them online, resulting in some missing essential medication for a few days. The postponement of routine injections accessed through Primary Care was also raised as an area of concern along with the delay of other treatments and operations through Secondary care, leading to a decline in health.

## **Telephone and Video Consultations**

Remote consultations were noted as beneficial for carers who were able to access these methods especially for carers who may find it challenging to leave home due to their caring responsibilities. However, challenges to remote consultations were reported by many. These include:

- Issues for carers who don't speak English. These carers currently depend on family or friends to assist with translation and rely on their availability, which frequently delays access to healthcare services.
- Issues for those without access to digital technology such as the ageing population.
- Lower sense of reassurance over remote methods.
- Greater difficulty to express oneself and share information over the phone or video compared to face-to-face.
- Concerns around misinformation, misdiagnosis and medication prescribed when not seen face-to-face.

Carers felt it was essential that they are offered a choice in the method of engaging with healthcare services and suggested that healthcare professionals check-in and monitor the health of those who don't have access to these methods to ensure they are not forgotten.

## **Increased used of NHS111 and 111 online**

Many sources of information presented to carers instructed them to contact 111 if they needed healthcare assistance hence many used NHS 111 services. This resulted in some confusion as it was reported that carers would call 111 when they needed to contact 999.

## **Information provision**

Overall, adult and young carers felt there was a lack of information available on how, where and when to access healthcare services. It was suggested that a direct dial number exist for carers to call and gain information on services available. Carers who felt they had received enough information actively searched for guidance or had contact with many health and social care services who kept them informed. Concerns existed around the information currently available carers felt it was not always clear or accessible to different groups such as those with disabilities, people who don't speak English or for people who do not have access to digital technology, where most information was circulated.

Issues were also raised with communication between services but also with patients regarding operations and treatment. Carers noted that they either received no information about when their postponed treatment or operations would take place or they received contradictory information with one carer noting "administration has been a mess i.e. phone calls and letters...". This also caused anxiety in some such as those with Autism who need to know in advance what is happening with their treatment.

## **Behaviours regarding accessing services**

Carers reported fear of catching COVID-19, hesitance to add further pressure to the NHS or shielding as reasons for avoiding healthcare services. Access to transport to attend appointments was also noted as an issue with some carers not having their own vehicle, unable to afford private taxis and having to rely on public transport when they are also meant to be shielding.

## **Choice of services and appetite to continue to use same services going forward**

The few carers who reported accessing services differently used NHS 111 and pharmacy services more for advice. Carers appreciated remote consultations but stressed the importance of offering everyone a choice. Many carers noted that they want services to return to the way they operated pre-pandemic. Carers particularly want to access respite services again, such as Day Centres, as they have been providing additional care during the

pandemic which has been taking a toll on their own wellbeing. Some would like the free delivery of medication to home continue.

### **Discharge from hospital**

Feedback from most carers who had experience of discharge felt that the process was rushed and had concerns for the safety of their loved ones. Carers did not feel very involved in the care of their loved one and reported a lack of communication about the health conditions and information on home care. Some carers were not informed when their loved one would be discharged, which did not give carers time to prepare for their return home.

Comments on the quick discharging of patients to care home were made with initial concerns around the lack of COVID-19 testing for these patients. The need for consistency in visiting rules at care homes and greater support for care home staff when working with COVID-19 patients was reported.

### **Other comments**

Some carers suggested that the administering of a COVID-19 test prior to appointments with Primary Care and the wearing of Personal Protective Equipment (PPE) could be approaches taken to ensure people are able to have face-to-face appointments. It was also suggested that patients are matched with healthcare professionals who speak their language to ensure greater accessibility for those who do not speak English. Carers noted that greater efforts need to be made to support mental health, single parents caring for more than one child and a child with disabilities and the remote monitoring of patients at home and care homes have also been suggested as beneficial.

Carers who have lost a loved one during the pandemic have been struggling to cope as they were not able to see them as they were moved from care home to hospital.

## **Deaf Community**

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There was a consensus of opinion that a 'one size fits all' approach simply does not work with this patient cohort.

Services and patients approached through this research fed back the difficulties they had encountered in accessing services and information. Without exception, all reported accessing services was more difficult for them following changes to service delivery. This was particularly the case for those with additional or complex needs, e.g. hearing and sight loss, hearing loss and a disability, hearing loss and frailty or poor mobility.

The key issues that were consistently raised by this patient cohort were as follows:

- Where GP Surgeries suspended booking online appointments during the pandemic, deaf patients had no option but to use the telephone to book appointments. This meant that they often had to rely on other people to make telephone calls.
- Patients were offered online or phone appointments which did not meet their needs.
- Wearing face masks means that lip reading is impossible. The deaf community tends to rely on visual cues; the wearing of masks removes access to this and makes deaf service users feel very vulnerable and nervous in healthcare settings.
- Those without computers or smart phones were unable to complete online questionnaires prior to making appointments.
- Background noise or music, or an echo on the line, makes phone calls very difficult for those with hearing loss.
- Assisted technology is available, but installation engineers were not able to visit the homes of those who were shielding.

- Those who were asked at a phone medical consultation to provide their temperature and/or blood pressure reading are unable to do this without talking equipment, which is out of stock with all providers.
- Many had been sent letters saying that their appointments were postponed and that they would be sent an appointment by phone, but this didn't happen.
- Service users found having to liaise with receptionists or nurses they didn't know was more likely to leave them with unresolved issues.
- Letters were not routinely sent out in large print and whilst a large print version was offered, this was often mentioned at the end of the letter and too difficult for partially sighted patients to read.
- Changes created major problems for deaf service users particularly those who have both sight loss and hearing problems.
- Service users without smart phones and computers particularly struggled.
- Many deaf service users are worried and frustrated with limited access and services and did not understand fully how to access services or what to expect.
- A patient arranged a telephone consultation with their GP Surgery via an interpreter. When a third party is involved it is imperative that the GP calls as scheduled, wherever possible.
- Deaf service users said that they were not aware of how to access services when lock down began.
- The GP surgery is often the first point of contact for this patient cohort.
- Service users reported that NHS staff appeared unaware of the needs of deaf people when wearing masks. However, most commented that when they realise it is a deaf person, they remove the mask.
- Many within this cohort would not access healthcare via video consultancy and are not digitally connected and don't want to be.
- This cohort of patients would benefit from having information sent to them via post, so they have it readily to hand. Some would not approach their GP or A&E unless it was an absolute necessity.
- Deaf patients have not been able to access services very easily due to most becoming telephone service such as befriending, also workers have not been able to resolve this as assisted technology within their home hasn't been set up and could be some time before anyone is able to go into their homes. (link worker feedback)
- Very few of the changes to services made life better.

### **Case Study 1**

A deaf patient attended their GP Surgery during the pandemic. They felt there was no attempt to accommodate their communication needs. The patient rang the doorbell for Reception, but this was not answered or dealt with, although Reception staff were in the building.

### **Case Study 2**

The leader of one community-based project spoke about a service user who is 80, has had three strokes, is registered blind, is deaf, and is very frail and vulnerable. His eyesight was getting worse all the time and his speech "wasn't good". He lives alone in his own home and is very reluctant to access help. The community leader had contacted Social Services to try to lever in some support for him but had been told he had to ring himself because of Data Protection. Because of Covid-19, Social Services were doing everything remotely and the community leader had been told that he would have to ring, but this was totally impossible because of his hearing loss.

The community leader said she had also encountered similar problems when contacting his GP. Whilst she understood that GPs couldn't share information, there needs to be a way of accessing help for vulnerable individuals. The gentleman was struggling with taking medication appropriately. The community leader asked the Practice if they could advise her

which of his many medications was the most important for him to take, so that they could prioritise that, but nobody would speak to her. She said that she felt that there needed to be individual adjustments which took into consideration the vulnerability of service users and services should not just make blanket decisions.

### **Case Study 3**

A deaf service user with a disabled daughter requested that her GP got in contact as her daughter's medication had been changed to a different brand without explanation and her daughter was refusing to take the new medication.

After two weeks the GP still had not been in touch with the deaf service user who made a complaint to her support worker, who in turn approached the Surgery. The usual medication was out of stock due to the UK leaving the EU and so the GP had prescribed an alternative and did not feel that it was necessary to contact the patient to explain. The Pharmacy was very helpful and tried to find the original brand of medication, but unfortunately failed. The service user eventually accepted the explanation and change but felt that the GP could have been significantly more helpful.

### **Case Study 4**

One service user reported that she had a blood test during the pandemic, and it was a very distressing experience. She felt that the nurse was angry with her request to lower her mask (which was refused) and said that she felt humiliated and commented that the nurse had complained in front of other staff and patients.

She asked why medical notes couldn't raise a red flag that a person is deaf and be treated accordingly. She commented that staff were too busy to look at the front cover of her patient file which identifies that she is deaf and uses a BSL interpreter.

### **Case Study 5**

The volunteer leader of a support group is an elderly gentleman with hearing difficulties. He has a heart condition which is being managed with a pacemaker.

He had some dates scheduled for a range of medical appointments. He had been contacted via phone from the hospital and GP Surgery to cancel his face-to-face appointments and have them over the phone. The calls were not expected, but he was pleased they had called and clarified the situation.

He had one call from a consultant at Kings Mill, consultant to check on his pacemaker and general wellbeing. The Consultant sent a follow up letter to the patient and wrote to his GP with the results.

His second interaction was with his GP Surgery to check on his medication and discharge him in relation to his heart. The nurse is doing warfarin tests at his home which he was very pleased about as he had been concerned about sitting in hospital with lots of other people, worrying about infection. These tests are anticipated to be monthly.

He would be happy to have phone consultation as long as his wife was present.

### **Case Study 6**

A 94-year-old patient with Macular Degeneration, hearing loss and mobility problems was scheduled to have an injection in her eye. The appointment still went ahead. Her experience at the hospital for her injection was positive - she just had to wait. The hospital PPE was good and the instructions on safe distancing and wearing masks were very clear. The patient was relieved that living in Newark & Sherwood she had not been sent to Kings Mill. It is difficult to get to Kings Mill, and without transport impossible. Previously, she attended Kings Mill for ear and eye macular injections, but then the procedures were transferred to Newark.

Normally she also had annual hearing aid checks, but as the service was closed in Newark, Kings Mill quickly posted replacement batteries to her and she was extremely pleased with the service. This highlighted the complementary way the two hospitals work together.

### **Key messages**

- Deaf patients have not been able to access services very easily owing to most switching to telephone services during the pandemic.
- Assisted technology is available, but installation engineers were not able to visit the homes of those who were shielding.
- Transparent face masks are not widely available / utilised, making lip reading impossible.
- GP consultation by telephone / video call was not possible for this patient cohort.
- The deaf community feels that not enough is being done to accommodate them.
- GDPR and safeguarding considerations can be an issue for organisations supporting vulnerable service users, particularly those who cannot advocate for themselves.

## **Dementia**

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The level of response we received from the groups supporting people living with Dementia and their carers was excellent and we received valuable insight and feedback.

Through the feedback it became apparent that not only was this patient cohort at greater risk from Covid-19, there was a profound impact on every aspect of their lives from the virus.

### **Changes to the delivery of healthcare services**

Age UK commented that the changes and reduction in outpatient and other regular health care services for those with long-term health conditions has caused concern. On one hand people are concerned that their long-term health condition may deteriorate without treatment, but after many months at home they are now worried about the risk of COVID-19 infection, as and when, services begin to reopen.

### **Alternative provision of treatment for people who were shielding**

The feedback in relation to access to services was mixed. Some things worked well, others not so much. Some adjustments to services had a significant negative impact on this cohort of patients.

Two members of a Dementia support group required footcare and as they were also shielding, they were treated at home. Both were initially very apprehensive about this, but the healthcare professionals were fully equipped with PPE, and were helpful and informative and this had gone a long way to reassuring these patients.

### **Feedback on video and telephone consultation**

Two members of one Dementia support group had had telephone consultations with their GP and were happy with this. The GP Surgery also offered video consultation but neither had a computer, laptop or smart phone to access this. As both were shielding one needing a repeat prescription, was able to phone for this and the Pharmacist was able to deliver their prescription which they found extremely helpful.

Another point raised frequently, both by services and those accessing them related to the anxiety service users felt when expecting a call from their GP surgery.

