Your healthwatch Leeds

Appendix 1

Digitising Leeds: Risks and Opportunities For Reducing Health Inequalities in Leeds

People's Voices Group

Contents

1. Introduction

The aim of this insight report

The aim of this briefing paper is to highlight people's experiences in Leeds of the move to digitised health and care services during Covid-19 and pre-Covid-19, with a particular focus on hearing the experiences of people with the greatest health inequalities. It intends to help inform a city in which digitised and remote services provide patients and service users with a *wider* range of choice and improved outcomes.

Who is it for?

This insight report is for anybody who has a role in the future design of health and care services in Leeds.

Who is it by?

It has been written by the Leeds People's Voices Group (PVG)[1] chaired by Healthwatch Leeds, which has formed a Digital Inclusion Subgroup in response to the pandemic. The PVG brings together partners from across the public and third sectors in Leeds to work together as one health and care people's listening team with a focus on hearing the voice of inequalities.

The subgroup includes representatives from Forum Central, Leeds City Council, NHS Leeds Clinical Commissioning Group, Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, academic and research organisations and wider third sector partners. (For a full list of members, please turn to Appendix (b) on page 30.) Draft copies of this briefing have been shared within each of these organisations to ensure it is relevant to their digitisation work as they emerge out of lockdown.

[1] The People's Voices Group: https://healthwatchleeds.co.uk/our-work/pvg/

The subgroup's members have each contributed by submitting engagement work conducted locally and nationally to the group's chair. Over the course of its sessions, the subgroup then identified themes from across the various reports, paying particular mind to work with special relevance to Leeds. The collected research has been distilled to create this report. For a list of papers referenced by the subgroup, please turn to Appendix (c) on page 33

Defining "digitisation"

While this paper uses the term "digital inclusion", it refers not just to internet-based modes of communication but to telephone and other forms of contact such as text messaging.

While digitisation has long been on the agenda across the UK, the coronavirus crisis has lent it extra impetus. National government has previously identified four key barriers to digital inclusion[2]:

- access - not everyone has the ability to connect to the internet
- skills - not everyone has the ability to use the internet and online services
- confidence - some people fear online crime, lack trust or don't know where to start online
- motivation - not everyone sees why using the internet could be relevant and helpful

This paper reflects these barriers while also highlighting some of the key findings from engagement work done in Leeds around digital inclusion. At the heart of this city-wide piece of work is a desire to strike the right balance between digitisation and sustainability on the one hand and improved outcomes and reduced health inequalities for the people of Leeds on the other.

[2] https://www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy
https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is

How digitised is Leeds?

100% Digital Leeds[3] is a Leeds City Council-funded programme designed to lead digital inclusion in the city. As well as working to ensure everyone has the skills they need to improve their lives through digital technology, it is supporting organisations to develop their own confidence and connectivity. Prior to the coronavirus crisis, it identified that:

- 90,000 adults in Leeds are without essential digital skills
- 50,000 are not online at all
- 40% of council housing tenants are not online

2. When do people in Leeds say digitisation works for them?

Lockdown has helped to identify circumstances in which digital access to health and care works well. It has undoubtedly accelerated planned changes towards virtual health and care appointments and presented the city with a great opportunity to get digitised services right.

From what people have told us, digital and telephone access can be helpful when it offers people a quicker, more convenient experience. For example, it might mean that:

- Patients do not have to take time off work to access healthcare, especially when it is routine
- They do not have to travel to their appointment (saving them time and money)
- It is easier to combine caring duties with medical appointments, for example if they look after young children or other loved ones
- People with reduced mobility can access care and information more conveniently

[3] 100% Digital Leeds: https://digitalinclusionleeds.com/

What benefits did people tell us about pre-COVID-19? - A few examples

"Skype is as good as face to face and easier, as there is no sitting in the waiting area"

"I would like a mixture. It's a good to see someone face to face but I would find it more convenient to FaceTime a consultant"

"I work 55 hours per week. I can't take time off easily for appointments. It would be so much better for me to have a Skype or telephone call. I never need examining so it would work just fine for me to do that"

"I'd be ok with technology if I was feeling okay but if my condition was changing I would prefer a face to face consultation"[4]

What benefits have people told us about during COVID-19? - A few examples

"[It was] excellent. I called at 9.30am. Not too long to wait, receptionist asked what the problem was, then they took my number and gave me a time for a telephone appointment at 2.30pm, later in the day."

