



Unlocking The Digital Front Door

Keys to inclusive healthcare

ACCELERATED ACCESS COLLABORATIVE

The Accelerated Access Collaborative (AAC) is a unique partnership between patient groups, government bodies, industry and the NHS. Hosted by NHS England and NHS Improvement, it is the umbrella organisation for UK health innovation, acting as the 'front door' for innovator support and setting the strategy for the health innovation ecosystem. The AAC's purpose is to get the best new treatments and technologies to patients and clinicians faster, and to make the NHS a great place to innovate for the benefit of our citizens.



National Voices is the leading coalition of health and social care charities in England. We have more than 170 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people. We work together to strengthen the voice of patients, service users, carers, their families, and the voluntary organisations that work for them. Our mission is to democratise, humanise and equalise health and care.

Unlocking The Digital Front Door: Keys to inclusive healthcare.

Executive Summary

“During COVID, we were driven to innovate, and able to do so quickly due to the rapid response of our whole system to the crisis and the recognition by our Health and Care partners of the value the VCS brings in times like this. Ensuring that digitally excluded older people were able to access support was critical to our community, and the shared efforts to make this happen enabled us to implement a new way of working within days.”
Nicola Upton, CEO, Age UK Sutton.

This report explores how the move to remote service models impacted people and how the Voluntary, Community and Social Enterprise sector (VCSE) has led innovative ways to deliver healthcare and support people during the COVID-19 pandemic.

The VCSE sector all over the country have played a huge role in meeting local community need over the last year. Many organisations have rapidly developed new partnerships and found creative ways to meet new needs and keep people well. Through our research we have found many inspiring examples of local innovations. For example, Silverline Memories quickly switched to a digital offer for people with dementia and their families, offering a free confidential 24/7 phone line and supplying iPads with a “kitchen window” support offer for those unfamiliar with the technology. St Mungo’s, a homelessness support charity, transitioned their recovery college to an online model within ten days of the first lockdown. A wide range of volunteers offered one to one digital skills support, including how to use apps, and well-being sessions. They also provided devices, data and training on accessing WiFi hotspots.

The COVID-19 pandemic meant that access to health services changed significantly, with many services switching to remote access. Through our [listening exercise](#) we explored people’s experience of this rapid shift. We particularly wanted to understand how this impacted on communities who might be digitally excluded and how these barriers might be addressed. Our research and wider evidence¹ shows that people may be digitally excluded for a wide range of reasons and there isn’t a ‘simple fix’ of giving people equipment or training. Often a combination of access, health and social elements need to be addressed for people to engage successfully in remote models of healthcare or find a suitable alternative. For many of those we spoke to remote models do not provide a positive experience or high quality of care.

1. <https://www.nationalvoices.org.uk/publications/our-publications>

We found many examples of innovative partnerships between healthcare organisations and VCSE organisations coming together to think creatively to tackle the challenges of remote healthcare. Themes of peer-to-peer support and offering more tailored, personalised responses featured strongly in inclusive approaches to delivering new models of care. Community organisations were able to draw on a deep understanding of their community needs and their established peer networks to offer skills development, confidence building, well-being activities, translation support and other activities to enable people to better access health and well being support.

The pandemic created an environment where new partnerships, innovation and creative solutions could flourish. People worked in new ways to make a real difference to people's lives. We need to nurture and grow this culture. We need to make sure that care meets everyone's needs, not just those who are digitally active.

From this work, we have developed five recommendations for inclusive innovation:



Make inclusion the core principle.

Offer the same levels of access, consistent advice, and outcomes of care to everyone, regardless of channel. One size does not fit all.



Co-design with people.

No matter how urgently new systems need to be implemented, access requirements need consideration. Focus on people who are at risk of exclusion.



Offer supported choice and personalisation.

Adapt communications, offer different formats so that people can access care and information in a way that works for them. Listen to what they say.



Support staff to innovate.

Build a positive culture around testing new ways of working, put training in place and embrace and learn from feedback.



Know that health is wider than healthcare.

Many successful projects provide services and activities that are wider than healthcare to engage and support people, and through this people are better able to self-care or access services.

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Introduction

The Accelerated Access Collaborative² (AAC), a unique partnership between patient groups, government bodies, industry, and the NHS, asked National Voices³ to undertake an insight piece exploring how the Voluntary, Community and Social Enterprise sector (VCSE) has led or shaped innovative changes during the COVID-19 pandemic.

By innovation, we mean new and creative ideas that are put into practice to improve lives. Some innovations are technology based, but more are low tech approaches that creatively address the specific challenges created by the pandemic. Many of the ideas that were rapidly put into practice led to new ways of working, often across complex organisational boundaries, requiring new finance, data sharing, safeguarding and governance arrangements.

The outbreak of the COVID-19 pandemic necessitated a rapid, unexpected, and seismic change in the way that healthcare is delivered. Many of the new approaches involved a shift towards remote healthcare that had to be rapidly implemented to enable people to continue to access care, whilst being in lockdown.

We particularly wanted to explore how some of the challenges of moving rapidly to a digital access model could be addressed and how well-being could be supported. The aim was to explore what worked, and what didn't and to understand how VCSE led innovation can support various health and care models.

In some cases, this move to remote access has been welcomed, with people reporting that they appreciated the focus on infection control and not having to travel to all appointments⁴. For many people, a connection with others via remote means has been a lifeline during periods of isolation and lockdown. There is a moment now, to build on these positives and learn from them.

However, in many cases this shift has brought about even more barriers to getting good care, for those who do not have the resources, confidence, skills, knowledge, appropriate environment to access care or connect socially via digital means. There are numerous reasons why people might be digitally excluded, and we know that, if we exclude people digitally, we are widening the inequalities gap: people with higher burdens of ill health are less well served by the existing models of care^{5,6}. When virtual healthcare is poorly executed their quality of care suffers.

This report offers inspiring examples for people designing and delivering services. It offers recommendations around how to create the right conditions for innovation.

Innovation is led by people first, then technology. The VCSE sector has quickly adapted its support offer during the COVID-19 pandemic and has much to share. This has included innovations in peer support, as well as creative approaches to socially distanced support. When there is a need for rapid change, community relationships, advocacy and peer networks have enabled creative thinking about different types of personalised support that might be needed to support access to services.

Effective innovation for inclusion works when healthcare services and communities work together to find solutions. Our interviews with innovators have highlighted that inclusive organisations co-design with people who use services, build long-standing relationships with their beneficiaries, focus on both informal and formal support, involving peers and advocates and give people time to build skills and confidence.

People understand that there are benefits to digital engagement, but need time, support, and resources to change and adapt. When people contact health services, they are often worried about something, they need a warm and welcoming experience of care. There is often a sense that the onus is on individuals to change and whilst there is much that can be done to support people to access virtual systems, there is also an important need for organisations to own the problem and strive to become more inclusive.

People need informed and supported choice first, digital second⁷.

