



## Contents

Contents .....	1
Background .....	2
Digital by default .....	2
Ease of access .....	2
Convenience of telephone appointment.....	3
Virtual appointments not meeting needs.....	3
Problems in the transition to virtual care .....	4
Separation of COVID-19 and non COVID-19 patients .....	5
Help us to help you: Seeking advice from 111 or primary care before going to A&E or other hospital setting).....	7
Quicker discharge from hospital.....	8
Inpatient and Community Mental Health Care .....	8
New Approach to LTCs .....	9
Shopping and prescriptions.....	10
Ongoing support needs post pandemic .....	12
Enabling people to make informed choices may reduce ongoing need .....	12
Reablement may reduce ongoing need .....	13
Wider determinants of health including access to wellbeing and healthy living support and financial support.....	13
Loneliness and isolation.....	13
Housing .....	13
Issues relating to carers .....	15
Digital Divide .....	16
Online shopping .....	16
Access to care .....	17
Accessing information .....	17
Inequalities .....	18
Conclusions .....	18
Virtual first and Help us to help you .....	18
Communicate the risks and measures being taken.....	18
Articulating plans and involving patients.....	18
Inpatient and community mental health care .....	18
Reablement and wider support needs .....	19
Restarting face to face support.....	19
Housing .....	19
The Digital Divide .....	19

## Background

Healthwatch Richmond collected 376 experiences from people between 12/3/20 and 9/7/20 relating to care and wellbeing during the coronavirus pandemic. The dates related to the timing of this data analysis rather than any fixed points.

The three methods used to collect this were:

- **Wellbeing Survey** 102 people responded between 7/4/2020 and 22/6/2020
- **Healthcare Survey** 114 people completed the survey between 22/4/2020 and 05/07/2020
- **Patient Experience reports** 160 experiences shared with us by phone or online methods between 23/3/2020 and 9/7/2020

Separately we engaged 350 young people and collected their experiences of accessing care and support needs. This will form a separate report.

The following are headings emerging from this data as viewed through the lens of informing the recovery from the peak of the coronavirus and associated social distancing.

## Digital by default

The themes identified below about virtual appointments were consistent across the experiences collected through the *'Health care during Coronavirus'* survey and those shared with us by phone, email or through our remote outreach sessions.

### Ease of access

Many people experienced swift and easy access to care through virtual appointments. Some reported that they were able to access care when they needed it. They were able to have a telephone appointment more quickly than they had previously accessed a face-to-face appointment.

*"The receptionist took my name and number and within 30 minutes a doctor had called back"*

One patient felt moving to virtual appointments would free up time for GPs to do the important face-to-face appointments that are *"actually needed"*. They felt this was a positive long term change that has happened due to coronavirus.

Telephone appointments were reportedly *"well organised and helpful"*, and patients were able to have their questions answered and get the care that was needed, and patient's felt listened to.

Despite a possible barrier of not being able to be physically examined one patient felt the telephone appointment worked well as “[the GP] asked very specific questions about the appearance of my body where it hurt”.

In some cases, people also spoke about ‘virtual by default’ being a good way of accessing care quickly when they needed face-to-face appointments. The telephone appointment acted as a way of triaging to determine the care that was needed for that person. One person was given a face-to-face appointment 30 minutes after they had a phone consultation and much faster than they might have expected pre-lockdown.

### Convenience of telephone appointment

People who accessed virtual appointments had a mixed response to being given a time window for an appointment rather than an actual appointment time. On the positive side, one person was satisfied with the 2-hour window they had been given for a phone appointment. Another person appreciated the candour of staff who told them that the appointment time was indicative so that they could manage their expectations.

A person felt that their follow up appointment was much easier by phone compared to a face-to-face appointment. The reasons given were that they did not have to find childcare or pay for transport to travel to the appointment.

Those with more negative experiences of virtual appointments said that appointment times were not always met and one person felt it was more intrusive than a scheduled face-to-face appointment. One person felt “it interrupts what you are doing” and they found phone conversations very tiring. One person was left unsure when they would receive the phone call they were expecting and this left them in limbo without a clear diagnosis or treatment.