Age UK commented that their service users reported feeling stressed. They are told to expect a call from their doctor or consultant but with no confirmation of the time and in one instance, even the day. This has led to anxiety where service users feel that they need to

stay indoors and be by the phone for fear of missing the call and worrying that they would not get another one.

### **Accessing services during lockdown**

Four members of the Forget-Me-Not Group had hospital appointments during lockdown. These scheduled appointments were rearranged, and when the appointments eventually went ahead the patients found everything to be well-organised. The amended processes meant that things were done a little more slowly, but they found this to be better and said that it gave them time and chance for things to “*sink in better*”. They were initially anxious about the risk of Covid but reassured by all the precautions put in place. They felt that everything was calmer and felt more at ease.

One of the Social Prescribing Link Workers described the experience of a patient accessing support. The gentleman is a carer for his wife who is living with Dementia. He needed input from the falls team, and an alarm system was put in place by AGE UK. This was achieved without problem.

Face-to-face memory clinics have stopped, so many patients are part way through an assessment process for Dementia, but do not have their diagnosis or the support they need. They are in limbo waiting - Nottingham Alzheimer’s Society is making 700-1000 wellbeing calls every week with a staff team of 6.

A service user at the Newark and Bridge Community Memory Café had her annual review done over the phone.

She described it as being a little inconvenient, as she didn’t know what time to expect a call and couldn’t use the phone for fear of blocking the line when the GP called. This was followed by two appointments at the surgery for blood tests. Whilst she had been impressed with the precautionary measures at the surgery, one-way-in, one-way-out, she had to wait outside in the rain and there was nowhere to shelter.

When the GP rang to give blood test results, the GP asked if she had any other worries. She mentioned a long-standing cough and was sent for an X-ray. The GP rang back with the results and disclosed that she had one lung larger than the other and the probable reason for this was heart failure. She was shattered, especially as heart failure ran in her family. The GP arranged for more blood tests and then called back to say it wasn’t heart failure. The cough was most likely reflux and she was given a course of tablets. To hear such news over the phone was devastating. The lady lives on her own and had no one to talk to or share how she felt. She said that she would have preferred not to receive worrying information over the phone and didn’t feel that she should have been given a diagnosis before the results came back.

### **Information and access to services**

#### **Reticence at accessing health care**

One common theme which came up repeatedly in this research was the reluctance of some of this patient cohort to access health care through the pandemic. This appears to be a combination of factors: fear of contracting Covid-19, not wanting to ‘waste the time’ of health care professionals, or concern about exposing a vulnerable family member to risk.

Age UK commented that there is a growing concern that some Extremely Vulnerable People have become institutionalised, lost confidence and just want to stay at home where they feel safe. This is particularly the case for those who were previously shielding.

The leader of the Forget-Me-Not service said that there was very much a concern amongst their service users that they were “...*wasting time*” as health care professionals had “...*more important things to do in treating Covid*”.

Another member is becoming quite frail and is not at all well but is so afraid of contracting Covid that they are *'keeping their distance'* and not accessing health care.

Another support worker commented, "I do a Wellness Check for a gentleman who was a carer for his wife with Dementia. He had a GP appointment for a blood test, but knew that if he went, he would have to take his wife with him, and she was in the shielding category. Although I telephoned the Surgery, and the Surgery telephoned him to reassure him that ...it was a safe environment, he still would not attend. So, ...a patient's health was impacted directly by lockdown."

### **Deaths during lockdown**

Three members of the Forget-Me-Not support group died during lockdown. One was a carer and the other two were people living with Dementia. This was extremely difficult as extended family were unable to say their farewells and the person left behind couldn't have family around them for support. The death of the carer had an additional knock-on effect, as extended family had to make alternative care arrangements for their relative, as well as cope with bereavement. The extended family had been shielded from the extent of their family member's Dementia by the carer and the bereavement of the person living with Dementia was compounded by the change of routine arising from the sudden death.

One member said that she had had to deal with everything on her own, as other people couldn't be there at the most difficult point in her life because of lockdown. She said that the funeral directors had been extremely helpful, as had the hospital.

Age UK spoke of another service user who had been a long-term carer for her husband who was living with Parkinson's. During the lockdown they stayed isolated and did not access any form of support or respite. When the lockdown restrictions were eased, the client made the decision to allow her husband to access respite at a home that he had visited previously. Sadly, her husband contracted Covid-19 in the home and has since died. The service user is blaming herself for her husband's death, is completely traumatised and will need a great deal of support to deal with what has happened.

### **Perceived lack of information around diagnosis of Covid-19**

Patient feedback highlighted misconceptions around diagnosis of Covid-19 on three separate occasions from two different sources<sup>1</sup>.

One Key Worker talked of two patients who had lost relatives during lockdown. The key worker had been told that the cause of death in each instance was recorded as Covid-19, even though relatives had not been aware of this diagnosis. The relatives were of the belief that the deaths would not be investigated by the Coroner and there would be no post-mortem, *"...because people whose cause of death was recorded as Coronavirus don't have a post-mortem and this is a cost-saving exercise"*.

We also heard the same thing from another source (reportedly through a non-clinical member of staff at Kings Mill Hospital).

Whilst rumour is almost inevitable in situations where people feel vulnerable and powerless, this illustrates the importance of effective communication. More explicit communication around testing and diagnosis may prevent misconceptions.

### **Struggles through shielding & accessing social care**

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<sup>1</sup> In one instance a patient had spoken to a key worker who relayed the conversation to us and in a second instance a patient talked of something they had heard 'on the grapevine' from a non-clinical employee at Kings Mill Hospital.



Two group members were finding it very difficult to cope through shielding. One woman is the carer for her husband who is living with Dementia and had found lockdown extremely difficult.

Another member cares for his wife living with Dementia. Normally he is able to cope reasonably well with the support of his daughter, but as his daughter was also shielding because of her own health issues, he was really struggling to cope. He had tried to contact Social Services numerous times but had not been able to get through. The automated service suggests that people go online, but he does not have a computer, tablet or smart phone. In the end he gave up trying to access Social Services for support.

Another member has difficulty walking and is now walking with a frame. His wife had Dementia and died shortly before the pandemic. Initially he was shielding, but his family have become increasingly worried about him and stepped up their visits. He doesn't have a computer, so all communication has to be by telephone, and he is feeling very isolated. Although his family visit and telephone he is finding shielding a struggle especially spending so much time on his own. He is really worried about his health and losing his independence but frightened to call for help - because of the risk of catching Covid.

Routine is important for people with Dementia (and those with other impairments) but Covid 19 is disrupting this.

### **People living with dementia in care homes**

Apart from the disproportionately high number of deaths in care homes due to Coronavirus there is the issue of isolation and impact of lockdown on people living in care homes.

Three of the members of the Forget-Me-Not group have spouses who are living in Care Homes as a consequence of Dementia. They have found not being able to visit through lockdown incredibly difficult. One man said that not being able to visit had meant that his wife had now forgotten him completely. He said that when he was visiting her regularly, he would often see a little glimmer of recognition from her, but that she now just stares blankly at the wall and appears to have forgotten him. He is absolutely devastated and is finding it very stressful. People living with Dementia don't understand why their loved ones can't visit and it is stressful and has a devastating impact on all family members. Without contact on a regular basis the relationship can slip away. They all felt that lockdown had sped up the progress of dementia in their loved one.

### **Accessing A&E**

A married couple had a very good, if traumatic, experience with A&E. The wife is the carer of her husband who is living with Dementia. The wife had an accident whereby she accidentally chopped off the ends of her fingers. Because of lockdown she would have had to attend A&E on her own, but she is not able to leave her husband unaccompanied and there was nobody available to look after him. She said that the Ambulance crew were absolutely fantastic and when they got to A&E they explained to ED staff that the husband has Dementia and not only did they see her straight away, whilst she was having treatment he was *"...thoroughly spoiled with tea and biscuits"* and looked after. They were able to reattach her fingers, she has no feeling in her fingers at present, but is hopeful that this will return.

### **Speed of treatment**

One couple - the husband is a carer and his wife has Dementia. The husband became unwell, his GP did a telephone consultation and consequently referred him to hospital. Contact from the hospital was very quick. He was told to isolate for a week before coming in for a scan. He has been diagnosed with bladder cancer and has again been told to isolate for seven days. He is scheduled for surgery on the 7<sup>th</sup> August. He feels okay so far and is very pleased with how quickly he is accessing treatment but is really concerned about his

wife as nothing has been put in place for her care whilst he is in hospital. He is very worried about what is going to happen to his wife.

### **Increased requests for support**

Social Prescribing Link Workers have repeatedly received referrals from GP regarding individuals caring for someone with Dementia and needing support during Covid-19.

### **Need for greater awareness of working age dementia**

The Working Age Dementia Group talked of the importance of greater awareness of working age Dementia in health care settings and how the condition presents in younger people.

### **Wellbeing and the impact of social isolation**

Age UK reflected that the fact that many people have stayed indoors for several months has led to increased frailty and put people at risk of falls and other health complications.

### **Key messages**

- Support services feel that Lockdown has led to increased frailty, poorer physical health and psychological frailty.
- Carers feel forgotten and many are in crisis.
- Bereavement and restrictions imposed during the pandemic have been catastrophic for this patient cohort.
- Access to services has been particularly difficult for this cohort during Lockdown. It is difficult for a person with Dementia to get through to a doctor at this time (the process is too complicated).
- Testing is not accessible.
- Information is not accessible – keep it simple!
- Lockdown led to an escalation of support needs.
- Many people are ‘waiting for services to return to normal’ and have failed to appreciate that some changes are long-term.
- Digital exclusion is a significant issue.

## **Gypsy/Traveller Community**

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Newark on Trent has been a traditional ‘stopping over’ point for travelling families and show people for hundreds of years. Today, the largest significant Gypsy Traveller community still resides in Newark, a site where families have lived for over four generations. Most recently this community is made up of 250 travelling families from Eastern Europe, Wales and Ireland. There is, in addition a large population of house Travellers resident in Newark.

For the purposes of this report we liaised extensively with Newark & Sherwood District Council, who actively engage with the community, to seek their advice, as to the best approach to the work. This engagement with six elders from the community was done with their assistance. We particularly want to acknowledge the help of Ms. Nickie Anthony.

### **INFORMATION AND ACCESS TO SERVICES**

Knowledge within the Gypsy and Traveller community about shielding and social isolating is limited and linked in part to literacy issues.

### **Anxiety about covid-19 – contributory factors**

There is a great deal of anxiety about Covid-19 within the Gypsy and Traveller communities. Media coverage had served not to inform the community as much as resulting in them being extremely fearful and anxious.

There is a heavy reliance on social media and TV for information, partly arising from sporadic low levels of literacy. Limited access to accessible and appropriate information coupled with a sometimes-challenging relationship with the wider community means that the Gypsy and Traveller community can be inward-looking, inherently independent, and wary of others.

Social media use means that there is greater likelihood of exposure to conspiracy theories within these communities.

Added to this, aspects of their culture mean that they are more susceptible to influence by conspiracy theories, especially those 'doing the rounds' on social media. This was particularly illustrated by the theories about 5G masts spreading Coronavirus which were rife early in the pandemic. One traveller site in the West Midlands is near to a 5G mast and there was a rumour within the community that they were being told to isolate and Lockdown near this 5G mast as it was being used to spread Coronavirus to control and cull their community.

The Gypsy and Traveller community will usually go to their GP Surgery (and will attend the same GP even if they have to travel) but because of seeing/hearing about the pandemic on the TV they were reluctant to go to their GP and stayed at home through fear of infection.

One man with sleep apnoea chose not to go to his GP because he was frightened of contracting Covid-19.

Access to information from limited sources meant that they were often unaware of the complete picture. They knew only that they could get infected and should therefore stay home and isolate. News reports said only to lockdown not how to access services if really needed.

### **The experience of those accessing services**

However, those who went on to access services were reassured by the processes and procedures in place. When one of the travellers eventually used 111 and was persuaded that she needed to go into hospital she was very impressed with the service and regained confidence in accessing services. After discharge she had a follow up consultation with the consultant and was very happy with the whole experience.

Another person admitted to hospital said that having a side room during her hospital stay and very good staff care gave her confidence. The early discharge follow-up video call with the consultant was very good and if necessary, she would be happy with the same service / process again. She was able to return home quickly and the video consultation follow-up gave her confidence everything was going as well as it could. She said that she would definitely use video consultation again to reduce the risk of infection.