We know that the move to remote and digital care models in practice is challenging for many people and communities.

We are advocating for people to proactively think about inclusive innovation and design principles that enable more people to get the care they need.

2. <https://www.england.nhs.uk/aac/>

3. <https://www.nationalvoices.org.uk/>

4. <https://www.nationalvoices.org.uk/publications/our-publications/dr-will-zoom-you-now-getting-most-out-virtual-health-and-care>

5. <https://www.nationalvoices.org.uk/publications/our-publications>

6. <https://phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/>

7. <https://www.nationalvoices.org.uk/publications/our-publications>

What we did

To understand the perspective of people attempting to use services we have worked with three partners to carry out a listening exercise: the Abbey Centre in Central London, the Centre for Seldom Heard Voices and Change People. They have interviewed 27 people at risk of exclusion about their experiences of accessing healthcare⁸.

In this report, we draw on the insight and input from our project group, members of National Voices covering a diverse range of health conditions and communities, who worked with us to better understand such experiences and what could be done to improve them.

We worked with the Patient Experience Library and Care Opinion to understand the available evidence⁸.

We have carried out interviews with people working in community and voluntary sector to develop a library of interventions, innovations and initiatives that describe their work, often in partnership with statutory services, to enable digital participation and inclusive remote support. This is not an exhaustive list and we have not carried out quality evaluations of these innovations, (these are often being done locally), it is meant to provide useful examples and case studies that can help people do things differently.

8. <https://www.nationalvoices.org.uk/publications/our-publications>

Listening to people's experiences

We wanted to understand the barriers to good care, particularly from the perspective of people with high burdens of ill health and who are affected by inequality. Through the listening exercise we have identified the following themes:

1. People understand the reason for and potential benefits of remote care.
2. Many people have struggled to access services during COVID-19.
3. People might be digitally excluded for a range of reasons.
4. People present with a range of support needs; one size does not fit all.
5. Poorly executed remote care negatively impacts on experience and quality of care.

1 People understand the reason for and potential benefits of remote care.

Most people are not all positive or all negative about the move towards more remote or tech enabled models of care. Even in this small sample, many can see positives as well as negatives, such as not needing to travel, not needing to organise child or other care for family members and monitoring health at home. Those with fewer health issues or impairments are more positive, but they express a strong concern for other people who might be excluded.

"I had a hospital consultation with the doctor and the appointment had to be switched from face-to-face to telephone which was quite convenient because it was a quick diagnosis and quite helpful."

"My overall experience with a virtual appointment was positive. It was quite quick and easy so with my phone consultation it meant that I did not actually have to leave the house to travel to the GP ... it made me feel more comfortable ... as I do not want to go to the GP Practice for fear of maybe catching COVID-19."

"The positive of having virtual session is I do not have to travel anywhere so my legs do not start hurting. Sometimes my leg hurts if I walk for a long time."

2. Our interviewees, many of whom were from marginalised groups/had high burdens of ill health told us they struggled to access services during COVID-19.

Participants shared many examples of the move towards digital triage and remote healthcare being implemented poorly and particular struggles with online triage forms. Many described frustration with not being given appointment times. The need for a specific time-frame was important for preparation, having someone supporting them and being in the right physical and mental space to have a conversation.

"I could not complete an online form, I couldn't do it, I wouldn't know how to access the app in the first place or how to put an app on an iPad, I wouldn't know where to start. I seem to get in a muddle but if I had to do something out the ordinary i.e. access and fill in an online form, I wouldn't be able to do it."

"When I phone to speak to GP, receptionist ask what the reason and she explains. Then she says the Dr will call you back. I do not know when the GP will call back. Later, when the Dr phone called, some of the things forgot. I cannot explain properly. It is very difficult."

"I couldn't use a computer, never had a smartphone, didn't know how to use one... it hurts your head at first believe me, if you're not used to it, it hurts your head."

3. People might be digitally excluded for a range of reasons.

We understand that people might be digitally excluded for a range of reasons. There is sometimes an assumption that equipment and skills will solve the virtual health access problem, but it is much more complex than this. People's experience is shaped by a combination of **health and social elements** that might include: ethnicity, gender, age, religion, class, financial situation, or location.

Often people have more than one reason why they might be at a disadvantage. People might face barriers to digital health if they are disabled, blind or partially sighted, deaf, have dementia, learning difficulties or mental health issues. People who are facing homelessness, Gypsy, Roma and Traveller communities, migrants, refugees, and asylum seekers, and those needing translators/interpreters may also face challenges.

Skills: People might have limited experience of technology. Low literacy also often goes hand in hand with low health literacy, and low digital literacy. We also know that these specific exclusionary effects interact with and are overlaid by wider dimensions of exclusion, such as language barriers.

Access, including Poverty: Many people have no, or very poor Wi-Fi⁹. Some people don't have access to regular charging facilities. Many require supportive communication aids or translators. People might not have access to or be able to afford a phone or computer. In addition, they might struggle to pay for data.

Confidence, Safety and Trust: People may be nervous because virtual healthcare is new, or because there are cultural or other personal barriers. They might lack a private space. People might be worried about and have low levels of trust in the health system generally, as well as in virtual healthcare. People might have questions about data protection and management. People might not have a safe place for virtual health, communication might be compromised.

"But sometimes people don't understand what I am saying because of my speaking problem. Over the phone makes it worse, I get more nervous and stutter. I have got an advocate. I have one at the moment because of COVID-19. They just talk to me online, not face to face. It's like putting a plaster on a giant cut. It doesn't cover everything I need."

"The first time I had a phone call like that I had to run away from someone to have it privately and... saying all those symptoms out in the middle of the street or on the bus, you're not going to."

4. People present with a range of support needs.

Many participants mentioned the need for translation, interpretation, and good quality communication, both for in-person and virtual care. In addition, some mentioned the need for support with access and equipment for remote care. Carer involvement is crucial.

- A lack of appropriate resources – such as functioning devices, signal, digital skills, virtual tools and platforms which are accessible for individual needs, as well as the costs associated – were repeatedly raised by interviewees as barriers to engaging in online healthcare and wellbeing support.
- Many interviewees reported a lack of confidence in digital tools or concerns around safety and as such, peer-to-peer support and fostering trusted community relationships has been central to many successful organisational responses to the pandemic. Clearly more digital solutions and inventions are not the answer for everyone, and providing choice and support is critical

"I hope they do not introduce this type of service (virtual healthcare) in the UK, especially for people like me whose English is not their first language. But if there is no choice may be to have interpreter, and smart phone, free data and good Wi-Fi will help."

"You must think about access requirements for people who can't hear."

"It is difficult because my husband has a lot of problems and he needs support. He needs someone to help him to just walk but they told us 'no, it's not allowed and it's just one person because of the situation'."