*“It is hard being cut off from the GP, I was mid diagnosis at the time of lockdown and am waiting for a phone call but have no idea how long it will be.”*

### Virtual appointments not meeting needs

Some patients were less confident in the advice that was given over the phone than they would have been from face to face appointments: “what would be the point [in seeking help] as what can be done over the phone”.

Some patients were not reassured that the GP could give them good advice without a physical examination. One person was told by their GP that they did not think it was anything to worry about and to keep an eye on it. This person felt this was “shocking” as they were still very concerned about their issue and felt the care provided in the phone appointment “was not the same” as face-to-face appointment.

Virtual outpatient appointments were often viewed as more of a “stop gap” than as a treatment. For example, physiotherapy was considered of a lower quality when given over the phone.

*“It was good to be able to have some exercise explained via phone and be sent a copy by email but I couldn’t have a physical evaluation which I felt might have been beneficial”.*

People told us of their concern that virtual appointments, both in primary or secondary care, could not replace the tests/scans that they would usually have had at the same time as their face-to-face appointment. Patients told us how they were not given blood tests, routine blood pressure measurements, echocardiograms or diabetic foot and eye checks. In one instance a person reported being in pain and being prescribed painkillers over the phone despite believing they needed a physical examination, x-ray or scan to rule out a broken bone.

*“My annual appointment was over the phone and was not thorough [enough] to understand if I am doing well as I usually have an echocardiogram and other tests.”*

Not all appointments can be provided through virtual means and this meant that patients experienced cancelled appointments, often with no rescheduled date. One patient had a dermatology appointment delayed by around 11 months. This left patients waiting and unsure what would happen. Patients were left in pain or suffering from worsening symptoms due to delays. *“My hip is really painful and my hospital appointments have been cancelled”*. A gastroenterology appointment was postponed 4 times over a 3-month period at University College Hospital: *“I am now vomiting most mornings and have been for 3 months”*.

A telephone appointment was cancelled and rescheduled to the following day for a patient with a neurological condition who had suffered a head injury by a fall. Before the appointment could take place this patient deteriorated and an ambulance was called by their GP. They felt this delay in care caused them to lose significant function.

Whilst this was clearly a problem for patients in the early weeks, there is some evidence that this may be changing as people we spoke to in late July told us that their cancelled appointments were now being rebooked for the Autumn.

### **Problems in the transition to virtual care**

As services moved to deliver care virtually towards the end of March, patients experienced difficulties in accessing it.

One patient highlighted to us that by seeing the doors of their GP surgery closed they were unsure how they (and others) would know how to access care.

Some patients who had their appointment cancelled were unsure why they were not offered a virtual appointment instead. They felt that their appointment could have effectively been carried out virtually and would mean there was no delay in their care or treatment.

## Separation of COVID-19 and non COVID-19 patients

Remote outreach sessions with groups of people with long term conditions, carers and those from ethnic minority groups highlighted the nervousness of attending routine hospital appointments. Notably this concern was proportionate to perceived risk; it was highest in those who were shielding and lowest in those who considered themselves at low risk.

People felt that transparency about the safety measures in place was important for them to have confidence in attending future appointments. In general, designating different areas within hospitals to be COVID-19 and non-COVID-19 was thought to be a good idea. So that if you were attending for other reasons you could be *“relatively sure of not getting it”*. One person was less keen to lose access to their local hospital.

Safety was seen as being of vital importance to people and it is notable that this covered both the arrangements for the service and also the perceived risks associated with traveling to services. Travel to appointments by public transport was something that people were keen to avoid and many said that they planned to park at hospitals to avoid public transport.

People reported to us that they felt social distancing measures were not being adhered to at health locations.

