Accessing health and care services – findings during the Coronavirus pandemic: Interviews with 104 respondents to the original survey – summary.

Introduction

The conversations outlined in this report were with a sample of people who completed the 'Accessing health and care services: findings during the Coronavirus pandemic' survey. This survey included a final question about people's interest in taking part in a phone call to talk more about their experiences. To read about the findings from this survey please see: https://www.healthwatchbrightonandhove.co.uk/report/2020-10-14/accessing-health-and-care-services-%E2%80%93-findings-during-coronavirus-pandemic).

From all those that agreed to a phone call (240) this paper reports findings from 104 interviews that subsequently took place. The interviewees provided an opportunity for people to talk more about their experiences of accessing health and care services during the pandemic and to provide deeper exploration into some of their survey responses. The conversations help to explain and understand more about some of the survey responses and also reveal exceptions to some of the trends evident in the survey (that may mask some of these alternative views).

Methodology

As a pan-Sussex survey, Healthwatch Brighton & Hove, Healthwatch West Sussex and Healthwatch East Sussex agreed to divide up the interviews between them.

The demographic profile of interview participants was known from the survey. Therefore, we were able to reach a maximum variation sample of people to call, in terms of their age, gender, sexual orientation, disability and ethnicity.

Phone calls took place between 9th August – 16th September 2020. Each person was asked the same core set of questions covering their experience of delayed appointments, experience of remote appointments and view on remote appointments in the future.

From the people who were available and who were willing to be interviewed, a total of 104 interviews were conducted.

The findings shown below group together questions where it made sense, for example, separating out the positive and negative responses about each appointment method. Where possible, we have shown links to the findings made in the original survey report, and where the interviews compared or contrasted to those findings.

In addition, given the survey found links between certain characteristics of people and views about remote appointments, separate analysis was undertaken to compare views from: people who defined themselves as living with a disability; people who defined themselves as LGBTQ+ and people aged 60 years or older.

Headlines

- Of those that delayed appointments, the majority said there was little or no negative effect on their health.
- For those where there was a detrimental impact, there were instances of increased pain and wounds needing to be dressed and in one instance, the need for emergency medical attention.
- Seven out of the eight people who felt the delay was detrimental to their health condition, had a disability. In the case of three of these people, they had multiple disabling conditions e.g. physical and sensory disabilities or mental health and physical disabilities.
- Two-thirds of the people who had experienced a remote[1] appointment found the experience to be a positive one.
- Positive reactions included less travel, less time in the waiting room and being quicker to get an appointment.
- In more detail, some people also said they felt they had the opportunity to ask the right questions, being offered a thorough discussion about the condition, not being rushed and being involved in the decision about what to do. Some had sent photos or videos of the condition and this resulted in being prescribed medication which helped resolve the condition.
- Around one-third of people we spoke to who had experienced a remote appointment had some negative experience. These included not having a specific time for the appointment and generally not feeling able, or being too rushed, to fully explain their condition in a remote setting. Technological challenges and wasting time for an initial phone call when the need for a face-to-face appointment was obvious, were other concerns.
- There were mixed views about different types of appointment. Some people clearly preferred face-to-face while others were happy with remote. Video and phone were considered good options while email or online forms were generally considered time consuming and not met by instant feedback.
- Face-to-face appointments were seen to be important for physical examinations (e.g. tests, seeing how a patient moved, checking a skin condition) and matters of a personal, private or emotional nature.
- Phone appointments were seen as favourable when a face-to-face was not necessary and generally more reliable than video appointments.
- Nonetheless, video was seen as an effective way for the patient and doctor to see one another, supported by the viewing of body language and facial expressions.
- However, of all the remote options, those by video were particularly susceptible to technological problems. Some computers were not compatible with the meeting platform used by the NHS, others had camera problems and some people were not comfortable or able to connect remotely.

[1] By 'remote' we refer to non-face-to-face appointments that include phone, video, or online (including email and online forms).

- People with more complex physical needs and mental health issues were more likely to favour face-to-face appointments, as their conditions were considered more complicated and needed the sensitivity of an in-person appointment.
- People aged 60+ years old had mixed views about using remote appointments. Some people in this age group were comfortable with technology and found it important to "move with the times". Others found it harder to adapt. Some Illnesses associated with this group made it difficult to access remote appointments.
- People accepted the inevitability of remote appointments becoming 'normal'. However, the need to ensure that patients had a choice about using them as an alternative to face-to-face, was considered important.
- The choice of appointments was often dependent on the medical need. For example, therapy was seen as being better in person, while video worked well for showing the condition (e.g. a rash) to the doctor and phone calls were sufficient for minor ailments. Most people were not offered this choice.
- In contrast to the above, the preference for appointments was less likely to be related to the type of practitioner or service. For example, people felt that GPs, hospital doctors, nurses, consultants could all be seen either in person or remotely, depending on the medical need.
- The pandemic and its reliance on technological communication has revealed a group who were excluded from having video and online appointments. These interviews demonstrate that this group while not exclusive to any demographic group, is more likely to include people over the age of 60 and/or people with disability(ies). This report demonstrates the need to do more work about how to engage this group with access to services.
- There will always be people who need and want to access services in person. People were concerned that these patients were unable to fully access the health services they needed. This preference for choice, often dictated by the medical need, supports the survey recommendation for a hybrid model of service delivery.

Conclusion

Within most of the interviews we conducted, most people accepted the inevitability of remote appointments becoming 'normal'. However, the need to ensure patients had a choice about using them as an alternative to face-to-face, was considered important. Also, people felt there were certain factors that should be taken into consideration when choosing their method.

Most people could see a benefit in remote appointments. However, there were some conditions that were considered necessary to be seen in person. For example, where a physical examination was required, or sensitive issues were being dealt with (including personal conditions and mental health issues). This clearly shows there is no single preferred option, rather that different conditions are likely to affect people's preference for type of appointment.

The challenge will be to successfully ensure that all people are able to fully access the health services they need. This includes those people who will always need and prefer to access services in person. The preference for choice and "inevitability" of changing methods of delivery indicates a recommendation for a hybrid model of service delivery, offering both remote *and* face-to-face options.