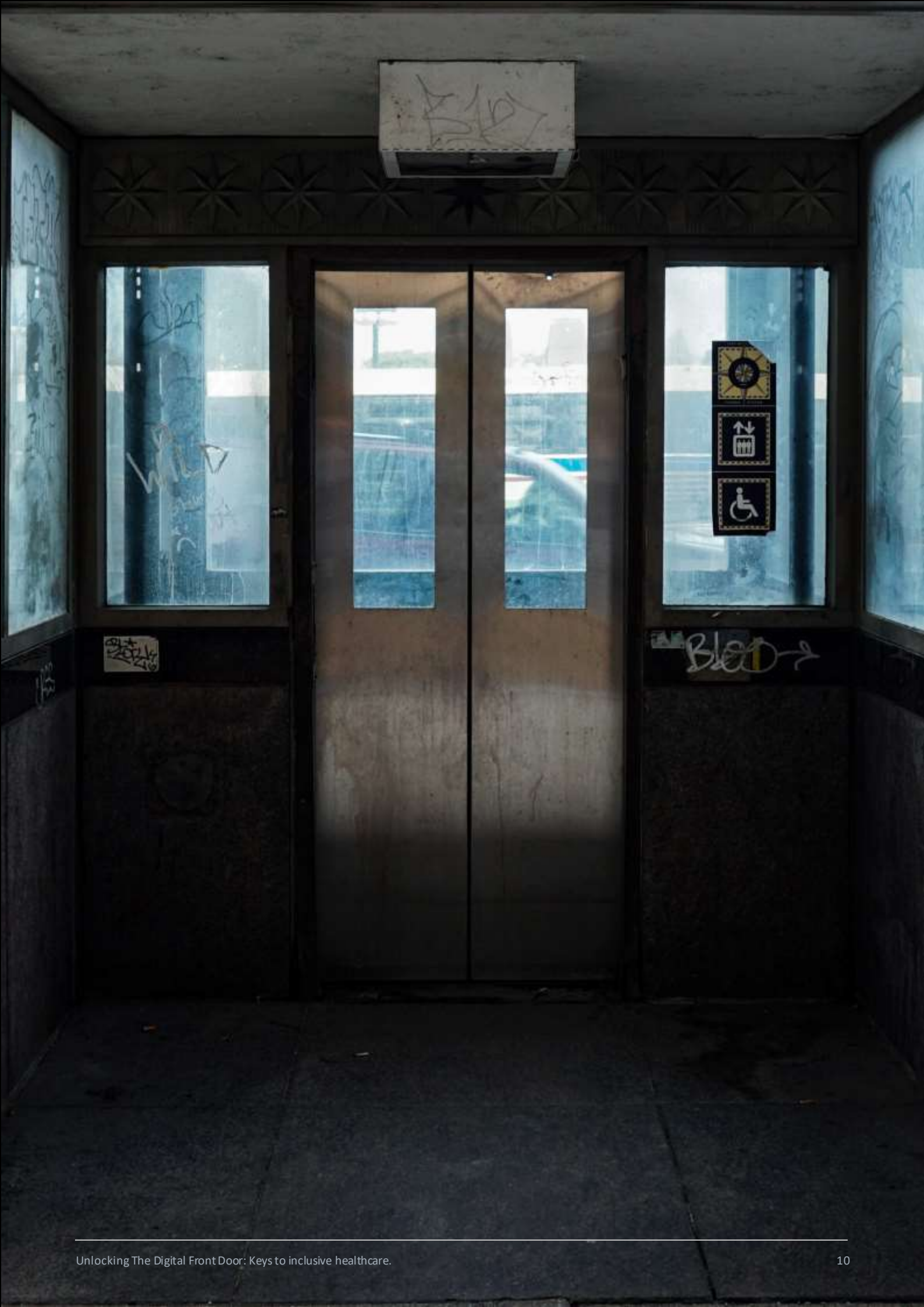
5. Poorly executed remote care impacts on experience and quality of care.

What is striking is that, for many who struggled to access care, their experience and quality of care when they finally accessed a provider was poor. The online barriers sometimes resulted in delays to booking or accessing appointments, with the delay implicating health outcomes. Communication needs and preferences were often ignored, or full clinical details were not able to be presented, rendering a full clinical consultation impossible. Online consultations simply did not work for some clinical interventions. Put simply, the shift in the access to appointments could have a real impact on clinical outcomes.

"I had a telephone appointment ... with the physiotherapy, for my hands. It was very difficult, and I could not understand what she was saying ... my hand was in pain; therefore, I could not focus on what she was saying. Also, the physiotherapist did not see me, she kept telling me 'do this, do that with your hand'. If she saw me, she would have realised that I was in severe pain."

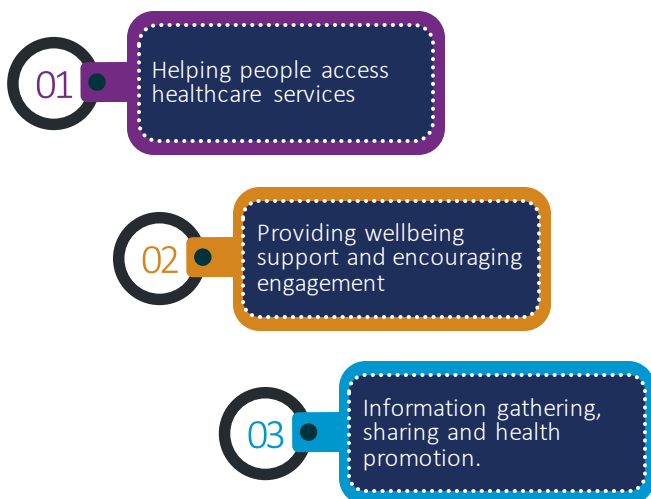
"Digital healthcare models are very stressful for me. They enhance my anxiety. Digital healthcare puts me off accessing services because I want somebody to talk to face-to-face, a doctor that can treat me like a human being."

9. <https://www.nationalvoices.org.uk/publications/our-publications>



Unlocking The Digital Front Door: Keys to innovation

Our interviews and research demonstrated an inspiring list of innovations and initiatives. We have grouped these examples relating to **three key objectives**:



Much of this innovation work is focused on digital inclusion – how people can continue or even begin to have better access to care in different settings. Some of these innovations were already happening before the pandemic, trying to address some of the remote healthcare challenges. Most of the innovations identified started during the pandemic, borne out of an urgent need to support people to access healthcare and stay well. The Voluntary, Community and Social Enterprise sector (VCSE) all over the country have played a huge role in meeting local community need over the last 12 months. The innovations identified here are only the tip of the iceberg.

We hope that these examples inspire ideas, insights and further conversations about how partnerships and innovation need to build and sustained locally.



The experiences people described in our listening exercise and interviews demonstrate that disseminating devices alone is not enough. Digital innovations designed to help people access healthcare online need to consider devices; installation; connection; training matched to disparate knowledge and skill level (both for intended beneficiaries and staff or volunteers); charging; ongoing assistance and troubleshooting support and coproduce with people most at risk of exclusion, to ensure accessibility needs are met.