"Really good video/telephone consultation with GP. Problem diagnosed and prescription emailed to local pharmacy which I was able to collect the same day."

"I was able to speak to a GP via telephone and it was much easier to explain myself than I thought it would be. I hope they continue to offer this after the lockdown as it is hard for me to get out due to mental health problems."

However, we have heard that these advantages are not available to everyone in Leeds. Some people would be excluded from health and care if they were no longer able to access it face to face, and there are junctures in the patient or service user experience where personal contact is felt to be more appropriate.

[4] These quotations are taken from LTHT's engagement report entitled *Listening Week, Outpatient Services, 23rd - 27th September 2019*.

3. When do people in Leeds say they would like a flexible approach to digitisation?

"There should always be an alternative for those without access"[5]

"Digital should be an enhancement to services not a replacement for it."

Digital and telephone appointments don't work for everyone. Sometimes personal circumstances make people more vulnerable to digital exclusion; sometimes digital appointments are suitable at one stage in a person's care but not another. It is crucial that both these elements are taken into account when making decisions about when patients or service users might require flexibility.

From the Digital Subgroup's work, we have identified eight factors which make people particularly likely to experience digital exclusion. They are:

1. Poverty
2. Age
3. Literacy & communication preferences
4. Skills & motivation
5. Precarious lifestyles
6. Privacy
7. Disability & specific conditions
8. Trust in IT

We have not listed these factors in order of importance or prevalence. Of course, in many cases, these factors will intersect and need to be assessed in combination when considering a person's digital needs.

[5] This quotation and those which follow are taken from Healthwatch Leeds' NHS Long Term Plan report and the various Weekly Check Ins it has published throughout the coronavirus crisis.

Poverty

"I don't have a computer and I don't always have phone credit to use internet access"

"I can't afford internet so wouldn't always be able to use. Also not private in libraries or places I can get it free"

People with low or no incomes (and little access to credit) are less likely to have devices, Wi-Fi or data. Those who do have devices are more likely to access Wi-Fi in public spaces such as libraries.

For example, Unique Minds[6] (which supports men from BAME communities, including refugees and asylum seekers) is one organisation which has reported its users not having access to devices during lockdown. Getaway Girls has also noted that its members – girls and young women aged 11 to 25 – sometimes struggle to access data.

During lockdown, 100% Digital has provided grants and equipment loans to third-sector organisations to enable wider digital access. For instance, it loaned six iPads to Arts and Minds (which supports mental well-being through the arts), two of which were handed to service users so that they can join online workshops.

Age

"I would not use it at my age"

Older people are less likely to want or have the skills to access digital healthcare. For example, according to governmental research, over 53% of people who lack basic digital skills are aged over 65, and 69% are over 55.[7]

[6] Comments for all third-sector organisations referred to in this section are taken from Healthwatch Leeds' Weekly Check Ins.

[7] See "Vulnerable and disadvantaged groups", https://www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy

During lockdown, third-sector organisations in Leeds which specialise in supporting older populations have repeatedly reported a significant number of their service users cannot access digital services but have, in many cases, managed to maintain links via telephone contact. For example, Bramley Elderly Action has adapted to lockdown by keeping in touch with service users by telephone, but it has not moved any services online. Similarly, Community Action for Roundhay Elderly reports that 90% of its service users rely solely on landlines to communicate; and New Wortley Community Centre notes that its older service users tend not to have Wi-Fi or don't know how to use technology.

Sometimes, older people have connected devices but use them for a restricted number of functions (such as, for example, voice calls and text messaging but not video calls). Carers Leeds, for example, has found that many of its older service users are frequent users of WhatsApp.

Literacy & communication preferences

"Can't speak English very well or read and write"

Some insight has indicated that people who leave school with no or minimal qualifications are less likely to access care digitally, but it is unclear whether that is due to purely educational reasons or it is also linked to poverty.

A lack of English language or literacy skills can be a barrier. For example, the Leeds Syrian Community organisation has explained that language barriers are a particularly significant issue for its service users, and Dream Leeds (which promotes social inclusion for disabled people) has expressed concern about how its non-verbal members will access digital platforms.

Computer skills & motivation

"i have access to I Pad but not confident about using it"

"I'm young and tech savvy but there is so much to be said for human connection. I have a good relationship with my GP and I want to continue to see her in person."

