Digital exclusion and access to health services

2021

healthwatch
Lewisham

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Your Voice in Health and Social Care is an independent organisation that gives people a voice to improve and shape services and help them get the best out of health and social care provisions. YVHSC holds the contracts for running the Healthwatch services for Healthwatch Hounslow, Healthwatch Ealing, Healthwatch Waltham Forest and Healthwatch Bromley. HW staff members and volunteers speak to local people about their experiences of health and social care services. Healthwatch is to engage and involve members of the public in the commissioning of Health and social care services. Through extensive community engagement and continuous consultation with local people, health services and the local authority.

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Executive Summary

For this research project, we wanted to engage with people who are more likely to be digitally excluded and gain a better understanding of how this might impact their experience with health and care services. We focused on primary care as this is the first point of contact for people accessing services. However, our findings will be relevant to all services which are moving towards digital delivery. We partnered with North Lewisham Primary Care Network (NLPCN), who have a shared interest in using patient experience to improve the offer and health of the community they serve.

We paid particular attention to people's experience of accessing services during the COVID-19 pandemic. In total, we carried out interviews with 45 residents as part of the project. Those we spoke with included older people, people with English as their second language, and people with disabilities. The reason why we chose these groups is because they traditionally experienced barriers before the pandemic, and we wanted to understand whether this had exacerbated as a result of the lockdowns.

Digital exclusion can be the result of a variety of factors, including affordability and limited accessibility because of disabilities, lack of support and language barriers. The stories we heard about people's access to health and social care were mixed. Some people found remote GP consultations to be beneficial and were understanding of the need to shift to these digital care methods whilst the pandemic spread rapidly. Others were unhappy with the quality of care and treatment received using remote consultations and didn't feel confident with the diagnosis and/or the treatment plan. Both groups advocated for a return to face-to-face appointments.

Feedback also suggests that many participants were disappointed with the level of service received, especially when it came to administration. Numerous participants highlighted the challenges they faced when trying to get through on the telephone. Waiting times for appointments were undesirable with some people not being able to receive appointments for over two weeks, which echoes similar experiences prior to the pandemic.

Some residents experienced multiple barriers when trying to access health care support (affordability, lack of IT skills, and language barriers) which caused high levels of stress and anxiety.

Primary Care professionals we engaged with as part of this project discussed the benefits of remote care but also acknowledged that a shift to remote consultations risked excluding a significant proportion of service users from health and social care services. As the NHS supports primary care to move towards a digital first approach it is essential that the needs of digitally excluded residents are embedded within delivery plans.

There is the danger that the drive for greater digital access leaves behind those who are unable to engage with technology and therefore deepens existing health inequalities. Through our engagement, it is evident that the majority of participants would prefer face-to-face appointments as they value them more than the digital approach. Services must ensure that they deliver a hybrid approach of in-person and remote consultations which meets the needs of the local population and which takes account of their access needs.

About Healthwatch

Our organisation is an independent champion for people who use health and social care services. We exist to ensure that people are at the heart of care. We listen to what people like about services, and what could be improved, and we share their views with those with the power to make change happen. Under the General Data Protection Regulations (GDPR) and the Data Protection Act 2018, we have a lawful basis to process information that is shared with us by services and service users. Confidentiality is important to us, and we will only keep data for as long as is necessary. If you would like to know more about how we use the data we collect, our privacy statement is available on our website, www.healthwatchlewisham.co.uk

Introduction

The unprecedented COVID-19 pandemic forced services to adapt their service strategies in order to protect staff and patients as well as mitigate the risk of the virus spreading. As a result, services had to adapt quickly and introduced new models of access, which included remote access and a total triage system*.

The rapid changes meant that there was little time to research the possible impact on health outcomes, patient experience, or health-related inequalities when using digital platforms. There is a legitimate fear, that as a result, a 'one size fits all' approach may further widen local health inequalities. Twenty months on and digital exclusion remains a great concern and raises multiple challenges that need to be addressed urgently.

To help understand the impact of the changes, we carried out a research project looking to better understand the impact of a 'virtual by default' access model (with focus on primary care) implemented by health and social care services in response to the COVID-19 pandemic on a socially deprived and vulnerable population.

The aim of the research project was to deliver targeted engagement with residents who have limited access to or don't use digital technology to address the gap in local knowledge. The project aimed to understand how the change to a digital model has impacted on this cohort's experiences of accessing health and care services. Intelligence gathered has been used to help support the development of alternative methods and pathways for those who are digitally excluded to have equity of access to the care and treatment they need. The project helped us:

1. To gain an understanding of the needs and potential barriers people who do not use/or have limited access to technology when engaging with services, with a focus on GP practices.

2. To produce a series of recommendations to help address the needs of people who are digitally 'excluded' based on the feedback received.

The findings from our report will not only highlight issues residents have had with new remote models in primary care but will be applicable to all local health and care services which provide a digital offer. We want to work closely with partners to address the issue of digital exclusion and the challenges residents face.

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* Total digital triage uses an online consultation system to gather information and support the triage of patient contacts, enabling care to then be provided by the right person, at the right time, using a modality that meets the patient's needs.' 15 September 2020. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0098-total-triage-blueprint-september-2020-v3.pdf

Background

The COVID-19 pandemic forced health and care services to make changes to their models of care and how they support residents. There has been a shift towards a digital model of telephone and online appointment systems. The Covid-19: Lewisham system recovery plan shows that between March and June 2020, 85% of primary care appointments were delivered virtually. New precautionary measures were established to keep vulnerable people and staff safe during the pandemic, however these methods of delivering primary care may become the new normal.

We conducted research with over 1000 residents on their experiences of remote consultations and accessing health services as part of our 'Impact of COVID-19 on Lewisham' [1] report during the first lockdown with the aim to understand how this rapid shift was received in the borough. Many residents highlighted the benefits of the digital shift, such as greater ease in securing appointments. However, there were also concerns raised about the exclusion of residents who cannot use or afford digital technology to access primary care. It was evident that there was a gap in local information regarding the experiences of residents that are digitally excluded and a need for research to be carried out to understand the views of those that have limited or no access to digital devices.

The London Borough of Lewisham is extremely diverse with 46% of the population being from a Black, Asian and minority ethnic background and residents representing over 75 nationalities. It is the 10th most deprived borough within London and ranked in the top 20% most deprived Local Authorities in England [2]. Vulnerable people already experienced barriers to primary care pre-COVID-19,

including poverty, language barriers and mistrust of the system, amongst others. Research that was conducted with GPs and support services for vulnerable patients indicates that these issues have likely worsened because of the pandemic [3]. Furthermore, new pandemic-related barriers have formed, which include issues around quality of information about changes to local service delivery, a hesitancy to share personal information via a triage system, removal of walk-in services and digital exclusion [4].

The NHS Long Term Plan outlines how the model of care found across the NHS will change over 10 years through the introduction of digital health technologies (DHTs).

Primary care services will adopt a 'digital first' system in which most patients are assessed through healthcare apps, telephone consultations, or through web-based platforms. This system would give GPs more time to have longer consultations with those in need [5]. The steady introduction of digital services enables feedback by patients and healthcare professionals to be incorporated, such that these services meet the demands of the communities that they serve.

COVID-19 resulted in the Total Triage (TT) model being implemented in a matter of days in March 2020 [6]. How each service incorporated the policy changes into their practice is still being examined, as is the impact of these changes on vulnerable groups [7&8]. The government planned for the changes enacted over the pandemic, such as TT to be embedded into services permanently [9]. However, the TT model ended in May 2021 as 'GPs were told the use of telephone and online consultations

can remain where patients benefit from them, but physical appointments must also be available' [10]. This report understands the experiences of digitally excluded residents and how they found these new systems. We have primarily focused on groups that historically have issues accessing healthcare, and those that could be at risk of digital services impeding their access.