1.a: Resource Dissemination and Training

Since before the outbreak of COVID-19, charities, services and community groups have been disseminating free devices to prevent financial and resource concerns holding people back from engaging online. The sight loss charity **Henshaws** have used various funding streams to invest in a package of portable technology devices that includes both mainstream and specialist technology; these include device and application solutions from Apple, Amazon, Android, and Microsoft. Their toolkit also includes digital magnifiers and evolving technology based on Artificial Intelligence.

The Greater Manchester project offers a comprehensive training and support programme to help people gain digital skills to support their independence. Following referral onto the programme, each service user was given a digital assessment to inform their digital journey.

Henshaws staff and volunteers help develop skills to use digital tools, working through technical fixes step-by-step using the same device. Ongoing support has been central to the success of this project, preventing people from having to rely on friends or family in the instance of technical problems. Henshaws now provide a range of [support and advice](#) around accessible technology.

This early work on digital inclusion meant that they were able to support people to access health services from the outset.

Many charities recruited volunteers to help with installation and training; [CroydonVision](#) , [Diabetes UK and Young Devon](#) are amongst many which set up dedicated online learning hubs and helplines to facilitate training and troubleshooting. For people who do not have the ability to access this online support in the first place, organisations have recruited volunteers to provide in-person installation and training support. For example, [Silverline Memories'](#) free confidential 24/7 [phone line](#) and their free iPads and "kitchen window support" for [people with dementia and their families](#).

[Living Well with Dementia](#), and the **South West London CCG** carried out some intensive work in order to create clear guidance and instructions detailing how to join the platforms, and tutorial packs. They also delivered 1:1 telephone support to help less tech-savvy members access the platforms. They provided an extra 15-30 minutes prior to meeting start times to address any issues and technological difficulties. They regularly invited people to feedback about the adapted virtual engagement.

Crucially, these organisations thought sustainably about their interventions, considering the need for ongoing support for both staff or volunteers and beneficiaries in case of breakages and glitches.

From community groups to national charities, many organisations rely on peer-to-peer support for resource dissemination and training, developing programmes such as [Wigan Council's](#) Tech Mates helpline¹⁰ and [AgeUK's](#) remodel of their Think Digital inclusion programme in collaboration with Santander.¹¹ The pandemic necessitated innovative thinking around volunteer recruitment, but many organisations found that online volunteering presents a less demanding commitment and removes geographical constraints, thus a wider variety of people can take part. AgeUK recruited 'Digital Champion' volunteers (and staff) to support older people across the country. They provided phone support and an e-learning video instead of the face-to-face training the Digital Champions attended pre-pandemic. In turn, Digital Champions deliver person-centred support, tailored to the needs and skillset of individuals, providing devices as well.¹²

Education is central to inclusive remote healthcare, especially as so many new and changing platforms and services have been rolled out so fast. For some people, the stress of introducing new technologies may not be worth the benefits - but designing in choice, information and coaching into service delivery helps to prevent exclusion of beneficiaries and staff who are less confident online.

In many areas, place-based collaboration has been vital to facilitate consistent approaches to innovation and uses of digital tools. In order to develop smooth social prescribing referrals from link workers to community organisations, **Community Action Derby** collaborated with Inspirative Arts to explore a framework which might be used to underpin digital social prescribing platforms. The intention was to support a consistent approach across the Midlands.

10. [Get online \(wigan.gov.uk\)](#)

11. In collaboration with Santander

12. For example: [Age UK Digital Champions | Leicestershire County Council](#)



Case study:

St Mungo's

St Mungo's adopted a varied approach to improve the health of people experiencing homelessness, providing health information, creating health improvement networks, training staff and volunteers, providing toolkits and promoting a range of health initiatives for staff and clients. St Mungo's Digital Recovery College transitioned from seven face-to-face colleges to an online service within ten days of lockdown.

Teachers, including volunteers from technology companies, offer informal, engaging, courses on digital skills from beginner level to advanced sessions as well as holistic sessions for health and wellbeing, for example on recipes, meditation and music.

The beginners' courses, such as the Wonderful World of Apps, provide basic explanations and avoid assumptions around clients' prior knowledge. Around 700 clients were given smart phones (with £50 worth of data) and headphones to access sessions. St Mungo's developed My Smartphone My World, a course available online and as a physical booklet, which guides clients through using their phone and connecting to WiFi hotspots once their data ran out. St Mungo's Digital Mentors provide ongoing one-to-one phone and email support, so clients are not alone if a device breaks or connection cuts out.

"No two clients we work with are ever the same, so we need to ensure our projects and services cater to the varying needs of the people we work with"¹³.



Case study:

Bevan Healthcare CIC, Groundswell, Leeds City Council.

The pandemic meant that people experiencing digital exclusion in Leeds, were often "locked out" of services as the move to digital exacerbated existing health inequalities. Bevan Healthcare CIC is a health and wellbeing provider specialising in the care of inclusion health populations in Yorkshire, including people with experience of homelessness and migrants in vulnerable circumstances. Having recognised the impact of multiple forms of exclusion on health and its determinants, they brought together Groundswell, a charity with expertise in peer advocacy, 100% Digital Leeds, a Leeds City Council programme driving digital inclusion for the city, and colleagues from the Helm project, experts in digital health solutions, to design a series of interventions to support digital health access.

The Peer Advocacy approach works to remove the barriers to accessing health services, improve people's confidence and increase their ability to self-care and access healthcare independently, including digitally. The volunteer Peer Advocates have relevant lived experience and have been part of a bespoke training programme to give them the skills needed to support others. Digital barriers have been addressed for both volunteers and service users with the provision of technology, connectivity, and digital skills training.

Ultimately one of the intended outcomes of the project is to enable users to access Helm, a Person Held Record, to manage their health records and share up to date health information with health services.



Case study:

Thomas Pocklington Trust (TPT)

TPT focuses on increasing engagement of people with lived experience and is expanding its network of sight loss councils. Led by blind and partially sighted volunteers, Sight Loss Councils advocate the needs of blind and partially sighted people and influence positive change locally, regionally and nationally.

For instance, Bristol Sight-Loss Council co-produced and circulated physical and digital guidance on accessibility and inclusion to GPs in collaboration with the Primary Care network. This included issues such as using screens to announce patient appointments in surgeries.

TPT has a website called Vital Tech which is a guide through the world of assistive tech for blind and partially sighted people. Because of collaboration across and beyond sectors, in many cases charities have been able to do more for their beneficiaries than ever before.

"You don't have to use tech, but if you don't, you're going to miss out. If we say 'don't worry about that' or fail to support people to acquire the skills and confidence to use services that they need, we are not doing our job to promote independent living." (Eamonn Dunne, Engagement Manager (North East), TPT)

13 <https://www.youtube.com/watch?v=BtadyMcTWFU>

1.b: Innovations that support better access

Our listening exercise shows that many people felt excluded from healthcare as their access requirements were not met, for instance Deaf people being told services are phone-only, or people with learning disabilities, visual impairments or for whom English is not their first language being expected to fill in often complicated, often untested online forms to get an appointment.