The experience of the Gypsy and Traveller community in using 111 was largely negative. They felt that it took a long time for calls to be answered and when they were answered the operator didn't appear to have the knowledge or expertise to help and were reading from a script.

### **The additional vulnerabilities of the gypsy and traveller community**

The Gypsy and Traveller community are likely to encounter additional barriers in accessing healthcare.

As an illustration, one female Traveller is deaf and is unable to sign and so struggles to communicate unless someone is with her. COVID has been very difficult for her as she is also grieving having just lost her mother.

Another Traveller cannot read or write and has no idea how to use the internet or a smart

phone.

Some practical issues not only make access to healthcare more difficult, but also substantially increase the risk of infection within these communities.

Newark and Sherwood District Council provided shower blocks and portaloos to reduce the number of families sharing as this was a clear transmission risk for Coronavirus.

Although some of the Gypsy and Traveller community would be happy to use online services on a regular basis, this is not always practical or feasible. They often have poor or patchy mobile phone signals and as they are often self-employed they may not be able to afford to pay for calls that are time consuming (such as trying to get through to a GP Surgery or dialling extensions to access other services). Options for flexible online and face-to-face appointments accompanied by information in plain and simple language would help this community to access services more easily.

### **Simple measures to improve access**

Many of the issues which led to the Gypsy and Traveller Community being reluctant to access services could be easily and simply resolved. As an example, many were reluctant to go to their GP Surgery because they were not aware of the measures in place to safeguard patients.

For example, some GP Surgeries operated a one-way system where patients enter and leave by different doors. The Gypsy and Traveller community were also fearful at the prospect of sitting in 'busy waiting rooms' not realising that Surgeries had adjusted services and converted most appointments to telephone consultations to reduce this risk. The community was fearful of infection, so simply did not access their GP. Not enough information has been provided on how safe it was to access services.

Issuing printed 'Easy Read' materials ensured greater access and better understanding. Newark & Sherwood District Council provided easy read posters and spoke to some of the Elders giving them more information to disseminate within their community. Less waiting time, early and easy to read information that explains what to expect should you access services are examples of how access could be facilitated.

One possible way of reaching the Gypsy community might be to advertise on Eastern European TV channels to raise awareness.

Simple messages need to say, '*Do not ignore your health conditions*' and '*We are doing things safely to keep you well*'.

Clear advertising around health concerns needs to be through the newspapers which are read by the Elders in the community

### **Key messages**

- Knowledge within the Gypsy and Traveller community about shielding and social isolating is limited and linked in part to literacy issues.
- There is a heavy reliance on social media and TV for information.
- Issuing printed 'Easy Read' materials ensured greater and quicker access and better understanding.
- There is a great deal of anxiety about Covid-19 within the Gypsy and Traveller communities – but those who went on to access services were reassured by the processes and procedures in place.
- Some people did not access healthcare through fear of Covid-19.

## Homeless/Sofa Surfing

In March 2020, Councils were given £3.2m by the Government to provide emergency shelter for homeless people. The 'Everybody In' scheme provided temporary accommodation for those who were rough sleeping or sofa surfing to safeguard them against an increased risk of contracting Coronavirus because of their living conditions.

Under Phase 1 of this scheme, the following number of **rough sleepers**<sup>2</sup> were accommodated:

District	Number	Evictions	Refused
Ashfield	12	2	0
Broxtowe	15	3	0
City	Data not provided		
Gedling	0	0	0
Mansfield	30	5	2
Newark & Sherwood	8	1	1
Rushcliffe	8	0	0
<b>TOTAL</b>	<b>73</b>	<b>11</b>	<b>3</b>

**In Ashfield, 45 people in total were accommodated** (this includes those who were rough sleeping and those who were sofa surfing).<sup>3</sup>

The 'Everybody In' initiative provided immediate, short-term relief and a potential platform from which to tackle homelessness in the longer-term. At the time of writing this report, 43 of the 45 people accommodated in Ashfield under 'Everybody In' had maintained their accommodation offer.

Whilst this has been an ideal opportunity to address homelessness in the longer-term, gaps in provision remain due to the complex and myriad problems underpinning homelessness.

The Rough Sleeper Initiative recorded the support needs of their service users. Of the 73 service users in the County their support needs are listed in the table below. Many of the services users had more than one support need identified.<sup>4</sup>

Support Needs	No.	Percentage <sup>5</sup>
Alcohol Misuse	3	4%
Benefits / Income	2	3%
Domestic Abuse Perpetrator	1	1%
Domestic Abuse Survivor	2	3%
Health	9	12%
Language	7	10%
Learning Disabilities	2	3%
Mental Health	28	38%
No Recourse to Public Funds	7	10%
Offending	6	8%
Physical Disabilities	3	4%
Substance Misuse	20	27%

<sup>2</sup> Data courtesy of the Rough Sleeping Initiative.

<sup>3</sup> Data courtesy of Ashfield District Council's Housing Options Team.

<sup>4</sup> Information courtesy of the Rough Sleeper Initiative.

<sup>5</sup> Rounded up or down to the nearest percentage point.

A wide range of organisations, services and forums<sup>6</sup> were approached to gain insight into the experience of homeless people accessing health and social care across the City and County of Nottinghamshire.

The conversations were a mixture of discussions with frontline services to gain their overall perspective and with individual services users to gain rich and in-depth insight on personal experiences in accessing services.

The perspective from those delivering Services

Whilst our approaches to voluntary sector groups, services and forums followed the basic format of the online survey, groups saw this as an opportunity to feedback more widely on the impact of the pandemic and subsequent lockdown on access to health services. As a consequence, whilst the data includes responses to the direct questions raised in the survey, we have grouped and prioritised the key points identified by the services themselves.

## **Changes to the delivery of healthcare Services**

### **Access to mental health services and impact on mental health & wellbeing**

The Manager of a drop-in centre<sup>7</sup> in Ashfield providing support for 60 service users a week<sup>8</sup> said, "...the *biggest problem during lockdown has been the impact of service users not being able to access face-to-face mental health services. This has been absolutely catastrophic and there has been a tidal wave of poor mental health as a result*".

The view that access to Mental Health services caused significant problems was also echoed by other services. The YMCA, Framework, Rough Sleeper Initiative, and Branching Out services all spoke of the serious negative impact of Mental Health Services being transitioned to telephone services during Lockdown. A Support Worker at the YMCA said that service users had "*suffered massively*" from not being able to access face-to-face support. Whilst they had been able to telephone support, this simply was not the same.

Alongside this, all agreed that Lockdown itself had a direct negative impact on the mental health and wellbeing of service users.

Not every service user reported difficulties in accessing and using Mental Health Services during lockdown (although this was the norm). One service user said that her Mental health worker had been ringing her regularly every two weeks and this had helped her greatly, she also had her dosage of Mirtazapine adjusted and had been surprised that this could be done remotely. The service user also spoke very highly of the social prescriber attached to her practice (in Ashfield) and said that they had been extremely helpful.

Service users also struggled with increased anxiety directly arising from changes in the delivery of services. Service users, many of whom are already vulnerable, spoke of their dismay at the prospect of video consultation with healthcare professionals. Two service users at the Emmaus Trust<sup>9</sup> commented that they had not used video calls, but wouldn't be happy doing so and said that they would feel '*awkward*' or '*uncomfortable*' and remarked that it would be, "*...like face-timing a stranger*". Both felt that the first time they met a health professional should be face-to-face, but thereafter video consultation would be acceptable.

Similarly accessing services unaccompanied was seen to be problematic and increased the levels of anxiety experienced by vulnerable service users.

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<sup>6</sup> List to follow.

<sup>7</sup> Sutton Christian Fellowship

<sup>8</sup> Aimed primarily at people who are homeless, sofa surfing, recently accommodated in temporary accommodation, or otherwise vulnerable.

<sup>9</sup> Providing supported housing for young people aged 16-25 years in the Newark area.

## Drug related issues through lockdown

The Manager of Sutton Christian Fellowship drop-in centre in Ashfield also commented, *"...the next biggest problem has been around drugs. Many of our service users have problems with drugs and lead chaotic lives.*

*During lockdown they have either been asked to present to a Pharmacist at 9.00am in the morning or been given Methadone or Subutex for a week or more and issued with a safe box. Both are disastrous.*

*Most don't even surface until about 11.00am, so asking them to go to the Pharmacy at 9.00am is an absolute non-starter and giving them more than a day's supply of drugs is a recipe for disaster. Most would prefer to have their prescription daily and that works for them.*

*Where they have been given Methadone or Subutex for a week or more they have just been selling it to buy heroin. Because their drug workers have not been seeing them face-to-face and talking to them on the telephone they have been lying and because the drug workers are not actually seeing them, they have been able to conceal what they are doing to a certain extent.*

*They need direct face-to-face support in relation to their mental health and more appropriate support in relation to their drug dependency."*

An escalation in drug use by service users was also reported by the Joint Interagency Homelessness Forum, the YMCA, and Framework.

As with the drop-in project in Sutton-in-Ashfield, the YMCA talked about the problems that had arisen from Pharmacists issuing prescriptions of Methadone or Subutex weekly or fortnightly. The YMCA also reported that their service had seen a significant increase in drug misuse during the pandemic. Once again, they felt that this had been enabled by Pharmacies issuing two-week prescriptions of Methadone at a time during lockdown and commented *"...service users were selling the Methadone and using the proceeds to buy other drugs. People who had previously been stable or managing their drug use definitely 'fell off the wagon' during lockdown".*

Another drug related issue raised by services related to the management of drug and alcohol dependency, where services had to be additionally vigilant to ensure that service users did not go into withdrawal. Russell House in Newark<sup>10</sup> reported that service users were at risk of epileptic fits unless their health conditions were managed effectively – this was challenging through Lockdown although they do work closely in partnership with CGL<sup>11</sup> to manage the health of service users.

The Chair of the Joint Interagency Homelessness Forum (mid Nottinghamshire) advised that lockdown had reduced County Lines activity<sup>12</sup> into Newark & Sherwood District. However, the availability of illicit drugs had not been significantly impacted as disruption to County lines activity had been met with opportunistic low-level and localised drug dealing.

Another situation relating to drug use which arose during Lockdown was that of cuckooing<sup>13</sup>. A female tenant was on the cusp of being evicted, but through in-depth understanding of the

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<sup>10</sup> Supported housing for homeless people in the Newark area provided by Framework.

<sup>11</sup> Change, Grow and Live – providing support throughout Nottinghamshire for people with drug and / or alcohol dependency.

<sup>12</sup> Organised trafficking of drugs.

<sup>13</sup> Referenced in more detail in the section on Vulnerable Women.

issues and on closer investigation it had become apparent that the tenant was a victim of cuckooing<sup>14</sup>.

### **Access to health services during lockdown**

A number of services and services users reported difficulties in accessing health care; often linked to difficulties in making or receiving phone calls to or from health professionals.

A service user at the Emmaus Trust with Type 1 Diabetes had had difficulty in making contact with the Diabetic team. She had been issued with a flash monitor to measure her blood sugar, to use this she needed a log-in. She was given a letter from the Diabetic Nurse and was given a time to expect a call which did not happen. She was later told that emergencies had been prioritised and this was the reason for the delay. This served to increase the level of anxiety she was already feeling.

Similarly, Branching Out<sup>15</sup>, in Newark commented that their service users had not been able to easily access sexual health clinics and the CAMHS service through Lockdown.

### **Access to services in general**

A homeless service<sup>16</sup> in Mid Nottinghamshire commented that there was “...a reduction or lack of drop-in and face-to-face services for homeless and newly accommodated service users living in temporary accommodation. Many services are currently offered on-line or by telephone, are more limited and the way they are accessed is more rigid. The fact that these service users lead chaotic lifestyles means that they can find keeping specific appointments difficult. If an appointment is missed, then they go without support”. The homeless service Project Manager also commented, “...staff in some organisations appear to have used COVID-19 as an excuse to become very rigid in the delivery of services, quoting rules and seemingly being unwilling to acknowledge the differing access needs of those with chaotic lifestyles. People with addictions and mental health issues often need people to be extra patient and to explain things in plain English and give them reassurance or they risk becoming overwhelmed and not accessing the support they need at all”.

### **Positive feedback on GP surgery providing support for homeless and rough sleeping service users**

The Friary Drop-in service commented, “...we are in the fortunate position of having direct access to a GP based in Sneinton, who has a clinic every Wednesday during normal times. During the pandemic he has been available to us on the phone. We also have access to the homeless health nurses. Although they are a City Council resource, due to the numbers of rough sleepers we see, they also support our centre.