Over the course of 2020 there has been a substantial increase in users of the NHS app [11], and the number of consultations conducted remotely in February 2021 was 40.9% [12]. Over the first lockdown positive reviews of GP consultations were reported, with people feeling that remote consultations

fit more conveniently with their schedules [13]. However, reports also found that most participants highlighted a need for the availability of face-to-face appointments to support those who have issues accessing digital services.

According to the Consumer Digital Index Report, approximately 9 million people across the UK struggle to get online without assistance (16%), and 11.7 million (22%) lack the skills for everyday life. These values are compounded by factors such as age, disability, and ethnic minority, with elderly individuals, and those who are most disadvantaged, having higher levels of digital disengagement [14]. These findings draw concern as digital exclusion could worsen already existing health inequalities, and risk some people being left behind in a 'one size fits all' system.

Currently, studies have documented how those from deprived areas receive poorer access to primary care [15], and how marginalised groups, such as sex workers, homeless individuals, drug-users, and prisoners have poor health outcomes [16]. This risks the NHS mandate of everyone having equal and fair access to care not being met. While the national Healthwatch report 'GP access during COVID-19' highlights some positive experiences of service users, it found ongoing issues within health services that need to be addressed, and the need for a more detailed assessment of the aforementioned groups experience of digital healthcare at local level [17].

The Healthwatch Lewisham study and resulting report supports many of the Healthwatch England key findings and addresses areas that need to be improved when accessing health and social care services.

Methodology

Our engagement was delivered across the London Borough of Lewisham from March – July 2021. Research suggests that residents with language barriers and disabilities experience difficulties accessing services. We wanted to hear from residents that do not use or have limited access to digital devices and the internet. Our primary focus was engaging with residents who are at risk of being digitally excluded and whether the shift to remote access has exacerbated existing issues.

We focused our engagement on people who were likely to have no access or limited access to digital technology. This included:
1. Residents who do not speak English as a first language
2. Older residents
3. Residents with disabilities or sensory loss

We partnered with North Lewisham Primary Care Network (NLPCN) who share interest in reducing health inequalities exacerbated by the recent COVID-19 pandemic.

We developed accessible leaflets to promote the project and encourage participation. We worked with local organisations and food banks to help distribute the leaflets to residents from targeted groups. Examples of methods of distribution included local newsletters, community mailing lists, leaflets, and attending online engagement forums.

To engage with this cohort of people and reach residents who would not normally use digital devices, we aimed to carry out face-to-face and telephone interviews. To recruit suitable participants, and to encourage participation, we worked with community organisations, such as Lewisham

Refugee and Migrant Network (LRMN), Age UK, Voluntary Services Lewisham, Lewisham Homes and Phoenix Housing. This required a lot of assistance from partners who actively recruited participants for the project and we would like to thank them all for their continuous support (Thank you, pg.31). On certain occasions, interviews and recruitment were conducted directly by partner organisations. This was the case where ethical considerations had to be considered. Some participants were reluctant to speak to external organisations. However, they felt comfortable sharing their experiences with organisations who supported them.

The Lewisham Refugee and Migrant Network (LRMN) empowers 'people and families who are destitute, homeless or have No Recourse to Public Funds (NRPF), from refugee, asylum seeker and migrant communities' [18]. Their team received consent and conducted interviews with 11 participants. We were also supported by Lewisham Council in identifying and facilitating conversations with Deaf residents.

Although our initial intention was to carry out face-to-face engagement, national lockdown measures meant that most interviews were carried out remotely to reduce the risk of spreading the virus and ensure the safety of staff, volunteers and residents. The interview questions were developed in partnership with the NLPCN using Healthwatch England's template from a similar study.

Participants were predominantly interviewed over the telephone. Zoom calls were also used in a small number of cases when requested by professionals and participants who felt it was more appropriate for residents that experience learning disabilities, language barriers and/or have long term health conditions. We also delivered several paper copies of the questionnaire to residents who preferred to fill it in by hand. This was mostly due to hearing difficulties when initially contacting them over the telephone.

The feedback collated consisted of both qualitative and quantitative data which was analysed to identify themes and trends. To mitigate bias, two members of the Healthwatch team (a Project Officer and Research Volunteer) analysed the data separately. We carried out two online engagement sessions that we promoted with the help of NLPCN to local primary care professionals. The sessions were attended by 10 participants. The aim of the first session was to better understand the impact of the new access models on patient experience from the perspective of primary care professionals, particularly hearing from GPs. A second session was set up to present the initial findings of this project and assist with co-designing the recommendations for this report.

Participant Profiles

Healthwatch Lewisham spoke to 45 residents between April – July 2021. In addition, we engaged with 10 primary care professionals to understand their perspective on this issue. These sessions took place in April and August 2021.

We gathered a substantial amount of monitoring information, and it is evident there is intersectionality. For example, several residents we engaged with would fall under the three traditionally disadvantaged groups we wanted to focus on: English as a second language, older residents, and people with disabilities.

People over the age of 55

25 people were over 55 years old (see Appendix 3). This group included:
- 65% women and 35% men
- 83% confirmed that they are 'Not in Employment/ not actively seeking work (Retired)'
- Several people had age-related conditions such as hearing or sight impairment

Disabled People

21 people identified themselves as disabled. This group included:
- 76% Women and 24% men
- People with physical disabilities, mental health issues, mobility and sensory impairment, long-term conditions, and learning disabilities
- Those that were happy to share their ethnicity identified as White British (38%), Black British (African/Caribbean) (38%), White Other (10%) and Asian British (Bangladeshi/Indian) (1%)

Primary care professionals

With the support of the North Lewisham Primary Care Network, we organised two engagement sessions open to all primary care professionals. The participants mostly consisted of GPs.

English is their second language

Of the 45 participants engaged with the research project, 16 people confirmed that English is their second language. This group included:
- People with varying levels of English proficiency. In some cases, we provided an interpreter to assist with carrying out interviews
- One Deaf person who uses Portuguese and British Sign Language (BSL). We organised an interview with the resident through Zoom with the support of a BSL interpreter.
- People who spoke Arabic, Igbo (also known as Ibo), Romanian, Maltese, Tamil, Twi (also known as Akan Kasa), and Spanish.

Ethnicity

Studying the monitoring information shared by most participants, we identified the following ethnic groups (see Appendix 4):
- 33% Black British (African/Black Caribbean)
- 31% White British (English/Welsh / Scottish / Northern Irish/ British)
- 9% White Other
- 5% Arab
- 2% Asian British (Bangladeshi/Indian)
- 2% Mixed Multiple (White & Asian)

Report Layout

The following chapters focus on analysis of the 45 interviews. We have highlighted the key issues which emerged through the conversations and have included several case studies which showcase the different experiences for participants when accessing services.