“Don’t make decisions about us without us, you have hearing privilege, we do not.” Feedback, evaluation and coproduction are critical to ensure that systems can support those who need it most. Ignoring access requirements risks stripping patients of privacy and agency as they’re required to ask friends and family to translate: one participant who is blind said, *“I battle a lot to try to keep my independence”* and a participant with a hearing impairment reported, *“I couldn’t hear so my husband was talking to me and feeding back to my doctor, it’s so frustrating. I deliberately come up here without anybody listening and when I talk to the doctor I come and close myself off because it’s personal and my health is my business”*.

Voluntary and community organisations have provided free-of-charge translations and interpreter services during COVID-19 through both formal and informal means, for instance WhatsApp groups connecting people to language interpreters who provide translations free of charge; via sign interpreter services; developing [pilot home testing kits suitable for people with visual impairments](#); accessible and accurate information and question and answer resources on many charities’ websites such as [Groundswell](#), [Crohn’s and Colitis UK](#), [Macmillan](#) and [Parkinson’s UK](#); and offering face-to-face training for people who would find it particularly difficult to switch to digital tools.

South West London Clinical Commissioning Group explored various channels such as Slack and Teams to disseminate important information including core guidelines about COVID-19 in 32 languages. In Merton and Wandsworth for instance, face-to-face meets were offered to help people make the switch to such platforms and people could also watch and contribute virtually.

Learning Disabilities centre [Generate](#) moved online at the beginning of the pandemic and offered a huge volume and variety of activities for their members, many of which were then delivered by participants, such as art clubs and quizzes.



Case study: BSL Health Access

In March 2020, a COVID-19 patient who was in intensive care and is Deaf found that doctors and nurses were unable to communicate with him and resorted to handwritten notes on coffee-stained paper.

As an emergency response to situations like this, BSL Health Access was born, providing a free, on-demand, 24/7 interpreter service. It received more than 44,000 calls between 16 April 2020 and 31 March 2021, helping paramedics, vaccinators, pharmacists, optometrists, dentists, doctors and nurses communicate with Deaf people through video relay technology.

SignHealth used its reserves to fund BSL Health Access and received some short-term funding, however has since had to close.

“My key ask would be to recognise the Deaf BSL community as having distinct needs and to ask us. Too many assumptions are made, or worse, Deaf people’s needs aren’t considered at all...When you finally open the door to a service, the community isn’t still standing there, they’ve left.”

Consistent use of the NHS’ [Accessible Information Standard](#) is crucial to avoid embedding inequality further.

Training and guidance for healthcare professionals is a vital part of designing and delivering services which work for everyone. Various organisations have coproduced useful guides for inclusion for clinicians and service providers, for instance the [NHS Confederation’s digital inclusion in mental health](#), [Thomas Pocklington Trust’s GP Guidance](#) and a Digital Ability Assessment tool [from Pluss Social Enterprise](#) to aid clinicians when engaging with patients to encourage healthcare professionals to avoid assumptions and ask the right questions to accurately assess (and act on) digital abilities and access requirements.



Although research participants did point to advantages of virtual care, for many people and in many situations, in-person care can never be replaced by phone or video: *"I am quite emotional, quite unwell right now, I need to see someone face-to-face, sometimes I am not very good over the phone. I am talking about my personal circumstances."*

Failing to take into account context or to provide high quality care and engagement opportunities online and offline risks excluding people from reaching out for help. The community and voluntary sector innovated in fantastic ways to develop virtual or physically distanced health opportunities as well as activities that promote wellbeing and build social capital more broadly, using informal interventions led by people who understand the needs and nuances of their own community.



Case study: Youth Access members

Many of Youth Access' community-based members, which provide information, advice and counselling to young people, transitioned to remote working. They developed online and offline support programmes to engage people during lockdown and beyond, such as: socially distanced "Walk and Talks"; deliveries of gardening kits, food parcels and support post cards; art competitions; lunchtime language lessons; Instagram "Pet Togethers"; interactive psychoeducational webinars; fitness and relation videos; and online gaming groups. Their informal peer-support services such as drop-in spaces give a broader addition to regular counselling and using platforms such as MeetUpCall allows people to access help without spending their phone credit. Case studies can be found [here](#).

According to Ros Arscott, Head of Wellbeing and Participation at Youth Access member, Young Devon, they had *"2-3 days of chaos, then 2-3 days of turnaround"* and acted to support staff as well as beneficiaries, buying and setting up IT equipment for staff working from home, ensuring they had comfortable seats and took breaks. Young Devon were driven by a "Just do what they need" principle, emphasising that each area and each young person has different needs and being led by young people's preferences.

"We focused on what works for them, as everyone is different. Some weeks it's calm and some weeks they motivate each other again with bursts of energy".

2.a: Community Aid

The introduction of shielding in March 2020 left many people without social interaction, access to food and unsure how to access health advice and services. Community aid played a vital part in the wellbeing of people classified as '[Clinically Extremely Vulnerable](#)', for instance through foodbanks, care packages, dog walking, prescription collection and signposting to charities and services. A wide range of community aid projects sprang up, from the national [NHS Volunteer Responders](#), to a wealth of local projects.

In **Bramphoe**, a **community organiser** used Facebook and WhatsApp to recruit over 100 volunteers who were assigned streets to support people shielding, organised by administrators who had DBS checks and GDPR training. Also, through WhatsApp recruitment as well as links with local charities, **Soothill Community Association** and **Dawatal Islam Foodbank** delivered 500 emergency food parcels in 8 weeks, Ramadan gifts to the elderly, hot meals to refugees and prayer hats and mats to local prisoners.



Case study: Horsforth Community Aid Project

This Leeds based project repurposed the local pay-as-you-fee Community Café to a Food Hub which provides necessities such as toilet paper as well as food to people in isolation - as well as GP surgeries, a woman's refuge and a local ambulance station - through volunteer-led deliveries.

Food packages come with Letters of Hope written by local children; one person who received a parcel said, *"Thank you so much for our box of goodies as we are having to shield. You are life savers, especially the four pints of milk."*

These successful endeavours harnessed the power of community, tailoring interventions to specific needs of local people and encouraging helpers to support vulnerable people close by, driven by compassion.

2.b: Projects Sparking Social Connections

Projects such as the **Jo Cox Foundation's** [Great Get Together](#) which encourages people to organise local events such as socially distanced street parties, and window visits of an NHS-branded pony from [Park Lane Stables](#) to people shielding all helped generate social capital, combat loneliness and spark community connections; the innovators believe that these projects made it easier for people at risk of exclusion to access information assistance when they need it.