*With this in mind, we have been in the fortunate position of being able to access healthcare for our service users.*

*The people we support rely on us to provide them with this access. Many don't have phones and others are fairly unreliable at raising health issues. Without the dedicated resource, it would be a real challenge.”*

### **Issues around testing**

Through the pandemic none of the people accommodated through ‘Everybody In’ tested positive for Coronavirus, which was obviously a great success. The Rough Sleeper Initiative reported an issue with testing early in the pandemic. The Manager said, “...providing test through drive-in facilities is simply not practical for our service users, but there is now a testing pathway in place.”

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<sup>14</sup> whereby vulnerable people are targeted, and their homes are used as bases for drug dealing

<sup>15</sup> Supported housing for young people aged 16-21 years old in the Newark area.

<sup>16</sup> Drop-in and signposting service for the homeless.



Other services also reported issues around testing. One service user at Russell House<sup>17</sup> presented with symptoms which could have been Covid-19. On advice of the support worker she rang 119<sup>18</sup> and requested that a test be posted to her. She was told to expect the test within 48 hours. When she didn't receive the test, she contacted her GP to try to get the suspected tonsillitis confirmed so she would not have to isolate, but her GP was reluctant to do this as she had a fever. She rang back 119 at the suggestion of the GP and when the test did not arrive after a further 24 hours, she tried to order the test online herself. Whilst attempting this, she realised that the dropdown menu would not allow an 'A' or 'B' to be selected which explained why the other test had gone astray. She gave up and isolated for ten days, but as she has agoraphobia, her mental health was severely impacted.

## **Information and access to services**

### **Issues with mobile phones & internet access**

People who are homeless/sofa surfing often struggle to have access to a phone (with credit) and/or IT equipment (which they may need support to use).

In Mansfield and Ashfield, particularly vulnerable homeless service users were issued mobile phones during the lockdown by the Local Authority, the Street Outreach Team and CGL<sup>19</sup>. This was intended to allow the Local Authority and other frontline services to have a means of checking-up if service users were symptomatic etc. This was not without problems. The majority of phones issued were 'Pay As You Go'<sup>20</sup> and were issued with either £10 credit, or no credit at all. Many service users were not able to afford to add credit to the phones and so could not use them to access medical or other services. Given the lifestyles of some of the service users in some instances, the phones were sold on.

### **Sharing information – expectation on services**

Service users were aware of changes to services and of information relating to Coronavirus – information on social distancing etc. This was through a combination of information issued by the UK Government and Public Health and through information prepared and issued by YMCA themselves. The Support Worker said that although their service users were aware and informed in relation to social distancing etc that they tended to have extremely chaotic lifestyles and so their adherence to the recommendations could not be guaranteed.

Information is often shared electronically to support services on the assumption that this can be cascaded to service users. Most service users have no access to the internet and would need support to access the information anyway.

There is little acknowledgement that these frontline services are often operating on a shoestring and have neither the capacity nor can they meet the cost of printing out information for multiple service users.

Much of the information provided directs people to websites to access more information or the services on offer.

### **What worked well through the pandemic**

One of the factors which helped services in Mansfield and Ashfield to deal effectively with the crisis was having supported accommodation through the YMCA, which now has 43 places on offer. The Manager of the Rough Sleepers Initiative said that the enhanced offer of accommodation (primarily in Mansfield and Ashfield) had enabled them to respond quickly

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<sup>17</sup> Supported accommodation for homeless adults in the Newark area run by Framework.

<sup>18</sup> The new test and trace number.

<sup>19</sup> Supporting people in Mansfield, Ashfield and Newark and Sherwood who have problematic drug and alcohol use; many of whom are also homeless.

<sup>20</sup> In some exceptional cases contract phones were issued where the service user was deemed to be exceptionally vulnerable.

and effectively. He commented, “...we did have to place some people out of area, but not many. In total 89 individuals were approached through the pandemic in phase 1 of Everybody In and 79 were offered accommodation.

*One of the things that is different about the service is the way that we work to wrap services around the individual with a housing first lead approach which takes into consideration pre-existing issues and is a move away from a more traditional approach to homelessness. Having readily available supported accommodation has been a vital component to this approach as has taking services out to people – e.g. street outreach and street health events. The task now is to take these initial steps and make them stick and address homelessness in the longer-term”.*

Another point worth noting is that some services continued delivery through the pandemic with little disruption or alteration. Whilst there were inevitably some adjustments to accommodate Covid-19 related precautions, the services were still delivered face-to-face and broadly delivered as prior to the pandemic.

### **Key messages**

- 'Everybody In' supported people into accommodation during lockdown and provided a platform to address homelessness in the longer-term.
- Closure / reduction of support services during the pandemic impacted heavily on the Homeless.
- Reduced access to mental health services described as 'catastrophic'.
- Insufficient access to accessible information during the pandemic. Information required as hard copies and in an easy to read and accessible format. Information needed for frontline services, but also for the services which regularly support the homeless and sofa surfers (e.g. foodbanks, crisis teams, housing teams etc).
- Reduced access to Pharmacies, changes in the issue of heroin substitutes and reduced access to drug workers during lockdown perceived to have exacerbated drug misuse.

## **Learning Disability**

Between 10<sup>th</sup> April and 15<sup>th</sup> May 2020, the CQC recorded 386 deaths of people living with a Learning Disability, in comparison to 165 deaths in the same period in the previous year. This is an increase of 134% in the number of death notifications on the previous year. Of these 386 deaths, 206 were the result of suspected or confirmed Covid-19<sup>21</sup> and 184 people were receiving care from community-based adult social care services and 195 from residential social care settings.

Kate Terroni, Chief Inspector of Adult Social Care at the Care Quality Commission commented, “...we already know that people with a learning disability are at an increased risk of respiratory illnesses, meaning that access to testing could be key to reducing infection and saving lives.”

During this research we liaised with a number of services and individual service users who raised concerns about the difficulties they had encountered, not only in accessing testing, but in accessing other services.

### **Changes to the delivery of healthcare Services**

Services spoke not only of the substantial barriers people faced in accessing services, but of the impact adjustments to services had on this patient cohort.

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<sup>21</sup> Source CQC <https://www.cqc.org.uk/news/stories/cqc-publishes-data-deaths-people-learning-disability>

A support worker from Framework's Brighter Futures service commented, "...two of our service users have Epilepsy and had appointments scheduled at QMC. The appointments were re-scheduled as video / telephone appointments, but this didn't really work for them. One was asked that someone record them having a seizure, but this was simply not possible. Another service user had a face-to-face appointment rescheduled and it will now not take place until February 2021."

*"The other problem is that these service users have been asked to go to QMC. One lives in Kirkby-in-Ashfield, the other lives in Warsop. To get to QMC will take at least three buses. They don't know the routes and also have Autism. Using public transport is a challenge at the best of times and they will be very reluctant to go to these appointments.*

*To get there would require bus routes they don't know, lengthy bus journeys and they won't know where to get off – it just won't happen, and they definitely won't attend the appointment. One service user would have to make three bus journeys, each lasting between 30 and 45 minutes. We did ask if an appointment time could be changed to accommodate one of our service users, but this was not possible.*

*Most of them know Kings Mill Hospital, it is familiar to them and even if they haven't actually been to the hospital, it is likely that they have driven past it on the bus."*

Similarly, Autism Unlimited described the experience of one of their service users attending an appointment with a paediatric specialist. Normally, routine appointments are held at a local clinic but during lockdown these were moved to hospital. This necessitated two bus journeys each way for the family and was stressful for the child who is 9 years old and on the autistic spectrum. The child's mother has mental health issues, was very anxious about becoming infected with Covid-19 and was unable to go with her son. The child's father accompanied his son for these routine height and weight checks. They had no choice but to attend as they were told without these checks his medication could not be continued.

Not only was travelling to the hospital difficult for the child, he is scared of doctors and seeing everyone in masks made the situation even more difficult. The parents asked if local clinics were not available during lockdown, why routine checks were not available through their local GP surgery.

For this patient cohort, attending an appointment in a more familiar health care setting, using transport systems they are used to and reducing the time they need to spend on public transport makes a significant difference. The positive benefits of this cannot be overestimated.

### **The use of face masks**

Other services also spoke of the difficulties their service users encountered in relation to the use of face masks. Framework commented, "...they are often anxious about having to either wear a mask or to engage with others who are wearing a mask. Those on the autistic spectrum can find the texture of wearing a mask very difficult and whilst they may be exempt from wearing them, they are very anxious about the possibility of being challenged or worried about having to explain that they are exempt."

There is also the issue of carers or medical practitioners visiting those with a learning disability in their home, particularly those who are shielding. People wearing PPE including face masks etc can make it difficult for this patient cohort in relation to understanding, interpreting, and relating.

### **Telephone and virtual consultation**

The use of telephone consultation has been a challenge for this cohort of patients. Whilst some have struggled, there have been those who have been able to use this facility with the

appropriate support or have found it to be more convenient. This is especially the case in relation to the management of long-term health conditions which have already been diagnosed, or for 'routine' issues.

A number of services remarked that in some instances, telephone or video consultations helped to reduce the level of anxiety felt by this patient cohort. The experience of a service user at Reach being fairly typical. The mother of a 15-year-old patient said that she had had two telephone consultations in relation to her son. They were easier for her son than a face-to-face appointment, as he was less anxious and can get 'very silly' and confrontational. Telephone consultation helped to avoid this.

Adjustments to the delivery of services have been made to accommodate this vulnerable group of service users, but whilst this works for some people, it does not work for all.

One service spoke of the offer of three-way calling providing support for people with Learning Disabilities. They commented that although this is a solution for some, it does not work for everybody. They commented that some of their service users simply don't like using the telephone, or struggle to understand what is happening.

Services commented that it is also easy to overlook the extent to which people with a Learning Disability use visual cues to help them to understand and interpret things, so telephone consultation can be really difficult for them.

There is also an element of some service users *'telling people what they think they want them to hear'* which adds to the complication of gaining a true understanding of the situation.

Whilst communicating through Zoom and Teams works for some and can be a good way of keeping in touch, this is not for everyone and some may not be comfortable in being seen via video calling or find it difficult to talk.

### **Do Not Resuscitate Order (DNR)**

In terms of the issues which service users most struggled with, these understandably related to end of life care, bereavement and the subject of DNR's being broached with families.

The number of families reporting to services that they feel that they have been encouraged, and strongly encouraged in some instances, to elect for a DNR is worrying. Feedback from services suggest that NHS guidelines have led to medics encourage patients/families to elect for a DNR as it is assumed that patients won't withstand treatment or have a quality of life worth saving.

Services commented that many blanket DNR's have been applied to patients with disabilities in care homes (particularly those with Learning Disabilities).

Whilst there may be a medical case for discussing the option of a DNR, the responses from services would suggest that some clinicians would benefit from additional training on broaching this subject with more sensitivity. Similarly, the perception that 'blanket' DNR's are being applied indicates at the very least that communication is failing.

### **Information and access to services**

Accessing information through the pandemic has been especially difficult for service users with a Learning Disability.

Framework commented that there is an assumption that everyone has access to mobile phones, the internet, and social media, which is not always the case. This view was also reflected by the One Walk, One Conversation service.

## **Access to information**

Secondly, the information which was provided was not always appropriate.

Framework said that they were not sure how service users would have found out about changes to services without their input. Framework adapted and disseminated accessible information to their service users using easy read and larger print guidance. They commented that some of their service users have a tendency to take things very literally and so there is a risk that they can misunderstand things. They also commented that the format of information is very important, *“...service users need hard copies so that they can see information repeatedly to help them absorb messages and to act as a reminder. Giving them information just once is no use – it doesn’t give them time to absorb and understand, it is much better to print something out and place near a door, for example, so that they see it when leaving and it jogs their memory”*.

This was also echoed by One Walk, One Conversation who suggested that it would have been beneficial had an official letter in a simple, clear accessible format been sent to everyone on the Learning Disability register at the beginning of the pandemic. This would have given service users clarity and confidence and therefore reducing anxiety.

## **Accessing testing**

Some organisations raised the issue of service users encountering significant barriers when accessing testing. These barriers were encountered as the delivery or location of services did not take into consideration the additional needs of this patient cohort.