Issues around skills and motivation include a general preference for face-to-face contact and a demotivating belief that seeing someone via a screen isn't "really seeing" them. Some evidence has emerged nationally that people aged over 45 and people with lower levels of income are more likely to fall into the "never have, never will" category.[8]

The way digital services are presented to people who would not ordinarily be attracted to them can have an effect on motivation. For example, if video appointments are presented as a lesser means of contact ("we'd like to see you face-to-face but…"), they are more likely to be seen as a downgraded form of service. Similarly, people can be discouraged if feel they are being pushed into a corner to use digital or that the consequences of a digital appointment going wrong would be severe.

Precarious lifestyles

People living in extremely precarious circumstances may only have devices for short periods of time because they may be quickly sold on or stolen (for example homeless people or people with drug and alcohol addictions). Engage housing support, for instance, has noted that some of its service users tend not to answer their phone or change phones often.

[8] See the section entitled "Never have, never will", https://www.gov.uk/government/publications/government-digital-inclusion-strategy/government-digital-inclusion-strategy

Privacy

"I would not like to try book an appointment using a PC in a library; not open all the time, not private enough and no good if you are not well."

Some people don't have the privacy they need to contact health services by phone or digitally. This has been even more the case during lockdown.

People suffering domestic abuse and carers are particularly likely to have reduced privacy in the home. People with low or no incomes are also more likely to be reliant on public Wi-Fi in libraries and so on, and people living in multi-occupancy housing may not have the physical space for a private consultation.

The potential safeguarding implications of this should be considered.

Disability & Specific Conditions

"I don't hear as well through phone/video as I do face-to-face"

"i am totally blind in one eye and from my own experience, using internet is very bad for my eyes"

Disabilities and long-term conditions undoubtedly have an effect on how willing people are to access care digitally.

In some cases, disabilities can make it impossible to use technology without assistance (for example for people with reduced mobility in their hands, people with dementia and, in the case of some platforms, hearing or sight impairments).

Recording communications and accessibility preferences in patient records and ensuring these records follow patients across services is particularly significant to this group. It is worth pointing out that the Accessible

Information Standard sets out an approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, and therefore needs to be fully integrated into any move towards digitisation.

The willingness of people with specific conditions to access services digitally can depend on what stage they are at in their care. For example, people who have been managing their conditions with confidence for many years are generally more willing to have routine consultations remotely, while people who require physical examinations by a doctor are more likely to have reservations.

There are also strong suggestions that face-to-face contact is best when patients and service users need reassurance, extensive explanations or when they are to be told bad news.

The picture for people with mental health conditions is complex. For some, technology can be intimidating and off-putting, while for others, not having to cope with face-to-face contact is an advantage. This demonstrates how important it is that solutions be tailored to individual circumstances and patients and service users be offered a range of choice.

There are some reservations among people with hearing and sight impairments about access care digitally. One key reason for this is a concern that technology will amplify the difficulties this patient group already experiences when accessing care – for example, NHS apps do not provide an option for booking a British Sign Language interpreter, subtitling solutions can be poor and video interpreting needs setting up carefully.

For instance, the Leeds Society for the Deaf and Blind has observed that some members of its community have minimal-to-no technology available to them. It should also be noted that the Leeds Hearing & Sight Loss Service run by BID has been building up a wealth of expertise in the kinds of facilities different platforms offer to people with sensory impairments.

Trust in IT

"It is very complicated and most of the time it doesn't work"

"I am not comfortable with my medical files being online due to all the people hacking and accessing other people's files."

Some people do not trust IT systems to function reliably or that their data will be handled securely. This is sometimes due to past incidents which have affected them or which have appeared in the media.

There is some evidence that certain service users might be less trusting than others regarding technology, notably people from black and minority ethnic backgrounds or with mental health conditions. For instance, Sisterhood (which provides support for women with mental health problems from BAME communities) has found that its members can be reluctant to give out their contact details.

There are also some concerns that certain patient groups would be vulnerable to cyber-crime. For example, Bee Friends (which runs social groups for older people with a learning disability) reports that its service users are particularly reluctant to communicate online because they worry that they would be making themselves vulnerable to scammers by doing so.

The risk of accessing false information about health is also present for all patient groups.

4. Other factors to consider

People living in care homes and assisted living settings

Sometimes, people living in care homes and other settings might be excluded from accessing services digitally by the factors listed above. (They are, for example, more likely to be elderly or living with disabilities and

long-term conditions.) More engagement is undoubtedly needed regarding this population group and digital inclusion, but there are two early findings that need to be taken into account:

- There are some indications that people working in care settings would find it beneficial to help their service users access services online, as this would save time and relieve residences of the need to organise travel for staff and residents.
- At the same time, it is not clear that all staff have sufficient training to support residents to use technology.