Befriending is an effective way to keep people at risk of exclusion engaged as regular, informal calls prevent mental and physical health problems going unnoticed and escalating. As well as various digital support tools such as wellbeing toolkits, a wellbeing cafe and online psychotherapy, **Young Devon** offer short, frequent catchups with young people in their area – they have identified reasons for success as being led by the community they are trying to serve, namely young people and shifting the power dynamic by consistently requesting feedback and being guided by beneficiaries to use technologies they prefer.



Case study:

RIX CENTRE and University of East London

The RIX Centre, at the University of East London enables people with learning disabilities and autism to realise the full potential benefits that digital and new media technologies can bring to their lives.

RIX were conscious that support networks and activities stopped overnight for many disabled people, as the first lockdown started, and they rapidly developed ways for people to stay connected and benefit from remote care provision.

RIX implemented an [online social & support network](#) for over 1,000 disabled people and their carers and extended their existing 'Buddies' support programme. Groups were formed as personal support circles and to unite people with similar interests, such as the [Lockdown Stories](#) group. A 'Lock Stars' group linked up with people with learning disabilities from London with a similar group from Canada. They had Zoom parties and exchanged their experiences of lockdowns by building a joint Wiki Website.

A Support Worker from an Adult Care Provider organisation taking part in the Stay Connected Project explained its importance for those taking part, *"It's helping reduce feelings of isolation and allowing people to share what they are doing in their day-to-day lives while in lockdown. It's also helping people build friendship circles, which I think is a real benefit at this time"*

2.c: Identifying people at risk of exclusion

Age UK Sutton's approach required working closely with their CCG, PCNs and local council. GPs and Social Care teams referred people they were particularly concerned would struggle to access healthcare advice and care and other support online. Age UK Sutton staff and volunteers checked on these people through calls and doorstep visits, asking specific questions based on Age UK Sutton's existing assessment tool, which includes the accredited [LEAF wellbeing tool](#) around food, isolation, health and medication, referring people to local charities and services if needed, and supporting them to access medical help and social care support if required.

They also developed a 'phone call companions' scheme, with volunteers checking on 600 60+ people 2-3 times a week as well as a range of social activities online and a pilot tablet loan and training scheme to enable older people who didn't own a device to take part.

"During COVID, we were driven to innovate, and able to do so quickly due to the rapid response of our whole system to the crisis and the recognition by our Health and Care partners of the value the VCS brings in times like this. Ensuring that digitally excluded older people were able to access support was critical to our community, and the shared efforts to make this happen enabled us to implement a new way of working within days." Nicola Upton, CEO, Age UK Sutton.

"I think you're marvellous - I can tell by the way you listen and the things you say that you really care. Thank you for your help." - COVID call recipient, John* (*name changed).

Goodboost, a rehabilitation programme for people with musculoskeletal pain who developed a 'land' version of their pool programme for people to do at home.

The **South West Academic Health Science Network** worked with local councils such as **Wiltshire and Somerset** to uncover projects intended to find and engage people at risk of exclusion. Using schools and online benefits systems is a common strategy for identifying people at risk of exclusion, but this will not work for people who are not on these systems and are digitally excluded. They used local libraries to identify those who didn't have internet devices in their own home and passed on their information to third sector inclusion charities, who then delivered second-hand hardware, trained people and provided services normally done through libraries. They identified major challenges such as data protection regulations and ensuring people felt safe to share their details, as well as a concern that people, especially elderly members of the community, would not want to engage digitally. However, they found that this was rarely the case and that using the information which local services already have access to, such as libraries, is a more effective way of finding out who may be digitally excluded than simply seeing who is not responding to emails, for instance.

2.d: Online Health Promotion Activities

With many in-person services shutting down due to infection risk, charities offered social and health promotion activities online for those able to access the internet, for instance: the **Alzheimer's Society** coproduced website [Community Makers](#) for people wanting to take traditional activities online; [PlaylistForLife](#) which promotes the use of music to spark memories for people living with dementia; **Leicester Partnerships Trust** eight week wellbeing cafes; and The Anna Freud National Centre for Children and Families (AFC) [self-care activities](#) such as crafts and ecotherapy, as well as piloting an [online treatment for adolescent depression](#) (explained [here](#)), which has been adapted from a treatment developed and successfully evaluated in Sweden.

03

Information gathering, sharing and health promotion.

3.a: Innovations in Information sharing, gathering and health promotion

The outbreak of COVID-19 meant that accessing health information from trusted sources became more important than ever, but with many in-person healthcare services no longer available, charities and community groups looked to other methods of disseminating information, especially for people without internet access. A research participant shared her experience: *“Since everything has become digital, for people of my age it is very difficult: a lot of us are not computer savvy, we’re too old now, our brains are very full up... With phoning, there’s nothing more irritating than trying to contact somebody and you get ‘if you want more information visit our website’”*.

Many voluntary organisations we interviewed reported that offering consistent information through varied outlets was the best approach to preventing people slipping through the net, as different formats work for different people and failing to provide options and translations risks excluding people from accessing information who may need it the most, thus exacerbating the inverse care law. Charities and community groups spread information using online systems, offline tools and even in person, for example **Leicester Links** which hosted socially distanced workshops of up to six people to provide mental health support. In the personal narratives, a participant, who is profoundly Deaf, suggested using **BBC TV** programmes to deliver bite-sized health information for adults and local libraries to host information sessions. **100% Digital**, in partnership with **Croydon Council** have developed the **Digital Inclusion Toolkit** a shared resource for any council or organisation, where people can learn from others as well as contributing their own learning and experience for the benefit of others.



Case study: British Heart Foundation

Since March 2020 the BHF coronavirus hub has helped over 5.1 million users to navigate the pandemic, delivering a staggering 7.4 million unique page views.

With patient insight at the heart of their approach, 88% reported feeling more confident dealing with their condition after engaging with the content (Jan surveys). The most popular content was exercise videos specifically for people who’ve received a cardiac rehab assessment.

“The BHF ensured that resources were quickly made available online which meant that we were able to direct patients to these excellent resources and use them remotely to support our patients requiring cardiac rehab.”
Cardiac rehab specialist nurse

2,335 people signed up to Cardiac rehab email journey (Feb 2021) an eight week support programme, including emotional well being, lifestyle, medications:

“I was really struggling before, and they have made me feel supported. They have really helped and I feel so much more positive and confident now. Thank you, you were my lifeline.” Cardiac rehab patient.

3.b: Virtual Dissemination of Information

Interactive social media groups, e-newsletters, social media and charity websites all helped reach people who needed health information, with informal approaches such as local WhatsApp groups helping to reach people who were not already on the radar of charities and health services. Examples include: **Dystonia UK’s** online support groups run by volunteer coordinators and information webinars reaching up to 5000 people across the country without creating travel costs; **Alzheimer’s Society’s** Dementia Voice local and national groups offering informative sessions led by members of the dementia community, www.3ndwg.org coproduced website, **Innovation Hub** and monthly eNewsletters; **Anna Freud’s** YouTube animations by young people for young people; the **Stroke Association** who have permanently become 100% virtual; the **British Heart Foundation’s** online support and events; **Youth Access’** online COVID-19 resource hub and toolkit of evidence-based practices for supporting young people’s mental health and well being remotely and creative use of social media such as **Twitter**, Instagram.