45
interviews

7
key findings

6
case studies

19
recommendations
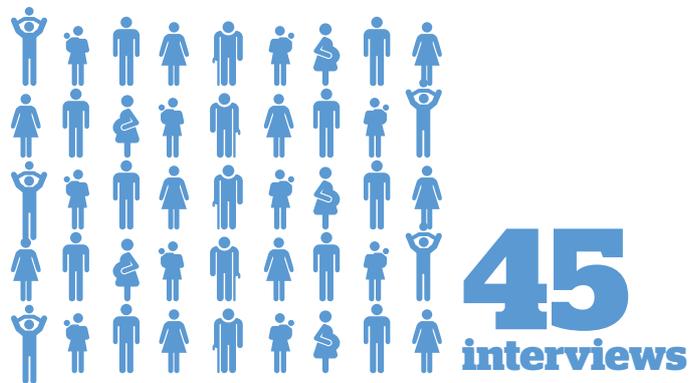
Key Findings: Limited or lack of Technology & IT Skills

Online appointments have created barriers for some of the residents we interviewed many of whom do not have adequate IT skills to access their GPs this way. This left them feeling unable to use the service after the introduction of new remote access methods because of the pandemic. The new model of access exacerbated by difficulties in contacting the practice via telephone, has led to some people giving up trying to seek help from their GP.

A participant explained that they can't get through when ringing their practice and due to poor health rarely feel able to attempt a call again. Another participant felt the new system was not inclusive as they were unable to access their GP because they didn't possess digital devices. When they called their practice, they were consistently advised to book appointments through the online system which they felt was discriminatory. They tried to get an appointment for months over the telephone and had no success, which caused a huge level of stress.

Feedback suggests that some respondents relied on family members to help with digital access and/or making steps to improve their IT skills by attending classes. Whilst some residents have had family members support them with digital issues, services should not rely on this support. They should take the necessary steps to empower all residents to have privacy for confidential discussions if necessary, and parity of access to their services.

The lack of digital skills has made it harder for some participants to access health information or know what services are available to them. This could be particularly challenging for those that are socially excluded for multiple reasons, such as learning difficulties or language barriers. During a NLPCN discussion, a primary care professional spoke about how "Our digital triage system has shifted the demographic of patients at the surgery. We have a university population close by so the demographic is young students. ...There is a shift away from patients who probably need services, because they can't use e-consult as well as younger professionals."

CatBytes is a non-profit organisation that support residents in developing their IT skills. We attended one of their technology workshops to get a better understanding of the work that they do and hear about their first-hand experience of working with individuals that want to develop their IT skills. Catbytes' Damian Griffiths said "I think the experience of helping people use digital devices has taught me that there are far more ways of getting things wrong than there are getting things right. They don't explain that in the instruction manuals. This is why person-to-person support will always be part of keeping people in the digital loop."

The above feedback suggests that change to new digital models may have had a negative impact on people who are used to accessing services in the traditional way. The difficulties in getting through on the telephone add further barriers for those who are unable to use digital technologies to access services.

"The advancement of technology makes you feel a bit alienated..."

".... I feel so restricted. I don't have a computer and they have an online app that is not working during the pandemic. There are no appointments available."

"I don't have access to online. There must be many in the same position as me."

Key Findings: Digital Poverty

Our aim was to engage with residents that are more likely to be digitally excluded. Whilst most participants we spoke with have access to a digital device (computer or smart phone), a few participants said that they don't have a computer or internet connection at home. 11% of participants confirmed they had used e-consult or had a video consultation with their GP practice (See Appendix 5). The findings suggest that some of the participants experienced significant barriers in accessing care remotely as a result of the lack of affordability. Some of the examples are outlined below:

- During an interview, a participant on low income asked if we could find them "a cheap computer" as they weren't sure how to locate one themselves and their financial situation has impacted access to technology.

- Several participants commented on phone bills being more expensive because of long waiting times when trying to get through to a GP practice. One participant doesn't own a landline or mobile phone. They had to use a phone box which they found exceptionally difficult as it costs more money. Although they eventually got through and had a positive experience getting a referral, they found accessing the service extremely frustrating and felt it was an overly complicated process. It took up a lot of their time, was more expensive and they would have preferred walking into their GP practice to book an appointment.

- Similarly, a participant highlighted the challenges they faced when trying to register at a GP practice. When engaging with a receptionist, they informed them that they didn't have access to a laptop and only have a telephone. The receptionist couldn't believe this and advised they go to a friend's house for digital support. The participant felt they were treated without empathy, and that their individual needs were ignored, which left them facing additional barriers registering with their GP.

Dr Al Mathers at Good Things Foundation says there has been a rise in data poverty during the COVID-19 pandemic. Approximately 10% of internet users have a smartphone to get online and 6% (down from 11% in 2020) of households were without access to internet and devices in March 2021 [19]. 55% of those that are offline earn under £20,000 [20].

> "It also costs a lot…. you have to hold onto the line, and you are in a list of people. Then something goes wrong, and you go right back to the start again."

> "You are made to feel like a second-class citizen if you don't use the internet."

Key Findings: Appointment availability & booking system

Prior to the pandemic, our organisation regularly found through our intelligence reports that access to GP appointments was the biggest issue for Lewisham residents in relation to health and care services. Overall, the findings from our digital exclusion project show that 90% of participants were able to access help from a primary care professional at least once during the pandemic. 59% confirmed they had managed to get a telephone consultation and 30% had received a face-to-face consultation. In most cases participants received face-to-face appointments if they were being seen by a nurse, having a blood test, or required urgent physical examination. This particular cohort of residents were grateful to receive their preferred type of appointment.

18 participants, however, highlighted that waiting times on the GP practice's telephone was the biggest barrier faced when trying to book an appointment. Other technical barriers were flagged such as people finding it difficult to use apps to book appointments, extensive phone queues and unreliable phone connections which would cause people to be cut off and must start the process again. The new remote system has not improved access to appointments for many residents. Difficulty engaging with services means that patients can choose to give up contacting the service and this could result in them interacting with services at a point of crisis.

Despite having access to a smartphone or the internet, the majority of participants rang their GP practice to get appointments. One person shared their story of being unable to get hold of their doctor and ringing NHS 111 for support. They were referred to a walk-in clinic in a neighbouring borough who managed to speak to their GP practice and arrange an appointment. It has been extremely difficult for them to get through to a person on the phone and they wished for better communication and more support.

Red Ribbon is a volunteer-led community organisation supporting people affected by HIV in the London Borough of Lewisham and surrounding areas. Most of the people they support are migrants, on low income and have no recourse to public funds. We attended a Zoom workshop with the organisation where participants shared their experience of healthcare access over the past 18 months. One of the key issues for Red Ribbon service users was the long waiting time trying to get through to a GP practice on the telephone. One participant said they tried calling and their GP practice was fully booked for the whole week. This is a concern for many Red Ribbon service users as they have a long-term health condition which can require regular medical attention but aren't always able to reach their GP when they need support.

The implementation of remote booking systems has also resulted in residents being unable to book appointments in-person within their GP practice. This provides an additional barrier for residents who either do not have access to technology or cannot afford to incur increased phone bills due to long waits on the telephone.

> **"They don't answer the phone and when you get through, they don't pay attention to you ..."**

> **"You are fifteenth in line and there is so much jargon."**

Key Findings: Communication

Several participants told us that a lack of communication from services during the pandemic meant they weren't aware of the access arrangements prior to engaging with the service. In some severe cases this led to hospital visits or a participant not addressing their health issues immediately causing further complications.

Internal communication between health and care services was also highlighted as an area for improvement. During an interview, a participant said that their prescriptions were delayed due to miscommunication between their GP practice and the pharmacy. This was an immediate concern as they have long term health conditions, which require regular medication. Another participant, that has Chronic Obstructive Pulmonary Disease (COPD), spoke about an issue concerning their repeat prescriptions. When they spoke to a GP at their practice, the doctor was unaware of their medical history and not a chest specialist.

The feedback we received shows that 33% of participants found out about changes to their GP's booking system when they rang the practice themselves. Whilst 20% of participants received a letter in the post and 11% received a telephone call from their practice to inform them of the changes being made. The other methods of communication, which received less than 10%, were email, leaflets, text, GP website and word of mouth (see Appendix 7).