Furthermore, a small piece of engagement work by Healthwatch Leeds during lockdown has indicated that, while many care homes say they are facilitating phone and video calls between residents and relatives, some relatives have found that such contact has not occurred regularly enough. This was usually due to a lack of staff capacity or skills, or equipment not working or being used elsewhere.

Questions regarding capacity to make decisions about preferences, data privacy and so on may also be particularly significant to this population group.

Getting the right platforms for the right people

"I would not use digital services if they were only available using a desktop device. My only means of accessing digital services is via my mobile phone so where services are desktop only, it renders the "service" useless."

"Some online platforms have proved useful, particularly those that enable use of emojis etc to respond when communication is difficult [… but] Platforms such as Zoom can be a huge sensory overload for many autistic people"[9]

There are all kinds of reasons why people might prefer some platforms over others, from the functions they allow (such as audio captioning) to how bandwidth-intensive they are and how familiar people are with them. Services' ability to accommodate these preferences has an effect on how accessible they are. Flexibility needs to be built in so services can adapt to users' preferred platform where possible, rather than the other way around.

One example of this is the finding that Leeds Deaf Forum members prefer texting and platforms such as Facebook to other communications tools. Similarly, Zoom does not necessarily offer the best audio captioning tool.

Safeguarding

It is essential that safeguarding processes evolve in step with digitalisation. Consideration needs to be given as to how to enable people who live in an abusive domestic situation or with carers to disclose any concerns.

Similarly, healthcare professionals should be asked whether they have any reservations about their ability to identify safeguarding issues during a telephone or video call. For instance, the Families Together Leeds service run by Family Action has shared its concern that remote support makes it harder for staff to pick up safeguarding issues.

[9] This quote is drawn from Advonet's digital inclusion summary document drawn up during lockdown.

Staff training

Staff's own digital skills and confidence are crucial to the success of online services. Staff need to feel able both to use technology safely and effectively and to support their patients or service users to do the same.

The way staff present digital options to patients can have a significant effect on how the latter perceive them. For example, if staff present a telephone appointment as a second-best option, it is more likely to be experienced that way by patients. It is very important staff feel comfortable with the digital options they offer patients.

Decision-making tool

At our digital inclusion subgroup meetings, LTHT has suggested that a practical tool to guide clinicians through decisions about whether digital services are suitable for individuals could help to boost staff confidence and support frontline workers to think through when digital is the right medium of delivering an intervention.

Digital services require ongoing conversations and support

Giving people the skills and confidence they need to use digital services often takes time and ongoing support. A single intervention to get a person online will not necessarily be enough.

Evolving landscape

The engagement we have seen indicates that people's experiences of digital services are evolving over time. For example, Forum Central has identified, through its conversations with third-sector organisations, that

while people were generally more willing to use digital services at the height of the lockdown, they have not necessarily retained the same motivation once other options have become available. In light of this, it is important that we continue to capture people's experiences so that decision-making is supported.

5. What next: challenges to consider

As part of this work, we have developed a framework to help organisations and the city to think through some of these issues.

The eight key factors provide an initial framework for identifying people likely to be excluded from digital services and are designed to be used as part of a patient-centred process. Each one is the starting point for a conversation with the patient or service user about their needs and preferences. Not being able to afford a device, for example, may be one obstruction to using digital services, but it might also mask several secondary obstructions such as a lack of IT skills or trust in IT.

Just as important as organisations' ability to record patients' preferences is their ability to modify these records dynamically. Thought needs to be given as to how these preferences are checked regularly, but also communicated from service to service via patient records.