The toolkit received 8,638 page views in June-July 2020 alone. **Young Devon** identified that one of the mistakes they made early on was trying to get through the mass of information they received about the crisis, which was a lot to take in. Instead, they set up task and finish groups with clear headings, to coordinate the jobs that needed doing, instead of half reading and half doing. Some of these groups worked and some didn't, but at least it was organised chaos then. In order to engage with its membership of Youth Information, Advice and Counselling Services on key issues during the pandemic, **Youth Access** held a series of webinars on different focus areas such as how to react strategically to the coronavirus crisis, safeguarding and engaging young people, and the role of the voluntary sector in recovery from the pandemic.

When the pandemic hit, many face-to-face support groups for people living with cancer had to adapt. The **Macmillan Telephone Buddy** service matches people going through cancer with a volunteer buddy to be a listening ear, reading to talk about support needs during social distancing and lockdowns. During the weekly phone call, the buddies can also let people know about other services and other ways Macmillan can help, so they don't have to go through cancer alone. *'This has offered me company and emotional support that wasn't available to me previously'*.

Scope's Big Hack offer accessibility advice identifying [clear trends in accessibility](#) and encouraging organisations to learn from lockdown to be more inclusive and embrace different ways of working. **South Asian Health Action** secured radio and television interviews for their beneficiaries who shared their story and signposted listeners and viewers to support groups. One successful outcome was an 82-year-old Caribbean woman who listened to a radio interview and contacted SAHA as she had been unable to get her first vaccine due to being a carer and accessibility challenges. SAHA liaised with her GP and organised transport.

3.c: Physical Dissemination of Information

Prioritising digital ways of sharing information excludes those who do not have the skills, tools or confidence to go online. That is why many organisations disseminated information by post and delivery. Wellbeing toolkits were a common approach, with many available as hard copies as well as online, for instance from [Alzheimer's Society](#), [Pathway and Marie Curie Research Department](#), [University College London](#), [Leicester Partnerships NHS Trust](#) and [Early Intervention Foundation](#) workbooks and materials such as CDs.

Sunderland City Council have been working closely with the VCSE sector to implement innovation projects which support the city's residents most at risk of exclusion such as ethnic minority communities, refugee and asylum seekers, disabled groups, LGBT+ people and veterans. In total about 40 organisations have established targets to recruit local people to become COVID champions, to shape, share and feedback on Public Health messages and how individuals and their families have been impacted by COVID-19.



Case study:

Diabetes UK

Diabetes UK gave healthcare essential cards to over 65,000 people and put posters in 330 pharmacies with QR codes for a feedback survey, resulting in 83% of surveyed participants saying they would now seek a flu jab.

As in-person educational sessions were paused, Diabetes UK distributed over 11,000 physical information packs across the Midlands and East of England to signpost people with Type 2 diabetes to information and local services, and to support self-management. Some of the literature distributed is here:

[Staying at Home and Managing Diabetes - Diabetes UK Shop](#) and [this Your diabetes care during coronavirus - Diabetes UK Shop](#)



Case study:

Keeping People Connected Project

In North East England and North Cumbria, learning disability organisations collaborated to deliver accessible information about the pandemic, signpost to services and reduce isolation, aimed at the 'missing 1000s' of people with autism and learning disabilities who are largely unknown by health or care services. Self-advocacy groups used their databases to identify people and local authorities and NHS teams also widely promoted the service. As well as disseminating information packs, the project has led to Zoom and Facebook groups being set up to organise activities such as quizzes, karaoke and cooking classes. The project uses phone calls and text messages, the latter of which can be especially useful for people who want a two-way communication, but in their own time on their own terms.

"I exist! It's nice to be acknowledged and know that someone, somewhere is concerned."

For people with a neurological condition such as dystonia, using a computer can be very difficult due to visual impairments and neck and eye spasms, for instance. As part of their [Reach Out Reach All](#) campaign, **Dystonia UK** aimed to bring the dystonia community together and share information around self-management through a variety of mediums. They found that 90% of their beneficiaries preferred to access information physically over digital, thus they post written magazines to subscribers and are launching a Dystonia Matters podcast to share expert advice and personal stories. Providing a variety of information outlets is critical to ensure people with different skillsets and access requirements access the same quality of material. They also launched the first episode of a new animation series '[Dystonia Animated](#)' aimed at children and young people and held 2 '[Dystonia Matters Digital](#)' events which are virtual conferences.

3.d: Gathering evidence, feedback and stories

Gathering data is vital for making decisions which are evidence-led and therefore are more likely to be sustainable and serve intended communities. Many voluntary organisations used digital means to garner evaluation of innovations and to hear people's concerns and needs, for instance: **National Voices'** [Our COVID Voices](#) platform collating the personal accounts of people unedited and submitted in their own time; **Leicester Partnerships Trust's** survey analysing success of digital care; **Alzheimer's Society's** Dementia Voice Reference Panel which send out and analyse online surveys; the **British Heart Foundation's** surveys and [Patient and Public Involvement Groups](#); **Greater Manchester's** Combined Authority [online survey hub](#) and virtual discussion groups, used to gather insight and [develop COVID-19 campaigns](#).



Case study:

South Asian Health Action

SAHA is a patient, carer and community led charity who have been proactive in carrying out targeted engagement with emotional, bespoke culturally sensitive and language specific support. SAHA runs entirely on volunteers and engages with over 600 people via WhatsApp groups.

In communities around the UK, WhatsApp groups function as a way to connect with local people and spread information. SAHA capitalised on such existing groups, around faith, specific health conditions and social groups, but also created new ones, such as the Health and Wellbeing Group in April 2020 which has around 90 participants. The forums tackle misinformation and isolation, allowing people to access information from people they trust in different languages, and find out about local services and activities. Many practitioners are on the groups and offer their services often free of charge, such as language translations and Zoom yoga. Although not everyone has a smart phone, people on the groups share the information with family and friends and encourage others to invest in a smartphone so that they can join.

SAHA also offered six week workshops for Learning Mobile Devices and Apps for over 50s. They recruited a trainer from India to run workshops in English and Gujarati and have had over 80 people attending each session.



Case study:

Leicester Partnerships Trust

Leicester Partnerships grew their involvement network from 20 to 70 members during the COVID-19 outbreak. The network has created a health and wellbeing workbook through a process of co-design. They also set up a new People's Council during this time, which is a group of patient and carer leaders and VCSE partners who are providing an independent voice to the work of the Trust, and reintroduced Our Recovery Cafes following the success of their first virtual café.

Their Virtual Communication Technologies Patient Experience Survey, codesigned with carers and patients including a specific survey for those with learning disabilities, was offered to patients or carers after online appointments, for instance through Attend Anywhere or Clinicic.Co, aligned with a Telehealth Staff Survey. Leicester Partnerships Trust analysed findings, for instance creating wordclouds from what people did and did not like about their online appointment and noting suggestions for improvement.