*“On one occasion a nurse came into the ward without a mask because the hospital had run out”.*

*“Disconcerting to have to use hospital. Phlebotomist was exemplary. Social distancing was not maintained in public areas of hospital.”*

*“They could have had clear floor markings to suggest where to stand and wait in the hospital areas. It seemed like they were not expecting anyone. Masks could have been made mandatory and a clear exit and entrance with barriers. People walked out of the hospital past us without masks and did not keep 2 meters distance”*

Where safety is managed effectively and overtly it is recognised and contributes to a sense of confidence and safety. This seemed to improve over time:

*“Service is always excellent, but visiting the surgery when frightened, I was impressed with the efficiency/kindness of nurse and doctor in full PPE clothes. It gave me such confidence that I had come to the right place to be treated”.*

*“Outpatient area almost empty. Temperatures taken to get in. Nurse extremely pleasant and helpful.”*

There were perceived risks associated with traveling to services. People contacted us with concerns about getting to hospital appointments safely, particularly concern around public transport for those that were vulnerable. Many expressed preferences to attend services that would not involve travelling such as a local community service or GP.

Anxiety and fear were a theme when people spoke of the risk of COVID-19 in hospitals. This anxiety may be allayed if patients understood about the separation of COVID-19 and non-COVID-19 patients. This is an important message to circulate to gain the patient's trust.

*“some people have been reluctant to be seen because of fears of Covid-19 infections”  
A healthcare professional*

Following our initial report in June 2020 we made recommendations to improve the way that patients are informed about the measures being taken to keep them safe. There is some evidence that this may be improving because towards the end of July a small number of people reported receiving calls or information from hospitals ahead of appointments to reassure them about the measures being taken to ensure their safety.

## Help us to help you: Seeking advice from 111 or primary care before going to A&E or other hospital setting)

Where 'Help us to Help you' leads to shorter waiting times, and faster access to care it is viewed as a positive development. A GP surgery utilised an online symptom checker before making an appointment and this meant the patient felt it effectively triaged them to be seen quickly due to their symptoms.

Those who felt that they were appropriately triaged to the correct service spoke highly of the service and recognised the benefit of quieter facilities at urgent and emergency care. Several people commented that using NHS111 online was very useful in confirming what treatment the patient needed to access and that the services they were directed to by NHS 111 seemed more efficient and saw them more quickly than normal.

*"Amazing service, why doesn't it work this well normally!!" [emergency care]*

*"Only one other person waiting, temperature check on arrival, seen almost straight away"  
[Urgent care]*

*"[using 111.nhs.uk] meant that the surgery knew I needed an appointment quickly because of my symptoms. There were only two days between me requesting an appointment and seeing a doctor. Normally I would have to wait two weeks." [Primary care]*

*"Had toothache in previously infected tooth. Phoned 111. Got call back + telephone consultation within 15 minutes. Calm, unrushed, effective conversation with dental nurse.*

*Advised to rinse regularly with warm salt water - which worked. But also invited to call back for possible anti-biotic prescription if pain persisted and/or got worse. Excellent service which could not have been better." [Dental care]*

Whilst there were benefits, the same principle as identified in "Digital by default" determined whether the contact resulted in the patient receiving timely, appropriate and effective care or not. Those who reported positive experiences were effectively triaged and offered appropriate care or self-care advice that resolved their issue. Those with negative experience did not access care at all, needed to make repeated contacts to access care or received care that didn't meet their needs (i.e. a virtual appointment when a physical procedure was necessary).

Given the reports of lower demand on services during the period that this data was collected it is unclear to what extent the benefits that people experienced from calling NHS 111 first will continue. The principles behind ensuring that people receive the care that they need however should remain the guiding principle of the "Help us to help you".

## Quicker discharge from hospital

Ahead of the lockdown we heard from a small number of residents who felt that they or their family members were being discharged from hospital prematurely and this wasn't in their best interests. In one instance doctors felt a patient was medically fit and the relative believed hospital staff were acting to free up beds for the looming coronavirus pandemic. This person had dementia and had suffered a bad fall with head injury. The relative felt they had *"deteriorated massively in hospital so how can they be deemed medically fit?"*.