A participant said that they have been registered for more than 8 years with their GP practice. They never received any correspondence related to changes at their surgery and only discovered the new triage system when calling the practice directly.

Another participant also was unaware of the changes accessing their GP until an LRMN advisor rang the practice on their behalf. Prior to this, the participant had made several attempts to call their GP and the line kept going to voicemail. Eventually they had to ring 111, which then led to them ringing 999 and being taken to a hospital.

Residents with sensory disabilities further highlighted challenges they faced including confidentiality, communication barriers and concerns around data protection.

A Deaf participant highlighted the barriers of accessing their GP as a result of interpreting services provided by the Council being paused. Prior to the pandemic they used the same interpreter at healthcare appointments which meant the professional was familiar with their issues and could communicate their concerns. During the pandemic, interpreter provision has been provided nationally which has prevented continuity and the resident found that some interpreters did not have the required skills to communicate their specific health issues with the doctor. Virtual appointments also meant that they couldn't meet with the interpreter beforehand to build a rapport.

Residents that access their GP practice regularly expressed their frustration in the lack of communication about changes in access during the COVID-19 pandemic. One patient, that has multiple health issues as well as being unemployed, described their current situation as "living through hell".

Key Findings: Communication (continued)

The lack of access to their GP has impacted their health and well-being because they have serious health issues that haven't been addressed. Due to not having a computer and limited technology skills, the patient has struggled to see a doctor over the past 18 months and resulted to visiting A&E when their health condition deteriorated.

During a NLPCN discussion, a primary care professional said that "Running a total triage system has given us increased capacity. But not having an open-door policy as well as poor messaging, makes some people think that our service is closed. Primary Care communication across multiple platforms is an issue." This finding was also identified in our 'Impact of COVID-19 on Lewisham Residents' report [21].

> **"My own GP would know me, and I have ended up in hospital when I don't need to go."**

> **".... government needs to give more money to GPs so they can take longer to listen to people, especially now after we have the problems of Covid."**

Key Findings: Face-to-face vs. remote appointments

The majority of participants said that their GP practice has been operating remotely since the start of the COVID-19 pandemic. 44% of participants felt the shift to phone, video or e-consultations had impacted their ability to access GP services in a negative way, with many expressing concerns that their health issues could not be addressed properly if they weren't physically seen by a doctor. 33% of participants expressed neutral sentiment, and felt their health needs were met, and 23% had a positive experience with remote consultations.

The majority of participants said that they weren't given a choice to choose between remote or face-to-face appointments. If given the option, most service users would choose face-to-face (See Appendix 6).

One of the reasons for preferring face-to-face appointments was the concern of being misdiagnosed, or the wrong medication being prescribed. People felt this was more likely to happen without a thorough examination in person. This indicates that the remote model reduces people's trust in the diagnosis and treatment plan.

Many participants felt that the face-to-face appointment was of better quality as it was 'easier' to communicate, especially for patients with multiple and/or complex conditions. The discussion with the primary care staff as well as feedback from participants suggests that face-to-face appointments creates a rapport between the patient and doctor and allows for more meaningful interactions.

One participant said they have multiple medical issues where it's only appropriate to talk to someone in person. They sometimes find it difficult to remember everything they wanted to say over the telephone. During a NLPCN discussion, a primary care professional spoke about the issues they had faced with remote consulting from a clinical perspective; "There are very few set things that remote consulting are good for, i.e., contraceptive pill. For the vast majority of problems, it is very difficult to do it in a satisfactory way for both a GP and a patient."

Similarly, a GP in Lewisham that attended one of our NLPCN discussion groups, told us that some asylum seekers have access to a telephone via their home office accommodation. However, language is often an issue, and they feel dissatisfied with the appointments they are receiving remotely. A telephone appointment, rather than face-to-face, is not valued and "acts as a deterrent to them booking appointments".

"You can't give a thorough examination without being in person."

"I would like to be able to have face-to-face....I can use Google translate on my phone to speak in person, I can't use this when I am on a phone."

Key Findings: Confidentiality

The issue of confidentiality was raised by several participants. People expressed their concerns around having to share personal information over the phone with a receptionist. They didn't want to be discussing private health matters with anyone other than their doctor. People also expressed concern around the use of personal data.

One participant, who is visually impaired, spoke about the challenges they faced when accessing appointments. They don't have an internet connection at home and booking an appointment requires a support worker, which they were unable to get over the past 18 months. Therefore, accessing health services during the pandemic was exceptionally difficult for them. Out of good will, a neighbour stepped in to help read letters sent from their GP practice. However, this has resulted in them no longer having privacy or confidentiality.

"I would prefer to have face to face ... You can sit down and tell them your griefs and it is confidential."

Key Findings: Continuity of care

Several participants expressed their concern about how the new access models impacted on continuity of care and being able to book appointments and interact with the same health professional. A Red Ribbon service user said that sometimes they are afraid of trying to access a health care service because they can't guarantee they will see their GP. They commented that members of Black communities tend to rely on people they know and connect with and that there is a lot of action to be done to ensure continuity of care and avoid a lack of trust in health care services.

"If you live alone, it is hard. I have my daughter and a carer for support."

Key Findings: Impact on mental health

Several participants said they felt incredibly anxious as a result of not being able to speak to a GP in person about their health conditions over the past 18 months. One participant commented that they found it difficult to trust what a GP said to them over the telephone and stressed how much more relaxed they would feel if they could be seen in person by a doctor.

On the other hand, another person said they felt safer speaking over the phone during the COVID – 19 pandemic. They thought it was better to only see a doctor in person if it was an emergency because they were worried about contracting the virus when visiting a practice.

Another participant said they had a 'fear of germs' in the small waiting rooms with chairs that faced each other. They felt more wary and at risk of getting COVID-19 in their GP practice. The participant also felt there was a lack of mental health and wellbeing support for people that are digitally excluded. Whilst they had been made aware of online resources, they preferred to have in-person counselling and couldn't access this over the past 18 months.

During a NLPCN discussion, a primary care professional discussed their first-hand experience with healthcare access for refugees and asylum seekers; "I had a patient who was coming to see me, on the same day he completed an e-consult… He submitted it because he got really anxious…. it meant that someone else has got to look at that through a triage system. But he also had booked to see me face-to-face at the same time."

> "Last year I gave up contacting the GP for anything…. it was causing me more anxiety than usual. My advocate stepped in …… and only then did I get an appointment."

> "One is inclined to worry more about their ailments."

Positive Experiences and Good Practice

The key findings from our engagement highlighted a variety of different issues that digitally excluded residents faced when trying to access their GP practice during the pandemic. However, as previously mentioned within the report, 23% of participants commented on how much they valued the support they received from their health services during the COVID-19 pandemic. Their experiences incorporated themes such as good communication, convenient access arrangement and excellent service.

For example, a participant spoke about the positive experience they had had with their GP practice's triage system. They received a mixture of telephone and face-to-face appointments which they said were equally satisfactory. They thought the quality of care received over the telephone was good and they felt safe going into the GP practice when the surgery required an in-person examination. The participant had found access to primary care during the pandemic to be easy. However, they also said they were not attempting to get same day appointments, which meant they weren't attempting to call their GP when the service opens at 8am.

Another participant commented that their GP practice "understands my limitations and they have known me for years. They always support me, so when I call, I don't have to go online." This shows how some services understand the needs of their patients and ensure they have a good experience when accessing health services.