Case study: Groundswell

#HealthNow is a national partnership led by Groundswell with the aim of reducing health inequalities for people experiencing homelessness using peer-led approaches. During Covid19 #HealthNow have promoted opportunities for people experiencing homelessness to have their voices heard and worked with partners including The Faculty for Homeless and Inclusion Health (Pathway) to improve planning responses for people experiencing homelessness through COVID-19.

Due to COVID-19 primary care services had to change and adapt to ensure health needs are met whilst preventing the spread of the virus. Providers reduced the number of face to face appointments and moved towards digital and remote delivery of healthcare. Monitoring the impact of COVID-19 on people experiencing homelessness exposed that people faced significant barriers trying to access healthcare remotely: *"Can't get through when [I] call the doctor... phones doctors but can't get through so [I have] given up trying"*

A number of digital programmes have been supported during COVID-19, many originating from an early event [Listen Up! Digital primary care: bridging the gap for people experiencing homelessness](#). In addition advice has been developed for people experiencing homelessness and those residing in hostels and temporary accommodation.



Case study: Macmillan

Macmillan's SafeFit is a free, self-referral intervention for people with a suspicion of, or a confirmed diagnosis of cancer at any stage in the cancer pathway. The intervention aims to provide personalised virtual exercise, nutrition and emotional wellbeing support with behaviour change at the centre, for people living with cancer while they prepare for cancer treatment and beyond during the coronavirus pandemic. After self-referral, the person is called back within one week, a robust screening and assessment process is undertaken which evaluates their suitability for the service, understands their needs and seeks consent for participation in the trial.

The delivery of the remote sessions is tailored to the wishes and needs of the individual. The sessions are delivered either as individual telephone or online sessions by cancer exercise specialists. The cancer exercise specialists have been specifically trained to provide information on basic nutrition advice and emotional support as well as exercise.

"[SafeFit] has enabled me to focus on my health and recovery from treatment, and allowed me to feel in much better control of my health going forward.... I feel confident that undertaking SafeFit has helped my recovery to the extent I now expect to be able to return to work next month - one month earlier than originally planned."

Inclusive healthcare: guiding principles



Make inclusion the core principle.

The innovations often started with the aim of ensuring that, no matter how people choose to interact with services, they should receive the same levels of access, consistent advice, and outcomes of care, regardless of channel. One size does not fit all.

- Design services with a deep understanding of the needs and preferences of people, particularly those at risk of exclusion and with the highest care needs and provide support.



Co-design with people.

As we have seen from our examples, co-design can happen at pace. The innovators were aware that no matter how urgently new systems needed to be implemented, access requirements need consideration. They sought guidance from people who use their services, about technology preferences and communication methods which allow people to reach out on their own terms, such as text message services or informal drop-in discussion groups and activities.

- Access requirements and user experience need to be the core consideration when implementing any systems.
- Listen to and trust people when they speak about their own health, and needs, and those of their own communities.
- Involve people directly in the design process.
- Build lasting relationships so that the co-design process supports a collaborative continuous improvement process.



Offer supported choice and personalisation.

Many of the organisations we interviewed spoke about adapting communications, offering different methods and formats – both online and offline – so that people could access care and information in a way that works for them. Informed choice means helping people understand remote opportunities, being encouraging about new systems, providing accessible information about services.

- Fully implement the [NHS Accessible Information Standard](#) to make sure the communications needs, and preferences of all people and their carers, are recorded, shared across services, and acted upon.

- Support people to make informed choices.
- Think through the personal agency of patients, the role of carers/family and don't assume or rely on informal support.
- Provide clear information on how to set up and use virtual healthcare systems.
- Explore peer support and advocacy opportunities to help people to build digital health literacy and confidence.



Support staff to innovate.

Virtual healthcare delivery at this scale is new for everyone and clinical and non-clinical staff need support to understand the challenges people might face and what support might be needed to deliver inclusive services.

- Build a positive culture around testing new ways of working, put training in place and embrace and learn from feedback.
- Acknowledge that change isn't easy and respond to frustrations.
- Include staff so that they can provide clarity and make sure people know what to expect.
- Think sustainably - interventions need to consider the user's journey far down the line.



Know that health is wider than healthcare.

Many successful projects provide inclusive health and wellbeing support through engaging people via social incentives, instead of being primarily health focused. Generating social capital and developing trusted relationships is an important part of engaging people in a way that gives them the connections, confidence, knowledge, and skills to access care. The Community and Voluntary Sector are vital partners to supporting services to co-design with people who might face barriers.

- Work in partnership and make the most of the creativity of organisations who know their communities best, who can reach out to them and think outside of the box to address challenges.
- Don't let systems and process be a barrier to innovation, encourage ideas and creativity. Test things out.
- Commit to working in the open, learning from what you have tried and sharing knowledge, including what hasn't worked.

Conclusion

We are excited by the examples of innovation that have been shared and the messages they send about the possibility for change.

The community and voluntary sector is well positioned to innovate effectively, and puts time and effort into building relationships, skills and peer support networks; they are well placed to understand real world community needs. In a crisis, VCSE colleagues have been able to reach out to vulnerable communities, with different needs and find workable solutions at pace. However, innovations and solutions that have been developed in response to a crisis will need ongoing support. As we move towards national recovery, we will need to create a culture that embraces innovation, with some key design principles at its core. We will need to explore new models of partnerships and funding for sustainability.

Our listening exercise and research gives us a clear understanding of the challenges to inclusive healthcare. If we exclude people digitally, people will have reduced access to care, a poor experience and ultimately worse health outcomes. The risk of direct discrimination is high because it is highly likely that people who are digitally excluded have higher burdens of ill health and/or are less well served by existing models of care.

People need to be able to express their preference for how care needs to sit in their lives, particularly where those lives are already made more difficult by social exclusion, poverty, or caring responsibilities. The cost of more personalised care is far outweighed by the risk of low-quality care that adds very little value to people's lives and wellbeing and is therefore, by definition, wasteful.

This is not an exhaustive list and we have not carried out quality evaluations, but it is clear that peer-to-peer support and engagement is central to many of the innovations that we have identified. Often these successes are built on established networks and trusted relationships within communities. Effective innovation is often found at the boundary of formal service provision and informal community-based support approaches. There is huge value in bringing people together across such organisational and relational boundaries.

The health system can't do this alone. Partnerships with the voluntary and community organisations that have shared their emerging practice will be crucial for the spread and adoption of these, and other, solutions. We need to value their understanding of the nuances and needs of their own communities and build on their experiences to create innovative solutions together.

Thank you

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Finally, people with often difficult lives agreed to being interviewed. Their insight and hopes drive our work. We are so grateful.

Thank you,
Dr Charlotte Augst, Chief Executive, National Voices



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