During the lockdown period people contacted us to ask how to get support with reablement or *"getting back on my feet"* after being discharged home early due to coronavirus. These people needed reablement support at home either because they had unmet needs when they were discharged or, in one case, where they deteriorated after a period of rehabilitation at Teddington Memorial Hospital (where both the quality of the care and staff were described positively).

We also received calls from a few people who contacted us to ask for help arranging support from community nurses following a discharge from hospital. It was unclear whether these people had developed needs after discharge, whether referrals to community nursing had not been made by the hospital or whether community nursing had not picked up the referrals.

It is notable that, because we were not briefed on quicker discharge from hospital until late in the data collection, that data here is scant. The unmet needs described by a small number of residents underlines the importance of articulating plans to enable patient and public engagement and the value of patient experiences in informing how the impacts of changes can be mitigated.

## Inpatient and Community Mental Health Care

We received limited experiences from people relating to discharge from inpatient mental health care during the period; however, it was largely negative. Anecdotally providers have reported lower levels of service usage during social distancing whilst stakeholders have reported higher levels of need during the same period.

A professional from a mental health support organisation told us that early discharge from adult inpatient mental health care can cause problems for patients because community mental health services were unable to deliver the care and support virtually that patients needed.

Carers of those who needed mental health support reported a substantial additional burden during the crisis from having to fill the gap that they said care coordinators were not filling.

Despite the limited amount of data on this area, problems with housing came up twice. On both occasions the cared for person had returned to living with a parent carer because they were or believe that they would be unable to cope with the limited support available to them in the community. The carers found this further increased their burden of care and also

recognised that the temporary solution would in fact leave their cared for person ineligible for housing or *“on the bottom rung of the housing list”* unless they were evicted.

Whilst these new issues arose, the challenges that we had identified in our previous reports were also as strongly evident as they were prior to lockdown. People spoke about difficulties with contacting their support teams including not receiving responses when they reached out for help, high turnover of staff and a lack of continuity.

*“There's no one at the Trust picking up their phones to speak to, there's no communication from them and it's clear that things are changing/have changed but impossible to have the conversation.”*

The support offered by the wellbeing service was spoken about positively by patients and presented positively in the Voluntary Sector Conference Calls.

*“Great response to coronavirus pandemic by talking therapies [compared to an out of borough service] used in the past. I was contacted by the service just after lockdown to check how I was feeling and offered two sessions as a “top up” treatment. I had been anxious about going outside and staying safe and this really helped”*

## New Approach to LTCs

As we were not aware of the nature of this new approach at the time of collecting the data we were unable to ask targeted questions. The findings under this heading are inferred from experiences collected during our outreach sessions and calls to the office. This highlights the importance of articulating the recovery plans so that patients' experiences can inform their implementation.

A group of people with diabetes said they were largely independent in managing their diabetes and their care themselves but that their GP was the first port of call if they needed support. Some elements of their care could not be done through virtual appointments e.g. diabetic eye screening and foot checking. Therefore, there were questions over how this care would be carried out.

One person expressed concern that the GP who specialises in diabetes care at their practice only works two mornings a week and will have a backlog of patients and therefore a long waiting list once face to face appointments are possible again. This concern about long waits and backlog was also highlighted to be a problem for the GP clinic that runs one day a week as part of the diabetic care team at Teddington Memorial Hospital.

People were flexible and pragmatic in who they would see but noted that they *“look for competency and experience”* initially and that longer term *“some continuity would be useful”*.

## Shopping and prescriptions

Whilst not unique to people who were older, had health conditions or lived alone, access to shopping, prescriptions and support was more of a challenge for these groups of people.

Those who were shielding had particular and long-running reliance on these services. We heard from several people who were shielding who did not have access to the internet and as a result struggled to find information about and register for support through the gov.uk system. We also heard from people who had access to the internet but struggled to register on the shielding list due to challenges with the system.