Finally, another participant said their practice gave them the option to choose between remote consultation or face-to-face appointments. At the height of the pandemic, their experience with a telephone consultation was comprehensive and effective, and they were happy with the quality of care they received from their GP.

A NLPCN discussion group identified that some health services have adopted strategies to better support those that are digitally excluded. These include:
- A direct phone line that is given out to vulnerable clients.
- Front of House Champions who support service users that need additional support i.e., online registration for a GP practice.

> "They got in touch with me to let me know their telephone number has changed."

> "The GP is round the corner from me so it was easy to commute."

> "I have had both vaccines. The GP came to where I live and did them at my home. We had letters to inform us about it."

> "I was quite happy speaking to the doctor over the phone."

Case Studies

For this report, we carried out extensive interviews with local residents. This enabled us to gain a greater understanding of people's experiences during the pandemic. We have collated a series of case studies, which showcase both positive and negative experiences.

Case Study: Participant A

Participant A is deaf and gave birth in late 2020. They primarily communicate in either Portuguese or British Sign language. Their experience of giving birth was complicated due to the number of people talking in the hospital and having no interpreter to translate for them. There have been multiple barriers, mainly due to poor communication, which has made accessing primary care more difficult for them over the past 18 months.

Participant A said that trying to access information remotely "has been quite upsetting at times". When they attended a remote consultation, technology wasn't always reliable; "...the picture kept freezing. They were wearing masks which made it harder to communicate. Those were the two main issues that were big for me".

They also told us that the interpreters provided by the GP practice had only basic British Sign Language (BSL) Level 1 or 2, which made it difficult to explain health issues.

Prior to the pandemic, Participant A had used an interpreting service provided by Lewisham Council to call a GP practice on their behalf and book a consultation with a BSL interpreter present. They also have experience using Sign Live, a service provider of online video interpreting services through its Video Relay Service (VRS) and Video

Remote Interpreting (VRI). However, they explained that most council services supporting deaf people stopped when the COVID-19 pandemic spread rapidly. This lack of interpreting support created a substantial barrier to accessing healthcare services. Pre-COVID-19, it was easier to use GP services but since interpreting services have changed, face-to-face interpreting stopped. Participant A's GP practice made face masks mandatory which added additional stress as communication became more challenging. Participant A said that they would like face-to-face appointments to go back to how they were pre-COVID-19 as you could "meet with the interpreter beforehand and discuss my situation... and appraise them. Having an interpreter physically with you and accompanying you through the whole process is much easier."

Participant A felt that doctors had not taken responsibility and reception staff hadn't taken into consideration how to get an interpreter that's suitable for discussing primary care needs of a deaf person. Communication needs to improve dramatically so that information is passed on correctly between staff to ensure support from BSL services improve within health and social care services.

Case Study: Participant B

Participant B, a Spanish national, had only positive things to say about the treatment he has received over the past 18 months. Whilst English is not his first language, a relative was able to act as a translator and has helped arrange remote consultations as well as being seen in person for ongoing treatment. Participant B said the only issue he faced when visiting a hospital was that he had requested a Spanish speaking nurse beforehand. Unfortunately, this hadn't been organised, but staff managed to find someone to act as a translator very quickly and the participant felt well looked after.

Participant B said he was very satisfied with his GP practice; "I have been here since 2002 and had no problems at all." He received his COVID-19 vaccines in January and March 2021 and the appointments were conveniently arranged by telephone.

Case Study: Participant C

Participant C commented on the positive experience she has had with her GP practice since the start of the COVID-19 pandemic; "I would say I always thought they were pretty bad, but they were excellent over the past year from the beginning of COVID."

When asked if their practice was using a triage system, Participant C said that she was able to book an appointment over the phone and would receive a call back from a doctor the same day. Pre-COVID-19, Participant C said that sometimes she would wait on the phone up to 30 minutes to get through to someone, and that things had significantly changed over the past 18 months. Participant C did say that she was fortunate not to have to ring her GP for anything seriously wrong. It was typically smaller problems that could be dealt with over the phone. In the past, she had to visit her practice often and it was unpleasant sitting in the surgery's reception. She said that a telephone call with her GP practice was more suitable, and less time is wasted.

Case Study: Participant D

Participant D is partially sighted. They said that their GP practice has been okay' during the pandemic. They mostly spoke with their surgery over the phone but saw a doctor when it was necessary, and fortunately the practice is walking distance from their home.

Participant D said that their GP predominantly offers telephone consultations and has introduced Personal Protective Equipment (PPE) for patients visiting the practice. The practice didn't contact them directly to communicate the changes to their system. Participant D found out through exchanges with close friends.

Participant D doesn't have access to a smartphone as they are unable to use one due to their visual impairment. They have a mobile but can't see texts therefore cannot engage with health services via this method. They also don't have access to internet at home. The GP practice's reception staff have a good rapport with service users and Participant D said they had had a positive experience with telephone calls and that remote consultations had not affected the quality of care. They have also been able to walk-in and book appointments in person provided they are wearing PPE.

The patient said that if they had a health concern that was treatable using remote consultations, this wouldn't have been a problem. However, due to their health condition, it is necessary to have face-to-face consultations when the matter is serious.

Conducting an appointment over the phone would not be beneficial for them if they needed a thorough examination and their condition was causing distress.

Participant D's only negative comments referred to the hospital. Last year they had 6 appointments cancelled for tests to examine their eyes as well as waiting 3 months for an ultrasound. When their last appointment was cancelled, they received no letters or correspondence from the hospital about rescheduling a visit.

Case Study: Participant E

Participant E has diabetes, mobility, and mental health issues. Their main experience has been a lack of accessing health and social care services since the start of the pandemic. One of the main issues for them is difficulty in getting through on the telephone. The shift to remote consultations has impacted their ability to access GP services. An increase in the number of people trying to call the surgery makes it very difficult for them to speak to anyone. They said that they call their practice at 07:00, wait in a queue, and then get told by reception staff to call back another time. Due to their health issues, they don't always feel up to calling back and waiting again in another queue hoping to get through to a doctor.

Participant E said that they are unemployed and on benefits, which has impacted their access to technology and made it difficult to access a GP practice during the pandemic. They don't own a computer and struggle to use a mobile phone, which has made it more stressful trying to contact a doctor. They hate using a mobile phone because their eyesight is poor. On several occasions they have had to ring 111 to get antibiotics because it has been so challenging trying to get through to their GP and request a prescription.

Participant E received a letter inviting them to get a COVID-19 vaccine. However, they haven't been able to leave the house stating that they have been isolating "even long before the pandemic…because of family history issues". In addition to not having the vaccine, they haven't been to a diabetes eye clinic or had their flu jab.

When asked what they felt a GP could have done differently to help them access care, Participant E said that if the doctor would call and check on them, on a semi-regular basis, they would really appreciate this. Pre-COVID-19 they had monthly check-ups, but this stopped when the pandemic rapidly spread. They said more support in the form of communication from a doctor was needed to help vulnerable people access services.

Case Study: Participant F

Participant F, has chronic obstructive pulmonary disease (COPD). They said their main issue with health and social services is the negative experience they have had trying to access their GP practice; "you just get in a loop of recordings that go on and on repeating itself".

Since the start of the COVID-19 pandemic, Patient F said that their GP practice has changed their automated phone recording several times. Previously, it would inform you of your position in the queue. Currently, it lets you know your position when you first connect but then never updates your progress, which has led to them being on hold for 30 minutes not knowing where they are in the queue; "when do you give up cause you can't stand it any longer.... there are quite a few occasions where I have given up entirely."