Reach spoke of one of their service users being informed that they were eligible for a Covid-19 test but were told that they would have to travel to Beeston (from Southwell) for the test. The service user travelled with a parent to Beeston for testing. The vehicle was wheelchair friendly with the whole side opening rather than just a window. On arrival, the parent was told that their son would not be able to access a test due to increased risk of infection. A home test would have been better but was not offered.

## **The implications of shielding**

Many services spoke about the difficulties their service users had encountered from a change in routine, and the massive impact of social isolation through Lock Down.

Framework commented, *“...many of our service users do not cope very well with a change in routine. Some have been shielding and live on their own. There have been regular well-being checks, but they are really struggling with a lack of social interaction and not having anyone to talk to.*

## **Access to prescriptions**

*On a practical level, some have Post Office accounts and have not been able to get money from the Post Office and so have found it difficult to pay for shopping done on their behalf. We had an issue of one service user not accessing their medication because they were shielding. The service user is epileptic and was very frightened about the possibility of contracting Covid-19. Once we found out that this was happening, we collected their prescription although this is not something that we would normally do.”*

## **The impact of social isolation on health & well being**

Age UK also spoke of the growing concerns they had around people’s general health and wellbeing following a period of isolation and the lack of facilities such as lunch clubs. They commented that one client with mild learning difficulties is really struggling as a Church run café had been his daily contact with the outside world and the place where he accessed a cooked meal. There are concerns now about his mental health and his physical wellbeing as he is no longer accessing nutritious meals. If places like lunch clubs, memory cafes and

community centres do not reopen then there is a real fear that loneliness, isolation, and poor health outcomes within our communities will increase.

### **Key messages**

- One size does not fit all – universal adjustments to services may not effectively meet the needs of people with a Learning Disability.
- There is a lack of clarity and knowledge on the circumstances under which vulnerable adults can be accompanied to appointments and services.
- The format, content and dissemination of information needs to be improved.
- Digital exclusion is a significant issue – need to address both access and support.
- Concerns raised around DNR's.

## **Long Term Conditions**

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### **Access to services during the pandemic**

A local Breathe Easy Group recognised the rationale for use of telephone consultations and have found this method of accessing consultations acceptable although it was stated there is no substitute for the human touch - seeing a patient and being able to assess and diagnose. It was noted that for younger people telephone consultations may present a better way of accessing services but for older people with multiple conditions or a mental illness this may not necessarily be the best way.

A range of positive comments were received about use of telephone conversations in that they don't interrupt work, no travelling time requires, saves cost of taxi fare, public transport costs or car parking charges.

For cancer patients, telephone consultations were received positively by most but there was a clear preference for more complex matters to be discussed during a face to face consultation. Reference was made to GP premises being locked and this was considered unacceptable. Cancer referrals have decreased during lockdown. There is a need to make attendance at the GP surgery as easy as possible, if someone attends and faces a locked door it presents an immediate barrier to someone who has taken that first step towards obtaining a diagnosis.

Communication whilst wearing face masks does cause problems for people with a hearing impairment who may need to lip read. Examination problematic around ear whilst patient wearing face mask.

Patients have been supported to use NHS App and this has worked well for some patients to obtain their repeat prescriptions.

Pulmonary rehabilitation online exercise classes have been accessed by some patients and it was suggested they should be evaluated in terms of patient outcomes and if they evaluate well, they should be continued.

Telephone consultation with oncology consultant was a positive experience, patient felt they were being listened to and follow up from initial telephone contact was good. Getting test results is a problem – receptionist unable to answer questions. GP has to contact patient to share result. Better way to use technology to avoid unnecessary use of GP time.

### **Information provision**

Access to information for carers has been very different during the pandemic. Carers have been unable to visit relatives in hospital nor accompany relatives to healthcare appointments. This has left carers feeling very isolated and it will be interesting to see how

this impacts on a carers ability to deal with, for example a bereavement, over the coming weeks, months and years.

### **Behaviours regarding accessing services**

Respiratory patients involved in the Breathe Easy Group expressed a fear of going near a hospital or ED due to the fear of contracting Covid-19. They were reassured by the use of independent sector facilities to separate Covid and non-Covid patients to deliver diagnostics and patients were very complimentary of this approach.

### **Choice of services and appetite to continue to use same services going forward**

Some patients would like to see continuation of telephone consultations however, it is acknowledged that some people will have difficulties with the use of technology.

A reduced number of patients seen face to face does mean patients are allocated to the right kind of consultation relevant to them delivering better management process for patients and the practice.

Impressed with the way GPs have assessed patients in nursing homes through digital stethoscopes. Innovative way of working that could be used in future to make better use of GPs' time.

Local support through PPGs and community groups is really important. Community Hub could include digital hub.

So far the use of telephone consultations within general practice has been good, however will the patient experience continue to be good when there is increased demand as the process has been implemented outside business as usual and not at scale.

### **Additional comments received**

Delayed diagnostics causes a real problem for cancer patients and impacts on a patients' mental health and anxiety levels and over time there may be an impact on survivorship. An observation was shared that District Nurses can visit a patient's home in PPE but a patient cannot see a GP – this is difficult to understand.

## **Maternity**

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In addition to the feedback provided within this report, the Local Maternity and Neonatal System have conducted a research study and are continuing with a piece of engagement which will feed into the restoration and recovery of maternity services. A copy of their report is awaited and will be available on our websites.

Feedback provided for specific services is outlined below: -

### **Experience of accessing healthcare services via Telephone and Video Consultations**

Digital technology works well regarding blood pressure monitoring but doesn't work well with women who may be having a mental or health and wellbeing issue or experiencing any other issues around safeguarding i.e. Domestic Violence, etc.

GP appointments have been great online and via telephone a lot quicker than usual and great that we can use technology to share information beforehand i.e. photographs of child with a rash although some parents and families are not happy with the phone service and they feel it is delaying prognosis, which in turn is often making their illness/injury worse.

### **Increased used of NHS111 and 111 online**

Families have used the NHS 111 who referred to the Walk in Centre in Nottingham. The service was excellent with the child being seen and treated in 20 minutes. Families used the NHS 111 service for when they were unable to obtain a speedy GP appointment for a family issue which was resolved easily. NHS 11 has also been accessed as the first point of call as they were unsure as and when they should contact and use their GP surgery during the pandemic.

### **Access to services during the pandemic Information provision**

Positive patient stories on social media platforms from women and families who have used maternity services during the pandemic and couldn't praise staff enough.

At the start there wasn't any key communication messages around antenatal, postnatal and birthing services and women were scared around what to expect. Communication is much better now about how and when people can access the maternity services including links with the Maternity Voice Partnership (MVP). The MVP Chair has been meeting regularly with Deputy Divisional Head of Nursing & Midwifery at both Trusts to provide feedback from families and monthly meetings have continued to try and provide reassurance to families on what the current requirements are in hospital settings. Social media platforms have been a good way of keep families up to date with information on visiting and what they should expect but unfortunately not all families have the financial provision of digital provision to access this information.

Feedback from one session was that the midwife was fully updated and provided excellent communication to expectant mums and the mum and partners felt reassured about giving birth in a hospital setting.

### **Behaviours regarding accessing services**

Attending Antenatal appointments alone was not the best situation for women as they needed support from partners especially in difficult situations. Women weren't attending antenatal appointments because they were scared and some had to use public transport and didn't feel safe.

Attendance at 12 and 20 week scans guidelines have now changed and the partner can attend but they cannot attend the growth scans with women – This is causing some anxiety issues especially if the women have any complications.

Parents, carers and families have really noticed any difference in Emergency Departments, other than people not using these facilities for silly reasons and actually only going when it was an emergency. Also there are some good points on how they have changed with only one person per child, no extra people in the departments has cut down on a lot of time wasting.

Dental Services have not been accessible for parents, carers and families and this has caused concerns due to problems with children's teeth and not having regular checks. Also, pregnant women are entitled to free dental treatment which may cause issues for financially deprived families when they cannot have regular checks or ongoing dental treatments that may have commenced and then stopped. There is also a backlog of dental appointments for families.

### **Choice of services and appetite to continue to use same services going forward**

Homebirths were suspended which caused some anxiety and fear for women who had to attend hospitals as this was not their preferred choice. Homebirths have now been reinstated within the Local Trusts.



One woman was referred to Ear Nose and Throat Services via a GP for a baby with tongue tie. The service was available in some areas of the Trusts but not in others. Is there a way that the services can work together in order that they are seen and treated? The child was seen but was thereafter advised to bottle feed her baby rather than continue to breastfeed. Labour suite – Reasonable adjustments were made to accommodate families. Parents, carers and families have accessed GP Surgeries for their baby's vaccinations and immunisations. It was easy and simple the staff were helpful and friendly. There are still a number of parents, carers and families who are still too scared to go directly into the hospital even with all the measures in place (although they happily go into pubs and shopping centres).

One woman commented that her child had a life threatening allergy attack and the mum had to call 999 and child admitted to hospital. The care received was excellent. Mum was scared if child was put in a ward with other patients and contracted Covid but hospital provided reassurance around restrictions and measures but in place.

Unfortunately a woman suffered a miscarriage and was admitted to hospital was upset and scared with partner being able to attend and support in a dreadful situation. Only issue I know people have had is when having a baby and the partner not being able to stop as long as they normally would. But it's a catch 22. They know why but still hard.

### **Discharge from hospital**

Questions and comments were raised around what will the impact of the pandemic have on the breastfeeding rates in our areas. Unfortunately mums could not attend support groups although there the local Trusts did operate online classes but not everyone would have had access to these.

Separation from the partner following birth has meant that they can only stay with the mother and baby for 6 hours which has caused distress for families.

One family member was admitted and moved to City and then Loughborough. There was lack of communication with family to keep them apprised of the situation and at one point was unaware of the transfer to City Hospital which had an emotional impact on the family as they were trying to contact the hospital for updates and weren't aware of the move to different settings. This was a stressful time and more communication was needed.

### **Additional Comments Received**

Some staff members found it anxious to return to a clinical setting and didn't know what equipment would be required to be worn and what the settings would be like. Still births – This had a huge impact on families due to social distancing and not receiving the help and support needed after such a traumatic time. All staff members both clinical and non-clinical have gone over and above what is required and they have proved invaluable during difficult circumstances.

## **Mental Health**

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### **Experience of accessing healthcare services**

People with lived experience of mental health problems shared mixed experiences of accessing healthcare services. Some people experienced no change, some people found access easier due to the remote support provided but a large number found access to GP and mental health services more difficult. Access times to contact GPs were reported as non-flexible and the highly valued support and check-ins provided by GPs earlier, had stopped. Concerns also existed around cuts made to mental health services and cancelled appointments which led people to believe that mental health is not considered as equally important as physical health. Long waiting lists were raised as issues for mental health services and hospital services which had a big impact on many, especially University

students. One student reported confusion over which waiting list to be on due to moving between home and University and as a result, they have experienced a delay in treatment.

### **Telephone and Video Consultations**

Telephone and video consultations were reported as logistically easier and beneficial for people who may feel more anxious leaving the house. It was reported that for minor on-going physical health issues, consultations over the phone would be beneficial as it saves time. However challenges with such methods were identified. These include:

- Remote consultations are not as personal as face-to-face support. It is hard to read body language via remote methods and sometimes harder to communicate your feelings with others through these means.
- Issues around privacy in the home environment were prevalent as some felt unable to openly discuss their mental health as others in their household could overhear.
- Issues for those who do not have access to technology and potential connectivity issues that can get in the way of appointments.
- Not everyone is comfortable on camera.

People also felt that remote consultations are not appropriate in all situations with one person noting that they were discharged from a mental health service over the phone which they felt was an easy way out. There was great importance placed on giving people a choice of how they would like to access mental health support, highlighting that one size does not fit all. It has been suggested that professionals such as GPs need to check in with people to see how they are progressing.

### **Information provision**

It was felt that people did not receive enough information on how and where to access services. One person noted that they had received a text from their GP asking them to go online but they noted that not everyone will be able to do so. It was noted that a significant number of people have not used mental health services though they were experiencing a decline in mental health and a reason for this being uncertainty in how to access support. Hence it was felt that more information and greater communication was needed with clearer details of how to access services and appointments. Emphasis was placed on self-help resources being made accessible online for people and families to use, especially if there is a second wave of COVID-19. It was suggested that information can be shared on social media, TV, radio and via a monthly newsletter that contains self-help tips and information on services you can access.