### Shopping

The most common reason people contacted our signposting line was for support was for help with shopping and 1 in 6 of the people responding to our wellbeing survey spoke about difficulties with getting food. Largely people were grateful for the support received from the community through family, neighbours and local volunteers which had enabled them to meet their needs.

Many of the concerns that people expressed about shopping relate to worries about leaving the house and so also apply to accessing care which is also covered by the section “Digital by default”.

The digital divide was significantly apparent in terms of access to food and prescription deliveries. However, many people, even those with access to the internet, reported struggles with arranging deliveries from supermarkets. People spoke about technical challenges such as using the booking systems for shopping deliveries. Some linked problems with accessing food deliveries to problems and delays with getting onto the shielding list. Others reported non-IT related difficulties with accessing deliveries such as and delays with getting onto the shielded list.

*“Really don't want to brave the big Tesco again so we are having to get things just locally. Know they are trying their best but I've stayed up past midnight waiting to see if I could get a slot but just put in a queue then nothing”*

Where food was provided people did not always feel that it met their needs. This was particularly the case for those who had dietary requirements for medical or cultural reasons. It was also noted by some people who received food boxes that they could not get things like cooking oil, cleaning products or essential clothing.

## Getting prescriptions

Predominantly people praised their pharmacies and GPs for effectively providing and delivering their medications during the crisis. Charities, communities and families were also important sources of support for collecting prescriptions for those shielding or self-isolating.

For many this process worked well. One person had a positive experience where their repeat prescription was organised through their GP and pharmacy more quickly than normal (took 1 hour as opposed to 1 day).

There were also significant challenges caused by the process of ordering prescriptions and of not being able to collect them.

Those who could not use online GP services reported difficulties requesting a repeat prescription from the surgery from the start of lockdown. In one case the automated phone message of their GP did not make it clear that you needed to key in a number to speak to a receptionist and it wasn't until they contacted us that they were able to find out how to speak to their GP and get their prescription. In another case the person was able to reach their GP but the receptionist told them that they had to order their prescriptions online despite the patient being unable to do this.

We also heard difficulties with requests for prescriptions not being completed and there were several people who identified problems when they needed to make changes to their medication or dosage.

There were also problems with arranging deliveries of prescriptions from pharmacies or with the need to queue for extended periods of time to collect them. People who regularly received deliveries before the crisis or who were shielding told us that they were not able to arrange delivery after lockdown and were signposted to the Community Hub for support. A few people, including pharmacies, also reported long waits and queues at local pharmacies to collect prescriptions. Some people found it difficult to get through on the phone and one person waited in a queue for 90 minutes.

Ultimately we were able to raise these issues with pharmacists during the period and we understand that this issue improved as a result.

## Ongoing support needs post pandemic

Whilst existing needs appear to have been met through the peak of the coronavirus and shielding periods, some people who were previously independent will need ongoing help.

### Enabling people to make informed choices may reduce ongoing need

Concerns about leaving the house, using public transport and about the way that risks are managed in the community, in shops and in clinical or care settings were widespread amongst people who had a high perceived risk from the virus. Most of the people who reported concerns were shielding or considered themselves to be at very high risk should they catch the virus. For these people there was a concern that their current support would be removed, leaving them unable to cope or exposed to risk until there was a vaccine:

*“While many may see the light at the end of the tunnel, we can’t”*

*“Other people will be able to move on, whilst us, the more vulnerable are going to fall back”*

*“I would only feel confident if there were no deaths in hospital and the R rate was near 0. Ultimately a vaccine is the only thing that will make me feel safe.”*

People expressed concerns about the lack of social distancing observed by other people, the perceived risks of using public transport and a perceived high prevalence of the virus.

*“I live a mile from my nearest supermarket, am 70 this year and do not drive. I try to walk to the Supermarket [to avoid public transport]. Pavements are very narrow, if I meet anyone coming the other way it is impossible to keep 2 metres away without walking in the road”*

We provided information during discussion with some of these people about local prevalence data from public health and details of measures being taken to protect people from infection in GP practices and hospitals. For some people understanding this made them feel more confident about regaining independence with shopping and going to appointments.