Participant F also commented on the automated phone system continuously informing patients that online consultations are available. They found this very frustrating as they don't use a computer. When their GP text to let them know their first COVID-19 vaccination was ready to book, they were given the option to telephone or use the practice's website to arrange an appointment. With their second vaccination, the text message only gave them a website option. They had to ring the practice multiple times to try and book an appointment. After several failed attempts, they eventually spoke to a kind receptionist who managed to book their second vaccine over the telephone; "it did work beautifully after a hiccup."

When we asked Participant F what has changed in the way their GP operates since the start of COVID-19, they said "it had gone very impersonal even before the pandemic. It was difficult to get appointments anyway." Their practice had written to say that changes would be made, and leaflets were also distributed locally informing residents that they would be using an online system; "there were fewer appointments available over the phone."

Because of their health condition, Participant F said they normally would have an annual review. In 2020, their review was carried out over the telephone. However, they were not given the option to get tested. Their GP practice also doesn't appear to have a primary care professional with COPD expertise since one of their nurses retired; "I don't know if I am getting the best possible treatment." They believe their condition has deteriorated because they have been unable to do as much exercise as they normally would over the past 18 months.

Participant F said that they would not be happy if the changes to the system stayed the same after the pandemic. They would like to be treated like a "human being... we are patients and not customers. The current system turns you into a customer, like phoning an energy company."

Conclusion

Through our engagement, we found that digitally excluded participants had mixed experiences when accessing and using GP services. 27% felt that their experiences had been positive during the pandemic (Appendix 1) and were supportive of the changes brought by the total triage model. However, 47% felt that the new systems either exacerbated or created new barriers which impacted on their access to services. It is vital that local systems learn from these experiences and address the challenges highlighted by disadvantaged residents to ensure they are not excluded from accessing basic health and care services.

Services would benefit from improving communication around access arrangements with patients, especially those who are most vulnerable and do not have easy access to the internet. People should be given a choice on the type of appointment available to them which meets their accessibility needs.

Practices must take into consideration that not everyone is confident with digital technology or has access to the necessary devices. There is a need for services to identify those users who are/ are at risk of being digitally excluded to ensure that all patients can access care when they need it.

During our interviews, we spoke with several people that had sensory disabilities, including sight and hearing loss. These interviews further highlighted challenges these residents faced including confidentiality, communication barriers and concerns around data protection.

The majority of participants would prefer face-to-face appointments when accessing their GP practice. Whilst some participants valued remote consultations and, in some cases, thought it improved patient access, other participants felt that a high level of care and treatment could only be delivered in person. Participants shared their experiences of unsuccessful remote consultations leading to misdiagnosis and felt a physical examination would have been more effective. Lewisham Speaking Up, a local charity supporting people with learning disabilities outline in their 'Research on Digital Exclusion since the Covid-19 pandemic 2020' report, that "Digital technology should be available, but as one element of a range of options for people to choose from" [22] and this is similarly echoed by our findings.

Residents who had positive experiences with their GP practices during the pandemic were pleased at having a mixture of remote and in-person consultations depending on the severity of the issue. A primary care professional said they had "found a combination of different things in communication with the patient quite useful...from an IT perspective, offering different routes (languages) and a variety of access through the platform as well as different services.... allows them the choice."

Several participants highlighted the stark reality of digital poverty and the impact total triage and remote booking systems had on their access to care. Some were unable to easily engage because they couldn't afford digital technology. Others highlighted the increasing cost of phone bills due to long waits in telephone queues or faults with telephony systems which cut them off.

Conclusion (continued))

Being unable to book appointments in person meant that residents had to incur charges if they wanted to have an appointment. Services must ensure that their access models enable equity of access or otherwise they could discourage people seeking support for their health and care.

The NHS Long Term Plan outlined the intention for more appointments to be made available via digital methods and the increased delivery of remote consultations. However, the outbreak of the pandemic has seen rapid digital developments within primary care. Our digitally excluded participants felt that the changes had had a negative impact on their experience of GP services.

Feedback of service users must be taken into account as we move out of lockdown and systems are reviewed to ensure adequate service and parity of access. For the implementation to be ultimately successful, services must bring residents along with them by empowering them to use digital methods and most importantly providing alternative access options for those who cannot afford or cannot use digital solutions.

> **"I am really happy that I have had the opportunity to be interviewed and shared my concerns. There are people in the system who are responsible to check on the vulnerable and ensure they aren't left out."**
>
> *Lewisham Resident*

Recommendations

The feedback received from patients who participated in our research further endorses the idea that there is not a 'one size fits all' model for access to services. Based on our data analysis, we have made the following recommendations, with support from primary care professionals that attended our NLPCN discussion groups, on digital isolation.

Appointment availability & booking system

Finding:

Getting through on the telephone to a GP practice was the biggest barrier for digitally excluded residents when accessing services. In extreme cases, people chose to no longer access the service due to frustrations in getting through to their practice.

Finding:

The implementation of remote booking systems has meant that residents are unable to book appointments in-person within their GP practice. This provides an additional barrier for residents who either do not have access to technology or cannot afford to incur increased phone bills due to long waits on the telephone.

Recommendation:

1. Investment in improved telephone systems which are fit for purpose.

2. The adoption of telephone systems which can gather data on the number of people accessing the services would enable local services to have a greater understanding of the true demand on services and help them to monitor the issue.

3. Developing solutions to help reduce waiting times when residents are trying to access appointments through the telephone. One Lewisham practice has adopted a call back system which gives residents the opportunity to receive a call from the service rather than waiting on the telephone.

Recommendation:

1. Services must look to re-establish the option of booking appointments in-person to ensure residents who cannot afford to engage with the digital systems are able to access care.

Limited Technology & IT Skills and Digital Poverty

Finding:

For some of our participants, affordability and limited access to digital devices created significant barriers when trying to book appointments at health and social care services. Primary care professionals explained that they need to take into consideration that a certain cohort of patients may need different methods of access than others.

Recommendation:

1. Services to clearly outline and communicate to their patients all the appointment types available to them and how to access them. Additional efforts should be put in place to communicate the above with the most vulnerable patients.

2. Services to review telephone systems in place to ensure they are fit for purpose and do not disadvantage those that only have this access route as an option. For example, a Lewisham GP practice has set up a separate direct phone line that is given out to vulnerable patients. This has helped reduce the waiting times on their main service phone line and helped minimise the cost of some patient's phone bills. This model could be adopted by other services.

3. Services to ensure appointment systems allow for patient choice.

4. Healthwatch England (HWE) carried out a national research project 'Locked Out' which focused on people's experiences with remote GP appointments. Within their report they highlighted the need to further develop digital support on a national and local level to ensure everyone has access to public services. This is a key finding which was also evident from our engagement with Lewisham residents and therefore we would support the following HWE recommendations:
   I. Ensuring all GP practices are reachable by a freephone number
   II. Arrangements with telecom firms that no data charges will incur when accessing any NHS services.
   III. Including access to the internet in social prescribing schemes, funded by the NHS for those whose health may benefit from it.

Finding:

We found that the majority of residents we interviewed did have access to a digital device. However, most people used a telephone as the main method of accessing health services.

Recommendation:

1. With the expansion of digital services, local systems should look at supporting residents by providing a clear support and digital training offer for using their service.

Communication

Finding:

Several participants highlighted challenges communicating with front line staff when trying to access services. They told us that a default approach for certain services was to direct patients to book appointments through online systems such as Patient Access. On one occasion, a resident was advised to ask their family to help them book online appointments when they explained they couldn't do it themselves.