### **Behaviours regarding accessing services**

It was reported that the environment at GP surgeries now feel less approachable with it being likened to a 'prison' which makes some people more reluctant to visit the GP. To tackle this, it was suggested that having someone to welcome and reassure patients would make it more approachable. People felt that they tried to reach out for support but had been turned away or felt that they were not listened to.

### **Choice of services and appetite to continue to use same services going forward**

People reported issues with accessing medication during this period and as a result, some contacted hospital services to get medication as they struggled to access this via their GP. The people, who reported accessing services differently during the pandemic, spoke about seeking help from the third sector or community groups which they felt was more easily accessible and hoped to continue using this in future. People did not mind the use of remote technology but stressed the importance of giving everyone a choice of how they would like to access services as one size does not fit all.

## **Discharge from hospital**

Only one comment was made on discharge from hospital in which the person reported no issues.

## **Additional comments**

A lot of people have experienced a negative impact to their mental health during the pandemic with an increase in severity of existing issues and newly emerging mental health problems. People have been feeling lonely and isolated with some losing confidence in going out by themselves now. Some people noted that the language used by professionals when engaging with someone who is struggling with their mental health has not always been appropriate. It was felt that more services need to be in place for people who are struggling with their mental health such as group support to meet others, relax and help distract the mind.

## **People whose first language is not English**

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*'People in these excluded groups have difficulty accessing COVID-19 guidance and key public health messages, predominantly due to digital exclusion and language barriers. Where COVID-19 guidance is accessible, it is often not feasible to implement as guidance has failed to consider the life circumstances of people in vulnerable circumstances. This places these groups at an increased risk of acquiring COVID-19 and presents a wider public health risk of disease spread'.*

An Unsafe Distance – The Impact of the Covid-19 Pandemic on Excluded People in England

Doctors of the World<sup>22</sup>

Whilst the afore-mentioned report relates to the experiences of a wide-range of excluded people including refugees and asylum-seekers, the homeless, Gypsy, Roma and Traveller communities, many of the issues raised are also pertinent to people who do not speak English and are closely reflected through our conversations with services supporting those who do not speak English as their first language.

Whilst Nottingham City is ethnically diverse, there is far less diversity in other Districts in the County. This aside, there is a long history of settlement from Asian and Polish populations across the Districts and in recent years there has been a steady influx of Eastern Europeans, Roma and Syrian refugees.

Most of the conversations in this section of the report were through City-based organisations, although there were also contributions throughout the County which reinforced the key messages from City-based groups.

## **Changes to the delivery of healthcare services**

For many people, English is not their first language, so conducting appointments over the phone, or by email is not possible. It is hard for patients whose first language is not English, to explain their symptoms and needs. This can be compounded if a person has anxiety or mental health issues. There is no further advice to give besides go to the GP, but if a patient cannot access that service, or make themselves understood they cannot get the help they need.

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<sup>22</sup> Doctors of the World is an independent humanitarian movement working at home and abroad to empower excluded people to access healthcare. A full copy of the report may be found at <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/07/covid19-brief-rna-report.pdf>

This view was also reflected by a Social Prescribing Link Worker who commented that individuals for whom English is not their first language have experienced appointments being rearranged due to needing a translator for a conference call. Patients have also shared that they don't feel as confident speaking on the phone when English isn't their first language.

On a purely practical level, three-way calls can also be extremely difficult to arrange where a busy GP may not be able to ring as scheduled because of other appointments over-running.

Even where family members or others have been able to provide support in relation to translation, it is still fraught with difficulties. Firstly, whilst a family member may have a good command of English, this does not mean that they are well equipped to translate in relation to a medical issue. Apart from a lack of familiarity with medical terminology, the dignity of the person requiring the appointment is also to be considered. There are also potentially cultural issues which may further reduce access to language support in a medical appointment. It may not be appropriate for an unrelated male to attend (even virtually) a medical appointment for a female, thus further reducing the pool of available translation support.

### **Information and access to services**

It is clear that confusion about who may attend appointments with a patient is rife. Some services reported that interpreters have not been allowed to attend appointments with their clients. As a consequence, the client has been unable to seek medical attention.

Access to information is a major issue. Both services and communities report that accessing appropriate and accessible information is a major stumbling block. They consistently report that, "...*there has been no communication or resources for migrant communities.*" Perhaps more accurately, the truth of the matter is that translated and accessible information is not reaching these communities. Whatever the case, these communities do not know where to go for information and support.

The consequences of this can be devastating to communities, particularly as these communities are known to be at greater risk from Covid-19. Services have reported back to us that people are scared to go to A&E for fear of contracting Covid 19. Consequently, they stay away. If they absolutely must attend, they become very anxious. As their understanding is that support workers and family or carers cannot stay with them, they may put themselves at greater risk by discharging themselves before accessing the medical treatment they require.

Across the board we were told that video calling works well if a person is fluent in English and is IT literate, with access to the necessary equipment. If this is not the case then they may have to rely on the help of family members, which is not appropriate, due to issues of confidentiality and dignity. Others may not have friends or family to help at all.

In terms of getting the message out to these communities, services advise that support workers and community leaders can help to translate and disseminate information. The NHS is encouraged to send updates to organisations with key members of staff representing different communities. Furthermore, this communication and messaging must be in a variety of formats and mediums accessible to all.

### **Key messages**

- The NHS needs to improve and increase communication with all communities and their representatives. It is also important to understand the demographics of city wards and county districts because each will respond differently to crisis and intervention – one size does not fit all.
- There are still so many communities who remain hidden that are not accessing support. There needs to be more effort from the statutory sector to work in collaboration with the voluntary sector at a grassroots level to reach these people.

- A wide range of translated information is vital to facilitate access and this must be visible to these target communities.
- Communication by letter is helpful as it allowed people time to understand and digest information.
- Family members are sometimes used to translate for others (often a teenage child) this is not always appropriate within the context of a medical appointment.
- Appointments were sometimes rearranged for those who don't speak English as their first language due to needing a translator for a conference call.
- Three-way conference calls (patient/translator/GP) are subject to technical or logistical issues.
- Individuals do not feel confident about speaking on the phone when English isn't their first language.
- Information on who may attend an appointment or service in the capacity of support needs to be communicated more effectively.

## Single Parent Families

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### Changes to the delivery of healthcare Services

Whilst there was some variation in response, single parents mostly agreed that telephone consultation was helpful; far easier than the logistical problems of taking a sick child and possibly other children to a GP Surgery.

Home Start service users said, "...telephone consultations, have been brilliant, being able to speak to your GP rather than going to surgery has been really good. That should definitely continue".

One of the Social Prescribing Link Workers also commented that telephone call consultation had been easier for some as it enabled them to fit it around work and home-schooling commitments.

Another Social Prescribing Link Worker told of a patient who had fed back their experience of accessing health care.

*'My child had an ear infection and from my phone call to the GP practice to receiving the medication from the pharmacy and dispensing the medication to my child the whole process took only 2 hours. Before, this would have taken much longer. It would have involved waiting until the end of the day (whilst his pain was increasing) or taking him to a packed surgery with lots of other ill patients to a sit and wait session. None of the two previous choices would have been desirable. Instead I received a prompt phone call from my GP who through video consultation and guiding me to ask my child questions was able to quickly diagnose the problem. Once diagnosed an electronic prescription was sent to my pharmacy. I phoned my pharmacy who confirmed I was able to pick up my prescription. The service was excellent and I would not like to go back to the previous out dated system that was in my opinion inefficient and as we now know was actually detrimental to public health – having so many ill people confined in a GP waiting room for long periods of time. Then going in and out the GP's offices with their germs'.*

Whilst the responses were mainly positive in relation to this, there were instances where telephone and video consultation were not deemed to be either appropriate, or effective. In the first instance, there was a general consensus of opinion that telephone and video consultation was effective in the treatment and management of long-term or previously diagnosed medical conditions.

One community project spoke of their service user's experience in accessing treatment for her infant. Her child was under the age of one and the mother was sure the child had eczema. She had suffered from the same condition as a child and teenager herself and was certain that she could recognise the same symptoms in her child. The mother spoke to the Receptionist at the Surgery and was told by her that this was '*...not serious enough to see a GP*'.

The parent was very unhappy about this and felt that a child under one should be seen, especially as it was in a lot of pain. The parent took the child to the Chemist but felt that this was not an ideal solution as she felt that the medication that the Pharmacist was able to issue was not strong enough. She felt that the child needed a prescription and was unhappy at not being able to see the GP face-to-face under the circumstances.

### **Information and access to services**

In the main part, services said that their services users noticed the changes (or at least some of them) in health care services.

Home Start Nottingham said of their service users, "*The issues that were raised tended mainly to be around cancellations of out-patient appointments at hospital because of COVID 19. Some of my service users really struggled with the delay of out-patient appointments. This was down to a combination of factors. Families were worried about delays in accessing treatment because of postponed hospital appointments, particularly when this related to appointments for children or for treatments / investigation for more serious conditions, but they were also worried about the possibility of contracting COVID-19. They were fearful of not having the appointment as it would lead to a delay in treatment, but also fearful of having the appointment in case they and their families were put at risk. So, on one hand they want the appointment, but on the other hand they don't. Several of my service users have raised this as an issue.*

Home Start service users were not alone in relation to their views of the importance of re-instigating out patient appointments and simply reflected the general comments made by service users, who said that they felt that they had lost out and were not supported. One of the most commonly made statements made was of the importance of access to out-patients appointment as soon as possible.

Home Start also commented, "*...one of my service users has had an out-patient appointment delayed by eight months and has been very anxious about this. They raised this with their GP who has been really supportive. The GP has been ringing the service user every single week and it has really helped to ease the stress that the service user is feeling; particularly as the service user has mental health issues. The ongoing consultation and reassurance has made a really big difference to their ability to cope.*

Whilst there have been excellent examples of good practice, other service users have highlighted areas for improvement. Home Start also commented, "*Whilst one of my service users has been supported by their GP with weekly phone calls another has said that they felt like their GP was really dismissive and felt totally unsupported*".

Home Start also fed back, "*...some of my service users have said that they think that certain Departments in the hospital should start having clinics and that they should have separate areas for COVID-19 patients to reduce the risk. The clinics that should be the first to re-start should be children's clinics, cancer clinics and those providing care for elderly people. This will make a real difference and reduce the stress on families who are already struggling anyway*".

One service user has had their appointment rescheduled until February next year and said that this was simply not good enough.

Other services also fed back on the dissemination of information on accessing services and said that the County Council and City Council had been really good at sending out information as had the District Council. They did say that they were not quite sure if the information sent out by the Councils came from the Council or from health services.

### **Key messages**

- Telephone and video consultation cautiously welcomed by many single parent families for ease of accessing appointments.
- A lot of anxiety around cancellations of outpatient appointments. Families were worried about delays in accessing treatment, particularly when this related to appointments for children or for treatments / investigation for more serious conditions, but they were also worried about the possibility of contracting COVID-19. They were fearful of not having the appointment as it would lead to a delay in treatment, but also fearful of having the appointment in case they and their families were put at risk.
- Video and telephone consultation sometimes failed to correctly identify problems leading to a delay in accessing effective treatment.
- Some of the information provided was overly complicated.

## **Victims of Domestic Violence**

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The number of deaths occurring in England and Wales as a direct consequence of Domestic Abuse through Lockdown averaged 5 per week, whereas the usual number of deaths is 2 per week<sup>23</sup>. The increased number of deaths and higher incidence of domestic abuse have been attributed to an increased frequency of attacks (and not an increase in the number of perpetrators).

Although there has been an increase in the number of attacks on victims and a surge in calls to some domestic abuse charities in England and Wales; services in Nottinghamshire actually reported a reduction in the number of referrals into their services during Lockdown. Local services attribute this reduction to reduced opportunities for victims of domestic abuse to access help and support.

Local services believe that it has been difficult for victims to access help and support from services, with the perpetrator typically being in close proximity to the victim for extended periods.

Those living in an abusive situation are also likely to have restricted access to phones and the internet. This form of control is used to restrict contact with the outside world and results in victims of domestic abuse being wary of contacting services.

Additionally, greater knowledge, awareness and increased use of spyware and tracing and tracking applications has also made it more difficult for people experiencing domestic abuse. They may be fearful that this software has been installed on their devices and not know how to check or disable these features, or whether their perpetrator would be alerted if software was disabled.