Factor	Challenges for health and care organisations	Challenges for decision-making boards	What questions might require more engagement?
Poverty	How can organisations identify patients whose low income would prevent them from buying a device or paying for Wi-Fi or data? What mechanisms are in place for organisations to feed back to the city about the amount of provision required?	What provision is available to give people access to low-cost, high-quality Wi-Fi or data? What provision is available in public spaces to enable people to access Wi-Fi or data privately?	How many people in the city are not able to afford a device?
Age	What can organisations do to support older people who want to use technology (for example signposting to third-sector organisations)? To what extent should organisations consider unfamiliarity with technology to be a valid reason for using face-to-face services only?	What provision is available to help people become familiar with IT and increase their skills and confidence? What role could the community and voluntary sector play in normalising technology and embedding it within older people's social communication networks?	Do we have enough information about young people and digital health and care?
Literacy & communication preferences	How can organisations identify where low levels of literacy	What training is available for people whose lack of literacy	Why are people with lower levels of educational

	affect individuals' ability to use technology? How can organisations record people's preferences regarding platforms? To what extent can organisations adapt to people's preferred platforms?	skills prevents them from accessing technology?	attainment less likely to want to use technology? Is it often linked to, for example, higher levels of poverty?
Skills & motivation	How can organisations ensure staff feel confident and motivated to use technology when appropriate? What can organisations do to direct people to the training they need to use technology? How do organisations present the option of using technology to patients in such a way that it feels like a genuine choice rather than an imposition?	What can the city (including the community and voluntary sector) do to help people improve their digital skills? How do we do this in a way that emphasises the benefits to the user, rather than technology being a chore or an imposition?	
Precarious lifestyles	How do organisations identify patients who live in extremely precarious circumstances?	How can people living in very precarious circumstances be given permanent access to	Which other people might be affected by extreme precarity

		technology without being made responsible for keeping it safe?	(for example family members of people with addictions)?
Privacy	How do organisations identify people whose home environments wouldn't be sufficiently private for a health or care appointment? Can we offer a service flexible enough to accommodate people who may have sufficient privacy at one time of day but not another? What provision is in place to enable people to disclose safeguarding issues if they don't have privacy in the home or are reliant on others to get them online? Do contingency plans need to be drawn up for circumstances in which a person's privacy is breached during an appointment?	What provision is available for people whose homes aren't private places?	Is it more difficult for healthcare professionals to spot signs of abuse when holding appointments digitally?

Disability & specific conditions	How can we identify at what points in their care people are most likely to need reassurance (and therefore face-to-face contact)? Which platforms are most accessible to people with different conditions? (For example, does a particular platform have a suitable captioning service for people who are hard of hearing?)	How do we involve carers and extended families and support them as a city as they assist loved ones with technology? What is the policy for using digital when dealing with compulsory situations like Mental Health Act assessments? How do different organisations work together smoothly when using different platforms? What role can the community and voluntary sector play in feeding back information about disabled people's technology needs and preferences?	Do we need any further information about how specific conditions can affect people's digital access?
Trust in IT	How do we reassure patients that their data is secure; it will not be lost or shared inappropriately; and they will not be spied on? How do we provide patients with the information they	How do we help people tell the difference between reliable and false health information online? Which data protection policies need to be city-wide?	Do staff have all the training and information they need to help service users use the internet safely?

	need about data safety in an easy-to-understand way? How to we develop an opt in / opt out process for people to give informed consent? Should each primary care practice be incentivised to develop their own digital strategy as different approaches will be needed in different communities?	What role can the community and voluntary sector play in familiarising people with technology and educating them about safety?	

6. Summary of findings

- Digital is not a “one-size fits all”.
- People told us they want digital to enhance rather than replace services.
- Digital works for some interventions and is not the best medium for others.
- Some groups face significant barriers to accessing services digitally.
- For parts of the population digital works really well for some interventions.
- Some platforms work for some communities and not others.
- Digitisation should take a person-centred approach and needs to be considered in partnership with the Accessible Information Standard requirements.
- There needs to be a city-wide approach to tackle the issues raised.
- People’s experiences of digital are constantly evolving and the changing needs should be understood on an ongoing basis in the planning of services.
- Health and care staff need tools, support and training.

7. What next: recommendations

This briefing is being shared with senior leaders and key health and care decision-making groups in the city, including the Health and Well-Being Board, Partnership Executive Group, Health and Social Care Gold Command, the Informatics Board and the Health and Care Inequalities group. It is intended to put people’s experiences at the heart of decision making around digitisation in Leeds. We hope it will spark a city-wide conversation and a wider process in which Leeds’ services benefit from higher levels of digitisation while health inequalities are reduced for all citizens.

As referenced in the report, this is a constantly developing landscape and the People’s Voices Group sub-group will continue to work together to hear people’s experiences of the move to digitisation over 2020 and 2021. The group will act as a central point for decision makers to link into and understand people’s real-time

experience and support them to further develop services to respond and adapt accordingly. As part of this, each individual health and care organisation within Leeds is asked to capture people's experiences of digitisation on a routine basis. The group will then produce a quarterly report with the latest insight that we have heard and highlight any gaps where people are experiencing digital exclusion and the impacts it is having on their health and wellbeing outcomes.