Recommendation:

1. Training for front line staff on digital isolation and how to sensitively support people to access GP appointments. This report and associated case studies could form a basis for this training. For example, a GP practice within North Lewisham has established Front of House Champions which support patients with registration and being able to identify people that might need further assistance when booking appointments. This is an example of good practice which could be rolled out across the borough.

2. Services should look to capture information on whether a resident is digitally excluded or has a basic level of IT skills, or their preferred appointment type, in order to better understand if they have additional communication or access needs. Research carried out by Healthwatch England found that patients and primary care professionals 'suggested that it would be helpful for practices to code patient records with information regarding a patient's language and communication needs or level of digital skills, so that staff can be proactive about offering people an appropriate consultation type or pre-empt requests for adjustments in future' [23].

3. Services should ensure that staff are aware and able to signpost service users to local digital support groups.

4 Many health and care organisations are increasingly using their websites and social media as their primary approach to communication with their clients or the wider public.
We would encourage organisations to engage with people who may have difficulty accessing such digital media to identify alternative communication methods to reach people who may not have easy access to the internet.

Finding:

Participants had varying levels of awareness around current GP access arrangements. Some residents had been directly contacted by their practice (11%) whilst others had received no communication during the pandemic (Appendix 7).

Communication (continued)

Recommendation:

1. The COVID-19 pandemic has seen rapid developments with digital access. Services should actively communicate with patients, via texts, calls, or follow up letters, about changes to appointment and access systems. There should be additional focus on vulnerable groups who have barriers in engaging with online information. This will enable residents to be better informed when seeking to access treatment and care.

Finding:

A Deaf participant highlighted the barriers of accessing healthcare services as a result of interpreting services provided by the Council being paused. There were also challenges with interpreters provided not having the required skills to communicate the specific health issues or having the opportunity to discuss issues prior to the appointment.

Recommendation:

1. Services should look to reinstate interpreting services which enable deaf residents to have access to a designated interpreter. The automatic provision of face-to-face appointments for patients which need translation support would improve patient experience by reducing communication issues.

Choice

Finding:

The majority of participants explained that their GP practice has been operating remotely since the start of the COVID-19 pandemic and that they weren't given a choice between remote or face-to-face appointments. If given the option, most people would choose physical appointments. Several residents had positive experiences with accessing services as they were able to have a mixture of remote and face-to-face consultations.

Recommendation:

1. Services to offer a hybrid consultation system which embeds patient choice.

2. When services are developing new appointment models, they should always seek to capture feedback to help shape services that meet the needs of digitally excluded and vulnerable people.

Wider system recommendations

Finding:

Multiple participants told us that a lack of communication from services during the pandemic meant they weren't aware of the access arrangements prior to engaging with the service.

Finding:

Primary care professionals informed us that there is a lack of data available indicating whether there has been increased demand on other services because of people being unable to access a GP.

Recommendation

1. There is a need for a communication plan at national, regional and local levels to provide residents and professionals with clear and consistent information about changes to the health care system. Residents need to be informed about changes to access arrangements and the benefits of the different types of consultations.

Recommendation

1. Local health and care systems should collate the different access data from GP services, GPEA, 111 and A&E departments to understand the current access demand on primary care services and impact on the rest of the system. The data can be used to identify where resources would be best used within the system to tackle the issue of demand on primary care services.

2. A&E departments should look to capture information from patients on whether issues accessing primary care services had led to them attending hospital.

Appendix

Appendix 1: What was your experience of trying to access primary care during the pandemic?

Negative 21	
Neutral 12	
Positive 12	

Appendix 2: Monitoring Information, Gender

Prefer not to say 6

Female 30

Male 9

Appendix 3: Monitoring Information, Age

Prefer not to say 7

Age 54 - 14

Age 55 + 25
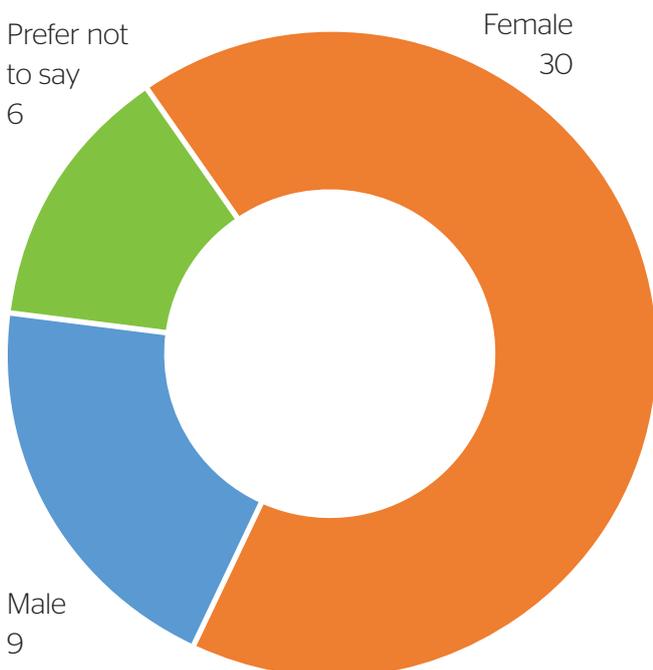
Appendix 4: Monitoring Information, Ethnicity

Prefer not to say
8

White Other
4

White English / Welsh / Scottish / Northern Irish/ British
14

Arab   2

Asian / Asian British - Bangladeshi / Indian   1

Mixed Multiple, White & Asian   1

Black British / Black African / Black Caribbean
15
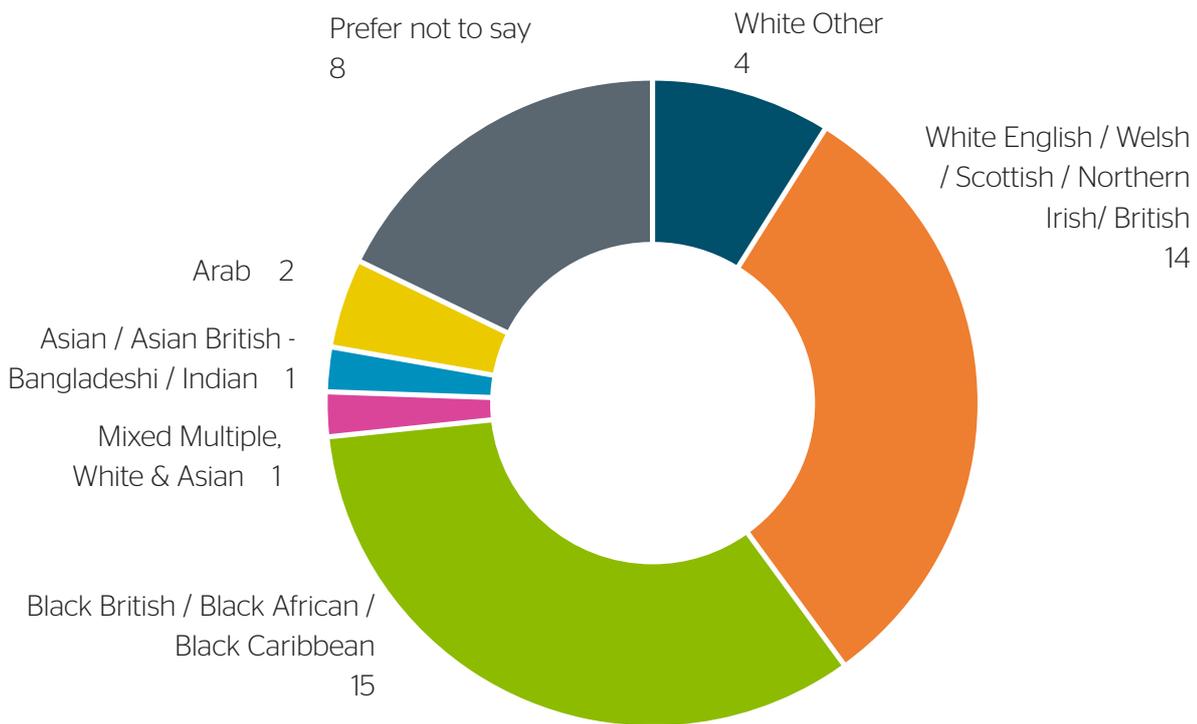
Appendix 5: What type of appointment did you have?