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<sup>23</sup> Dame Vera Baird QC, the victims' commissioner for England and Wales, told MPs at a remote session in April: "Counting Dead Women has got to a total of 16 domestic abuse killings in the last three weeks. We usually say there are two a week, that looks to me like five a week, that's the size of this crisis." A number of domestic abuse charities and campaigners have reported a surge in calls to helplines and online services since the lockdown conditions were imposed.

Whilst many mainstream services have transitioned to telephone services during Lockdown, this has been extremely difficult for domestic abuse services. NIDAS voiced what many other services echoed; that they are reluctant to contact service users who remain in an abusive relationship as they may inadvertently expose them to greater risk. They asked service users to contact them if they required support and felt it was safe to do so, but again, proximity to a perpetrator and tracking and tracing technology make it more difficult for people to discreetly access the support they need. Providers are in the position of having to consider how services can be offered to this client group and develop strategies which reduce the risk to the service user.

## **Changes to the delivery of healthcare Services**

### **Information and access to services**

All services and the majority of service users were aware of changes to the delivery of services and whilst many struggled with these changes, some did not have a problem.

The experiences of this cohort of patients in accessing services was variable and the following gives a flavour of the feedback received:

- Difficulty in accessing the CAMHS service, the service user left voicemail messages, but no-one called back leaving her feeling vulnerable and alone.
- Some service users commented that accessing GP services and outpatient services digitally was easier because of other commitments - they would be happy with the prospect of this continuing.
- One patient found her GP surgery to be inflexible and unhelpful on the scheduling of appointment times. She has PTSD and fibromyalgia and struggles with morning appointments, but the Surgery was not prepared to offer a later appointment.
- A significant number of patients reported long waiting times on the phone to their GP Surgery.
- One patient had a telephone consultation with a physiotherapist during which she was asked to carry out specific actions as part of the diagnosis. She felt the physiotherapist was very knowledgeable and reassuring. The physiotherapist diagnosed a probable lumbar spine issue which is to be confirmed, or otherwise, by an MRI. The patient was also sent some exercises.
- One patient had been seeing her GP every 2-4 weeks prior to lockdown in relation to her mental health. She had also had the support of the refuge. Now she is in accommodation and is not seeing her GP she feels completely on her own.
- A Type 1 Diabetic had been unable to have her annual check-up because this required a blood test which would have to be face-to-face.
- One patient had a cancerous lump removed three years ago and was told she would need to have mammograms every 6 months. As a result of her moving area she had not had a check-up for a year. She is registered with the local breast clinic but has to wait until procedures are being done again. This has increased her mental anxiety.
- Three people reported that they had used NHS 111 and described the service as very helpful.
- An ambulance was called by a GP. The patient had a very good experience and felt safe. Signage and PPE was very good once in the hospital.
- Another person who has Pulmonary fibrosis was well looked after at A&E and clinics and didn't experience any problems. Appointments and consultations online were good.

### **Barriers to accessing healthcare**

Whilst NIDAS raised the issue of people remaining in an abusive relationship finding it difficult to contact domestic abuse services, Broxtowe Women's Project also spoke of the difficulties of women who have fled an abusive relationship in accessing services.



They gave the example of women and children who have left an abusive relationship and been re-housed. Whilst they may no longer be in a situation of immediate and direct threat; they are often in an extremely difficult financial position. They may have left with little more than the clothes on their back and are likely to be waiting for benefit claims to be processed, needing to feed and clothe themselves and children, plus furnish and heat accommodation. In these circumstances data and credit for mobile phones can be a long way down their list of priorities. They simply cannot afford to ring their GP surgery. This was even more the case during lockdown when the financial impact of feeding children who were at home all day every day was taking its financial toll.

Apart from financial considerations, service users have said that they would be extremely wary about the prospect of video consultation. They are reluctant to turn on their camera and certainly wouldn't want to make a confidential health call using this technology.

### **The emotional impact of domestic abuse and accessing services**

A number of services spoke of the emotional impact of domestic abuse and how this may impact on the confidence of the service users and their likelihood of accessing services. Broxtowe Women's Aid said, *"...thinking of a lot of the families we work with, they are low in confidence and are struggling to cope - everything seems overwhelming and the pressure of everything gets to them. You can see how they get to the point that they say that they're not going to the Doctor's because there's no point. They are really reluctant to go. It's not helped when the receptionist at a GP Surgery says, 'call at this time', they can find that difficult. Their opportunity to disclose domestic abuse is reducing, but I can't think of an easy solution. So, it gets to the point, where they don't ring, don't attend, and the window of opportunity is further narrowed"*.

Low confidence, mood and self-esteem create an additional barrier in accessing services

A service user at Newark Women's Aid explained that she found speaking to people on the phone a challenge and it made her extremely anxious. She had a telephone medication review booked in for the following week with her GP Surgery. She had had to wait for two weeks for the appointment, which in itself caused her anxiety. She was worried about not getting through and having to repeat herself to different people. She also felt that she was not being heard. Phone consultations were difficult because of her reticence to make calls and she tended to 'put things off', sometimes permanently.

We R Here, a service providing support for the victims of domestic abuse, bereavement, and loss, echoed this view with their service users reflecting similar reluctance to use telephone consultation.

### **The need for emotional support when accessing healthcare**

Many of the different services working with the victims of domestic abuse spoke of the difficulties service users had in attending appointments without emotional support. Given the psychological vulnerability of some of these people, attending appointments unaccompanied was immensely difficult.

One service user was diagnosed with breast cancer just before Lockdown began. She was given a condensed course of radiotherapy to reduce her attendance at hospital and minimise the spread of infection, but she found this to be extremely challenging and set her back emotionally.

### **Feedback on proposed strategies to reduce risk & facilitate access**

One proposed solution which has been put forward to discreetly advise GP Surgeries that patients are at risk of domestic abuse is the use of a code word. This would let the Receptionist, for example, know that a patient is experiencing domestic abuse. Broxtowe Women's Project said that whilst this seems a good idea in principle, it wouldn't work even if

the code word was changed regularly because they go public so quickly. They gave the example of the code word 'Angela' which has been promoted for people to identify they need help in pubs and bars. Unfortunately, these strategies are so well promoted that it is no longer the intended discreet alert.

Broxtowe Women's Project said that this would be the same with those who perpetrate domestic abuse – they are very controlling and monitor their victim closely. They said that they didn't know what the solution is, only that the current situation exposes victims to more risk.

A typical experience of domestic abuse

Two services commented on the importance of better awareness from GP surgeries in relation to the ways in which domestic abuse can present.

Hetty's provides support for families who have a loved one who is dependent on alcohol or has problematic drug misuse. The Working Age Dementia Group supports people who have a loved one who is of working age and is living with Dementia. In both situations, people living in these circumstances can experience domestic abuse.

Someone with an addiction can become violent if they are going through withdrawal, for example. Someone living with working age Dementia may have full physical capabilities whilst their cognitive impairment and loss of inhibition means that they are an increased risk to carers.

The leader of the Working Age Dementia Group commented, *"GPs and Practices need to be more au fait with young onset Dementia, I don't think they understand the physicality of someone living with young onset Dementia. Because they are likely to be physically able, they can present differently to an older person."*

*One of the group members is 5ft 2 ins and maybe 9 stone. Her husband has early onset Dementia and is a good 6ft and about 20 stones. Not only is he stronger than her, but he doesn't have the cognitive ability to regulate, so if he lashes out at her he will kick or hit at full pelt. Because he doesn't hold back, it's as though he were stronger because of the Dementia."*

She spoke of another group member whose husband had become aggressive over a weekend. At one point she was trapped behind him in the bathroom, she couldn't get out and couldn't get past him to get to the phone. She couldn't access any help, but even if she had been able to get to the phone there was no-one she could get help from as it was the weekend.

She said that some people living with Dementia are far more likely to get anxious or aggressive in the evening and yet the service only runs till 5.00pm. She said that they felt like no-one wanted to know.

She said that different parts of the country are better and said, *"...I know for a fact that Sheffield have a lot more support than we do"*. I asked her why she felt this and she said that she was in some online support groups and through that and twitter other people caring for people with Early Onset Dementia had spoken about the services they accessed and it was better than Nottinghamshire. She said that Sheffield was an example of how it should be done.

### **Key messages**

- There has been a rise in DV during lock down.

- Difficult for individuals experiencing Domestic Abuse to speak freely. They are not in a safe space to talk owing to the perpetrator being around – whereas the GP Surgery is a space they can access alone.
- Difficulty of child-care arrangements when arranging / attending appointments.
- The GP is often the first point of call for most victims either by telephone or online. People who have experienced domestic abuse said that it would be helpful to have a quick shut down button on GP Surgery websites so that people are not caught trying to access help by their abuser.
- GP Surgeries need to appreciate the increased difficulties victims of domestic abuse encounter when accessing services because of lack of confidence and low self-esteem.
- Greater awareness by practice staff on domestic abuse would be helpful.

## Visually impaired community

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Notable positive experiences of the visually impaired community are detailed below;

- Most people like the telephone appointment system with their GPs and commented that it felt more like a one-to-one service and was more accessible because you could have an appointment with your GP without accessing public transport or negotiating the new signage in GP practices. Many said it felt like a more 'personal service'.
- When attending face-to-face appointments everyone had been offered sighted guiding by GP and hospital staff and no one was made to feel uncomfortable asking for this.
- Many people felt the system was running more smoothly than it did before Covid-19 with less people in waiting rooms and fewer queues to try to negotiate.

Notable negative experiences of the visually impaired community related to the following;

- Three people required blood pressure checks for a variety of reasons and all were asked to their own blood pressure, which obviously none of them could do without sighted support. All three live alone and so this is quite difficult for them. All three were forced to ask a sighted family member to take the reading for them, which doesn't facilitate either independence or patient privacy. It was suggested that practices should invest in talking blood pressure monitors if it is going to be an ongoing requirement for patients to monitor their own blood pressure at home.
- Access to drive through Covid-19 testing prior to attending hospital for a diagnostic procedure was a problem. Taxi companies would not undertake journeys due to risks to the driver. This was eventually resolved by a friend offering to drive to a test centre.
- Changes implemented to create one-way systems in general practice premises and other public places has meant that people with a visual impairment are no longer familiar with layouts and need to be accompanied by a sighted relative.
- Some people are anxious about the use of video appointments as they are not particularly accessible to someone with a visual impairment.

## Summary of Key Findings

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An overarching message arising from the insight gathered is that one size does not fit all – and adjustments to services are required to be inclusive of more vulnerable patient groups.

The summary of key findings have been organised according to the focus of the questions posed to participants;

## Access to services

- Language, literacy and access to the use of technology were significant barriers to some communities, eg. AS&R's when accessing telephone and online platforms for medical appointments. Privacy issues arose for the most vulnerable due to the sharing of mobile phones.
- Access to interpretation services absolute priority to enable those people for whom English is not their first language to successfully navigate or access healthcare services.
- A wide range of translated information is vital to facilitate access and this must be visible to target communities.
- Asian communities encounter many barriers in accessing services, including language barriers, housing and living conditions (inter-generational living in closely packed communities) and information not being effectively cascaded to these communities contribute to the difficulties they encounter in accessing services.
- When English is not your first language, appointments by phone or email are impossible and it is hard for patients to explain their symptoms and needs.
- Interpreters have not been allowed to attend appointments with their clients, so the client has been unable to seek medical attention.
- Using family members to translate for others is not always appropriate within the context of a medical appointment.
- Three-way conference calls (where someone needs support due to language barrier or Learning Disability, for example) may be subject to technical or logistical issues.
- Patients may not feel confident about speaking on the phone because of mental health difficulties or because English is not their first language.
- Information on who may attend an appointment or service in the capacity of support needs to be communicated more effectively. There also needs to be a recognition that some people feel unable to attend appointments without support.
- Deaf patients are heavily impacted by adjustment to services and feel that not enough is being done to accommodate them.
- People with a visual impairment require reasonable adjustments to enable them to maintain their independence, eg talking blood pressure monitors.
- GDPR and safeguarding considerations can be an issue for organisations supporting vulnerable service users, particularly those who cannot advocate for themselves.
- Lockdown impacted some service users heavily and they were potentially more vulnerable but less visible (e.g. those experiencing domestic abuse and those living with a Learning Disability or Dementia).
- Communication by letter allows people time to understand and digest information.
- Carers appreciated remote consultation but emphasised need for choice.
- Carers feel forgotten and many are in crisis.
- Digital technology received positively for some elements of maternity care but not so good for mental health or safeguarding issues.
- Extended use of video and telephone consultation was cautiously viewed positively, although additional measures will need to be in place to ensure that vulnerable patient groups are not excluded.
- Digital exclusion is a significant issue – need to address both access and support.
- Concerns raised about long waiting times to access mental health services.
- Reduced access to mental health services described as 'catastrophic'.
- Access to dental services has been problematic for many vulnerable groups.
- Third sector or community groups were more easily accessible and hoped to continue using these in future.