Sensationalist media coverage led some people to unrealistic beliefs about the risks that they faced that may have led to harm from not seeking care. We published an article countering some of these claims.

*“One person was very anxious about the risk of coronavirus to them as their treatment for cancer restarted. They described it as ‘facing death not only from cancer but from the virus itself’. They felt going to hospital was ‘having to face your worst enemy’. This view was based on misinformation that ‘the Nightingale Hospital was shut down due to the number of people dying’ and may have led to the person not seeking potentially life-saving treatment”*

Whilst writing this report we spoke to people who had received clear communication about how risks were being managed ahead of a visit to hospital they had found very reassuring. **There is a clear message to stakeholders about the importance of not just having robust measures in place but of communicating what these are to patients and the public and being candid and transparent to patients about the numbers of cases and deaths.**

### Reablement may reduce ongoing need

Some people reported losing independence either through deconditioning as a result of reduced mobility during shielding or through illness during the period. In one instance a voluntary sector professional highlighted that a client they recently took to the shops was exhausted by the experience. This was the first time out of the house for them and therefore their activity and stamina were much lower than before lockdown. The ability of people to do an activity that they want to do may become a factor as more activities are opened up.

Other people reported increased social care or reablement or mobility needs as a result of early discharge or unmet community needs (see Quicker discharge from hospital). It is likely that there will be ongoing needs for community based practical support and reablement.

## Wider determinants of health including access to wellbeing and healthy living support and financial support

The wider determinants of health sit largely outside of our remit in terms of advice and information, outside of our powers to review services and outside of our expertise and it was not the focus of our data collection. The information provided under these headings is more limited than in other sections and should be viewed as supplementary to other sources of intelligence rather than as representative of the population's experience.

It is clear, for example, from engagement with voluntary sector advice agencies that there was a substantial increase in the number of people seeking support about finances that is not represented in our data.

### Loneliness and isolation

People, particularly those living alone or who did not live with friends or family such as in shared housing, spoke about feeling lonely, isolated and missing face to face and physical contact during social distancing. These experiences were common across service users, carers, professionals and the wider public across all demographics.

A number of people including carers, vulnerable people and people who lived alone took the decision to move in together at the start of the pandemic to combat loneliness or isolation.

*“Our daughter and grandson have moved in with us and are great for mutual support.”*

Many people were unable to take part in their usual activities and had tried online events and activities to combat loneliness with mixed success.

People who lived with friends or family members generally reported being better able to cope practically with shopping or collecting prescriptions.

### Housing

Evictions were largely paused and street homeless people were accommodated during the period of data collecting so we anticipate that housing needs will increase beyond those identified here.

Some people with additional needs and their carers reported moving in together to bridge the gap left by reductions to services during the crisis. Several people with mental health needs and parent carers cited a lack of community mental health support as the reason for moving into the same home and described this usually as an essential way of managing during the crisis.

Whilst living with others had benefits on wellbeing and support, where people moved away from their GP or outside of their usual CCG they described problems with accessing primary care, prescriptions and mental health support.

*“[S/he] arrived yesterday, needs to see a doctor because his/her asthma is playing up but they will not take him/her on without proof of address!! S/he has none. All the bills are in my name not theirs, and no time to change driving licence or bank account details. Do I have to take them to a walk in centre or is the GP practice wrong?”*

As the restrictions relax people in this same group are now concerned about the risk of becoming trapped in this situation due to housing support eligibility. For people, particularly those with mental health needs and those at risk of eviction due to changes in income during the crisis, the implications of this can be significant.