Face to Face 18

E-consult 5

Video 2

Telephone 36
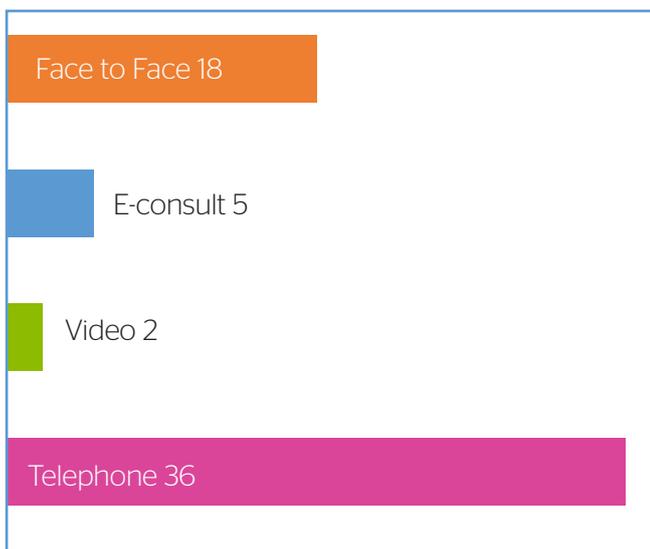
Appendix 6: If given a choice, would you have wanted a remote consultation or face-to-face appointment?

Mix of remote &
face to face
3

Remote
2

Face to face
26
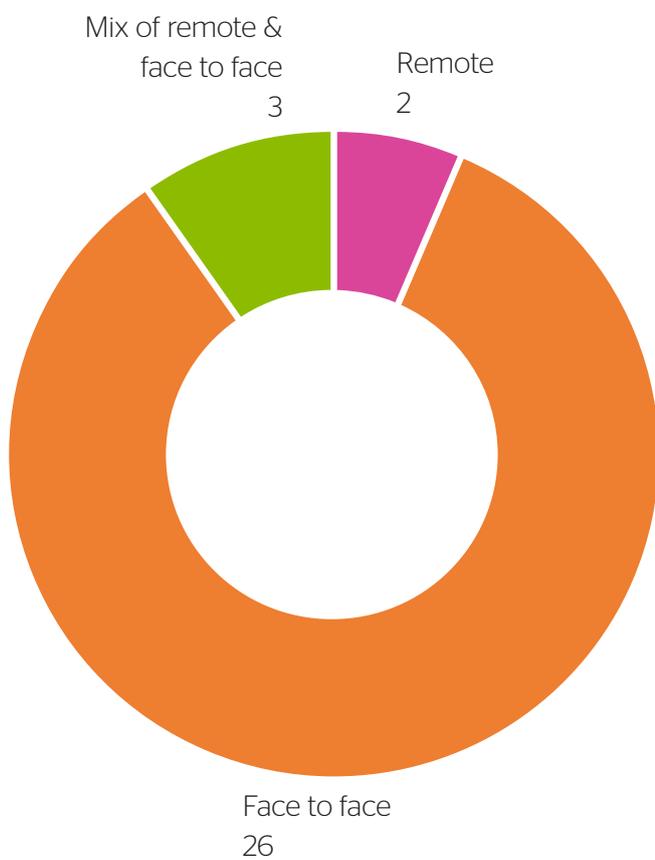
Appendix 7: How did you find out about changes to the system?

Email 3

Telephone - patient rang the practice 15

Telephone - practice rang the patient 5

Text 3

Postal letter 9

Website 2

Leaflets 2

Word of mouth / Friends 3

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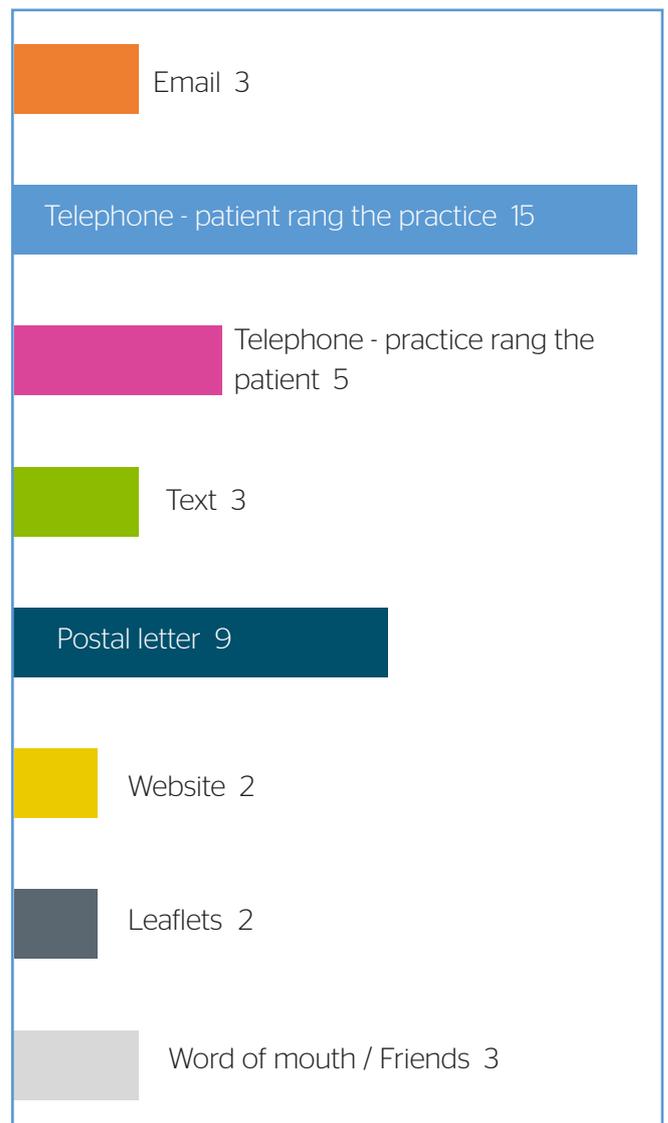
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- Lewisham Homes
- Lewisham Local
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- Lewisham Speaking Up
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- Metro Charity
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- LGBT Forum
- North Lewisham Primary Care Network (NLPCN)
- Red Ribbon Foundation
- Sign Language Interactions
- SLAM
- St Peter's Church, Brockley
- Table Talks
- Voluntary Services Lewisham

Digital exclusion and access to health services

Summer 2021

Your Voice in Health and Social Care is an independent organisation that gives people a voice to improve and shape services and help them get the best out of health and social care provisions. YVHSC holds the contracts for running the Healthwatch services for Healthwatch Hounslow, Healthwatch Ealing, Healthwatch Waltham Forest and Healthwatch Bromley. HW staff members and volunteers speak to local people about their experiences of health and social care services. Healthwatch is to engage and involve members of the public in the commissioning of Health and social care services. Through extensive community engagement and continuous consultation with local people, health services and the local authority.