## Behaviours

There was a general reluctance to access services due to;

- Additional risks to BAME communities.
- Fear of contracting Covid-19

- Not wishing to use public transport
- A desire to protect NHS services
- Anxiety about attending antenatal appointments and scans alone
- Feeling unwelcome when visiting GP surgery.

### **Information Provision**

- The format, content and dissemination of information needs to be improved and effectively cascaded into communities. Issuing printed 'Easy Read' materials ensure greater and quicker access and better understanding.
- BAME communities are not getting all of the key Covid messages and may not understand what lockdown means, or where to go for information and support.
- Confusion about access to urgent care – should it be NHS 111 or 999.
- There is a lack of clarity and knowledge on the circumstances under which vulnerable adults can be accompanied to appointments and services.
- Communication issues about recommencement of ongoing treatment
- Proactive approach to communicating key messages to pregnant women and their families. Social media platforms useful but not accessible to all families.
- Mental health service users requested more information and greater communication with clearer details of how to access services and appointments.
- Some patient cohorts encountered significant difficulties in accessing pharmacy services through lockdown (EVP who were shielding, those who were drug dependent, and older people from the Pakistani community who rationing medication because the messages about access to pharmacies have not reached them).
- Improvements need to be put in place in relation to testing which is often not accessible for vulnerable patient cohorts.
- Many people are 'waiting for services to return to normal' and have failed to appreciate that some changes are long-term.
- Knowledge within some communities about shielding and social isolating is limited and may be linked to language and/or literacy issues.

### **Discharge from hospital**

- Carers felt discharge process felt rushed and had concerns for the safety of their loved ones.

### **Other Comments**

- The closure or reduction of support services during the pandemic had a devastating impact on vulnerable service users.
- Bereavement and restrictions imposed during the pandemic have been extremely difficult.
- Poverty is a significant aspect of reduced access into services.
- There is a great deal of anxiety about Covid-19 but those who went on to access services were often reassured by the processes and procedures in place.

APPENDIX 1 – Groups engaged with by patient cohort		
ASYLUM SEEKERS & REFUGEES		
Organisation	Service	Area
Arimathea Trust	Support and housing for destitute asylum seekers, newly recognised refugees and victims of modern slavery and human trafficking.	City
Mojatu Foundation	Campaigns around the abolition of FGM, offers training, health initiatives, community events and activities	City
Vanclaron	Mental health support and training, wellbeing workshops & consultancy	City
Emmanuel House	Provides a diverse range of support services for homeless individuals and rough sleepers	City
The Red Cross	Provides 1-1 case work support relating to pre-asylum and no recourse to public funds, offers English classes	City & County
Migrant Help UK	Provides independent advice, guidance and outreach services	City & County
Housing provider; Tuntum	Provides housing, including support to the Syrian Resettlement Programme	City & County
Private (public sector) provider; Serco	Providing temporary housing for asylum seekers during the pandemic and working with partners to support for those people accommodated	City
Statutory NHS Service; Specialist Midwifery Team - Vulnerable Migrants	Providing specialist ante-natal support to vulnerable pregnant migrant women	City & County
BAME COMMUNITIES		
Organisation	Service	Area
Al-Hurrayah	Peer led BAME support service	City
Awaaz	Mental health support to BME and new emerging communities	City
Hetty's	Provides support to families affected by alcohol or drug use	County-wide
International Development Association		City
Nottingham Chinese Welfare Association	Support for Chinese people	City
Nottingham Muslim Women's Network	Muslim Women's support group	City
Reach	Feedback from Syrian	
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
Tun Tum Housing	Refugee support service (mainly Syrian, but some Eastern European)	
Yoruba Welfare Association	Support group for members of the Yoruba community (predominantly Nigerian)	City

CARERS		
Organisation	Service	Area
Carers Hub (Virtual support group and Asian women's virtual support group)	Charity providing support for all carers. The Asian Women's Group is a support group for Asian Women who are carers.	City and County
Carers Federation (Action for Young Carers)	Providing support for young carers in the City.	City
Carers Council	Charity providing support for carers who care for those with mental health problems.	City and County
Carers in Hucknall	Group supporting carers in Hucknall and surrounding areas	City and County
Nottinghamshire Hospice	Community based palliative care centre providing support to adults who are terminally ill and their families and carers.	County-wide
City Carers' Support Services	Support for carers who care for those receiving care from adult mental health services (provided by Nottinghamshire Healthcare NHS Foundation Trust)	City
Carers Roadshow	Roadshow aimed at providing carers with greater information, advice and guidance.	City and County
DEAF COMMUNITY		
Organisation	Service	Area
Community of Christ	General community-based service including service users with hearing loss	Ashfield
Deaf MacMillan Beyond Diagnosis	Deaf BSL users with a cancer diagnosis	County-wide
Hear to Meet	Group for people with Hearing Loss	N&S
Metropolitan Connect	Helping adults to remain independent; includes service users with hearing loss	Broxtowe, Rushcliffe & Gedling
My Sight Nottinghamshire	Service for people with sight loss, includes service users with hearing loss	County-wide
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
Peaceful Trust	Dementia Group	Mansfield
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
Working Age Dementia Group	Support group for people living with Working Age Dementia and their carers	Mansfield & Ashfield
HOMELESS / SOFA SURFING		
Organisation	Service	Area
Ashfield District Council	Local Authority support through the Housing Options Team	Ashfield
The Beacon Project	Drop-in & access to additional services	Mansfield
Branching Out	Wrap around support for young Homeless people	N&S
Broxtowe District Council	Local Authority support through the Housing Options Team	Broxtowe
Emmanuel House	Support & services for homeless and vulnerable adults in need	City

The Emmaus Trust	Support for young homeless people	N&S
Framework	Wide range of support for the homeless including supported accommodation & outreach	County-wide
Friary Drop-in	Support for homeless and rough sleepers	Rushcliffe
Joint Interagency Homelessness Forum	Forum of Statutory and VCS services providing support to the homeless	Mid Nottinghamshire
Mansfield & Ashfield Emergency Foodbank	Providing food parcels including those who are homeless or sofa surfing	Ashfield & Mansfield
Rough Sleeper Initiative	Initiative to end rough sleeping, working in partnership with an array of services	County-wide
Russell House (Framework)	Homeless shelter for adults	N&S
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
Sutton Christian Fellowship	Drop-in service for homeless, recently accommodated, sofa surfers and vulnerable	Ashfield
Tun Tum Housing	Wrap-around support for homeless refugees	Ashfield
YMCA	Frontline support including supported accommodation	Mansfield & Ashfield
LEARNING DISABILITY		
Organisation	Service	Area
Age UK	Connect Service – supporting independence for adults	Mid Notts
Autism Unlimited	Supporting children & young people with autism & their carers	Mansfield & N&S
Beacon Project	Homeless & rough sleeper support service (inc. service users with LD)	Mansfield
Cygnets Birches	Residential service for adults with autism	N&S
Disability Support (Nottingham)	Supporting people with disabilities and their carers	City
Framework Brighter Futures Service	Support service for adults with a Learning Disability or Autism	Mid Nottinghamshire
Mencap	Link workers attached to GP Surgeries	County-wide
Metropolitan Connect	Helping adults to remain independent; includes service users with LD or Dementia	Broxtowe, Rushcliffe & Gedling
Nottinghamshire Learning Disability and Autism Board	A forum for people with a Learning Disability or Autism to have input on services	County-wide
One Walk, One Conversation	Support service for people with a Learning Disability	Mansfield
POhWER Advocacy	Advocacy service for people with Learning Disabilities	City
Reach	Support service for people with a Learning Disability	Mid Nottinghamshire
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
LONG TERM CONDITIONS		
Organisation	Service	Area
Breathe Easy	Support and information for people living with a lung condition, and for	County



	those who look after them.	
Improving Lives	Providing support to adults with complex health and social care needs through offering services to empower them to manage the challenges they face more effectively.	City
Maggies Centre Breast Cancer Support Group	Offers support to people with or affected by breast cancer.	City and County wide
Nottinghamshire Disabled People's Movement	Run by disabled people for disabled people and looks at the barriers that disabled people face in their day-to-day lives	City and County wide
MATERNITY		
Organisation	Service	Area
Maternity Voices Partnership	A Maternity Voices Partnership (MVP) is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.	City and County wide
Local Maternity and Neonatal System staff	Developing local transformation plans and visions for the local community in relation to maternity and neonatal services	City and County wide
Small Steps Big Changes	Programme to improve the outcomes of 0-3 years olds. Parent Champions and Ambassadors feed in to work at all levels recruiting team members, helping to plan and design activities and organising community events.	City
MENTAL HEALTH		
Organisation	Service	Area
Nottinghamshire Mind	Charity supporting people with mental health problems.	Mid-Nottinghamshire
First Steps ED (EDISS)	Eating Disorder charity providing support to students at the University of Nottingham and Nottingham Trent University.	City and County
Arnold Methodist Church Mental Health Befriending and Support Group	Volunteer-led support group for people with mental health problems.	South Nottinghamshire
MH:2K	A youth-led project aiming to engage young people in conversations around mental health and emotional wellbeing.	City and County
PEOPLE WHOSE FIRST LANGUAGE IS NOT ENGLISH		
Organisation	Service	Area
Al-Hurrayah	Peer led BAME support service	City
Awaaz	Mental health support to BME and new emerging communities	City
Hetty's	Provides support to families affected by alcohol or drug use	County-wide
International Development Association		City
Nottingham Chinese Welfare	Support for Chinese people	City

Association		
Nottingham Muslim Women's Network	Muslim Women's support group	City
Reach	Including feedback from a Syrian refugee	Mid Notts
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
Tun Tum Housing	Refugee support service (mainly Syrian, but some Eastern European)	Ashfield
Yoruba Welfare Association	Support group for members of the Yoruba community (predominantly Nigerian)	City
<b>SINGLE PARENT FAMILIES</b>		
<b>Organisation</b>	<b>Service</b>	<b>Area</b>
Community of Christ	Community project supporting families, including single parent families	Ashfield
Home Start Nottingham	Significant incidence of service users escaping DV accessing support	Ashfield, Gedling, Broxtowe, Rushcliffe & City
Newark Women's Aid	Domestic abuse support service	N&S
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
We R Here	Families that have experienced domestic abuse, bereavement or where there is conflict following a divorce	Arnold, Gedling & City
<b>VICTIMS OF DOMESTIC VIOLENCE</b>		
<b>Organisation</b>	<b>Service</b>	<b>Area</b>
Broxtowe Women's Project	Domestic abuse support service	Broxtowe
Community of Christ	General community support initiative including service users experiencing domestic abuse	Ashfield
Hetty's	Support for families living with problematic drug/alcohol misuse significant risk of domestic abuse	Mansfield
Home Start Nottingham	Significant incidence of service users escaping DV accessing support	Ashfield, Gedling, Broxtowe, Rushcliffe & City
Mansfield and Ashfield Emergency Food Bank	Food bank - significant proportion of service users have experienced domestic abuse	Mansfield & Ashfield
Metropolitan Connect	Helping adults to remain independent; includes service users who have experienced DV	Broxtowe, Rushcliffe & Gedling
Newark Women's Aid	Domestic abuse support service	N&S
NIDAS	Domestic abuse support service	Mansfield & Ashfield
Social Prescribing Link Workers	Support for people with ongoing health needs (referred by GP)	County-wide
We R Here	Support for women who have experienced DV, bereavement, grief, and loss	Arnold, Gedling & City
Working Age Dementia Group	Nature of the service results in an increased risk of domestic abuse	Mansfield & Ashfield

Visually impaired community		
Organisation	Service	Area
My Sight Nottinghamshire	Promotes greater independence for visually impaired people of all ages throughout the county by providing emotional support, practical advice, information and training	County-wide