*“I’ll have to make my [cared for person with mental health needs] homeless to get them housed. Even then they’re only going into temporary housing and will be a long way from having a stable home.”*

In addition, existing housing and relationship issues were exacerbated by social distancing resulting in increased conflicts with neighbours and family members. This resulted in people seeking advice about leaving their home due to overcrowding or relationship breakdown during the crisis:

*“Caller is living with people who are caring for him/her and no longer wish to do this. Caller said that they do not have any money but wish to move into a care home and want help to understand what is possible.”*

## Issues relating to carers

Carers largely spoke to us about the needs of the person that they care for. This masks the extent of the impact of the crisis on carers. Specific focussed work may be necessary to understand the needs and impact of the crisis on carers and further consideration should be given to carers in planning the recovery.

In the past many carers told us about the value of peer support, that interacting with other carers *“has kept them going”* or that they *“they wouldn’t have known how to cope without support/networking groups”*. During the crisis, carers reported that these services had largely ceased.

In addition, carers felt an increased burden of care from face to face services being scaled back for their cared for people. This left carers having to meet the needs that the services had previously met as well as losing the respite that would have come whilst their cared for person was engaged with the service away from their home. Some said that *“Respite for carers would make life easier”*.

Carers of those with mental health conditions reported having to provide more care and support. Inpatient mental health support also changed and carers felt that there were fewer admissions and quicker discharge leaving them managing their cared for person’s crises more frequently and with less support.

## Digital Divide

The term “digital divide” has been given to the disparity between those who can access care (appointment booking, managing prescriptions, and virtual appointments), support (such as shopping) and accessing information on line and those who can’t.

Having appropriate technology is an obvious prerequisite for people to get online. However, people also need the skill or support to navigate the different systems necessary to access information, services and support online. It is instructive that a significant number of the people who experienced challenges with accessing support online were able to use email, video calls and online surveys to share their own experiences with us.

Those who were unable to access care and support online were disadvantaged as a result and worried that as services moved increasingly online that they would be “*left behind*”.

### Online shopping

Those who were not able to use technology were reliant on community support to access food and essential shopping. These people felt that they lacked choice over their food and supplies or said that that their dietary needs were not being met:

*“No one in this crisis is mentioning elderly people like me with special dietary needs... it would be hard for me to send someone to do my shop and I don’t know how to order online”*

*Comment received via an online survey*

People spoke to us (particularly those who were shielding) about the challenge of getting online supermarket deliveries slots. Even if they were on the priority list this was still a struggle for many and meant they had to seek help from the voluntary sector or friends/family.

*“S/he tried online food deliveries but struggled registering and also getting hold of an online slot, due to the high demand. Initially, some shops did not recognise him/her as vulnerable either. They are not confident with shopping online (despite having access to the internet using zoom) and this proved to be an additional barrier to accessing this support.”*

*Notes from a signposting call*

## Access to care

Many GP surgeries asked patients to use online services to request prescriptions and in some cases to book appointments. This is not accessible for all. We heard from people who had struggled with this change as they were unsure what to do. Patients were confused to see their doctor's surgery doors closed and hear automated voice messages at the start of phone calls directing them to online services.

*“It is more difficult to get repeat prescriptions. They say only by internet or at pharmacy. I am 75 years old. On my own it is too difficult. I have diabetes and cancer why do they make me go to pharmacy to order”*

Many GP surgeries provided the most up-to-date information about their service on their website which again is not accessible for all. Several people also reported problems with being pushed online by the recorded phone messages that played when they called surgeries or by staff when they got through to speak to someone

One person expressed concern that they would not have the skills and/or IT to enable them to access video appointments if they became standard for accessing GP and Hospital care. To complete the IT upgrades necessary *“would be a great trouble and expense”*, and they expressed a preference to do *“less healthcare then to try and to tackle the difficulties”*.

## Accessing information

Two key groups emerged in terms of how people accessed information during the crisis with an even and clear split between those who used the internet and those who did not and relied heavily on TV, Radio and print media.

Whilst most people said that information was easy to access and understand we experienced a high volume of calls to our signposting line. Many of the calls that we received were for information that is available on the internet. We also received positive responses regarding the ‘Guide to Richmond’s NHS, Care & Support’ which was distributed during the crisis. Other agencies have also spoken about high volumes of calls asking for support during this period.

The things that people sought information on also changed over time. Enquiries about shopping, prescriptions and testing were common earlier in the pandemic. Later in the pandemic calls covered a wider range of issues but more frequently related to accessing care.

We noted little in the way of integrated or coordinated communications from agencies during the pandemic and were not ourselves always kept up to speed with changes.

This demonstrates the importance of providing information through traditional methods as well as online methods and the need for a coordinated and integrated approach to communications.

## Inequalities

After data collection started, significant attention was given to equalities, particularly for BAME groups in relation to coronavirus arising from the PHE report and from world events.

The demographic data collected suggest that this report is drawn from a sample of respondents reflecting the diversity of our community and so we can be confident that the findings have some validity across the community as a whole. We also specifically targeted groups at unequal risk from the virus to ensure their experiences were reflected in the data.

This report highlights inequalities relating to digital access, living alone, caring roles, access for those with perceived risks, access to care for those with long term conditions and for people with mental health needs.

Further work may be necessary to provide meaningful insight into inequalities and it is likely that such research may need to take a broader scope than NHS, social care and community support and wellbeing.

## Conclusions

Whilst there is nuance to the findings of this work there are some clear messages that we can take:

### **Virtual first and Help us to help you**

People will be receptive to accessing care via remote means where it is helpful and easy where it meets their needs in a timely manner. There are benefits for some but others will want to seek face to face appointments, particularly where face to face assessments, tests or procedures are required or where it is necessary to build trust and rapport.

Measures of the effectiveness of these initiatives should take this into account.

### **Communicate the risks and measures being taken**

The messages about the NHS being open for business are important but it is also important to address the anxiety that people have about the risks of exposure to coronavirus in the community and in clinical settings and how these are being managed. Clear and candid messages about this are a powerful tool in encouraging people to be independent and to access support.

### **Articulating plans and involving patients**

With all changes there will be unexpected or unintended consequences. Articulating plans as early as possible will enable these to be identified and mitigated earlier and lead to better outcomes for patients.

### **Inpatient and community mental health care**

There are some suggestions that community mental health services have not been meeting people's needs effectively in the community. Face to face appointments should restart as

soon as possible and work should be done to understand the effectiveness of any changes. Some of the issues identified by our past reviews of services have not been resolved. It is especially important as services recover from the peak of coronavirus that people contacting South West London & St George's Mental Health Trust for help receive responses.

### **Reablement and wider support needs**

We anticipate that there may be an increased demand on reablement services as the need and support to isolate at home reduces. With quicker discharge from hospital it is also important that reablement, as well as social needs are identified and met. It is possible that services like the Nightingale Service and Social Prescribing may have a role to play in supporting those who are discharged earlier.

### **Restarting face to face support**

Those living alone are more at risk from loneliness and isolation as a result of social distancing and had less support to navigate and engage with other services. Even those who had remote support missed face to face contact whilst social distancing.

Carers were also disproportionately impacted by the closure of face to face support as they had to fill the gap left and also lost the respite that came from their cared for person being supported away from the home.

When social distancing guidance allows for face to face support to restart, people who live alone as well as carers and the people that they care for should be offered support to engage with them. It may help to monitor the uptake of services by these groups once they restart.

### **Housing**

As the social restrictions relax it is likely that some complex housing needs will arise as people face challenges with changing existing, or returning to their previous, living arrangements.

### **The Digital Divide**

Digitally excluded people include those with and those without technology and these people are significantly disadvantaged as a result. "Bridging the digital divide" requires either supporting people to gain both the technology and the skills necessary to access support online or providing support and information through traditional methods.

In the short term, ensuring that information continues to be provided through traditional methods as well as online methods is essential to enabling the digitally excluded to access support. The Community Hub and volunteer shoppers are good examples of this.

Despite the guide to Richmond's NHS, Care and Support and documents distributed by the local authority, many people were not aware of how to access support, care and information. A more coordinated and integrated approach to communicating the support available to people would help to address this.