Recommendations for health and care leaders

	Recommendation	Lead partners
1	Use this insight to build on the existing city-wide approach to digital inclusion.	Digital Information Service (LCC) working with City Digital Partnerships Team and nominated leads in H&C organisations
2	Develop city-wide metrics to measure how digital inclusion work in Leeds is progressing.	PVG Digital Inclusion group, 100% Digital and other interested partners such as those in academic settings
3	Build digital inclusion into city-wide staff skills development programmes.	Suggest the Leeds Health and Care Academy working closely with 100% Digital and possible national partners including Skills for Health / Skills for Care, the Good Things Foundation and NHS Digital
4	Consider how the city's existing physical spaces and resources can be utilised to improve digital access for people who need it most, and identify where investment is required to support our poorest citizens first.	Digital Information Service: Smart Leeds with Leeds Informatics Board (possibly Inclusive Growth for infrastructure and investment angle)

5	Continue to extend the role that the third sector plays in providing personalised support to the people in Leeds who are most vulnerable to digital inclusion and what resources they will require to do this.	Third Sector Leeds, including Forum Central and Voluntary Action Leeds
6	Set local standards and expectations that service users can expect of all providers. (For example: "Your data will be kept securely and only shared when...") Standards to be agreed by leaders and shared with all organisations.	City Digital Partnership Team in a co-produced way. PVG to support with co-production, plus any other interested partners, for example mHabitat.
7	Develop a resource for the public in Leeds around their choices when it comes to using digital services so that a single, consistent approach is developed across health and care organisations in Leeds.	City Digital Partnership Team working with the PVG Digital Inclusion sub-group.
8	Develop a "toolkit" for frontline staff to support them to understand when digital is the right medium to deliver an intervention and help them understand the issues related to barriers to access.	City Digital Partnership team working with the PVG Digital Inclusion subgroup and Clinical senate
7	The Leeds Health Observatory to update the Joint Strategic Needs Assessment to identify risks to digital inclusion, with the aim of supporting agencies such as primary health care to tailor their approach to local needs.	LCC Policy and Intelligence Team plus other members of JSA cross-city working group, then publish findings on the Leeds Health Observatory
8	The Leeds Safeguarding Adults Board should consider the implications of digitisation on safeguarding policy and procedures and amend them accordingly.	Digital Information Service (LCC) working with City Digital Partnerships Team and nominated leads in H&C organisations

Recommendations for individual organisations (i.e.: hospitals, GP practices, local authority departments, third-sector organisations)

	Recommendation	How to identify that the recommendation has been acted on
1	Organisations to draw up their own Digital Inclusion strategy, taking into account the insight from this report. We would recommend that this strategy includes the findings summarised in section 6.	Report back to Health and Care Inequalities group .
2	Share the report with all relevant staff and assess how it relates to their work, so that good practice is identified and shared, and proposals for change can be drawn up internally.	Feed this information (and changes enacted as a result) back to a) Decision-making bodies b) Potentially the new Health and Care Inequalities group
3	Consider whether they would be willing to serve as a digital inclusion case study so that their best practice, challenges and positive changes can be shared with organisations and decision makers across the city	100% Digital to oversee submission of case studies and share with relevant organisations and decision-making bodies.
4	Assess how the digital inclusion agenda can progress in tandem with existing work around the Accessible Information Standard.	Organisation representatives to feed back their assessments to the Inclusion for All Hub and PVG subgroup.
5	Identify where: a) Further engagement work is required to gain a deeper understanding of the issues (and their scale) in Leeds and identify actions. b) Patient/service users insights can be gathered on a routine, ongoing basis.	Organisations to share findings as widely as possible, including at PVG meetings and decision-making organisation boards.

Recommendations for the People's Voices Group Digital Inclusion Subgroup

	Recommendation	Who
1	To be a central point for people experience intelligence about digital inclusion in Leeds	All PVG member organisations to routinely share the insight with Healthwatch Leeds.
2	To feed into the citywide work to develop system-wide metrics that measure digital exclusion in Leeds	All PVG members
3	To support the development of a number of practical tools: • When digital should be used – a toolkit for frontline workers to understand when digital should be used and issues that need to be considered • A resource for people in Leeds to understand what the options for them are around receiving care digitally • Support the development of a set of standards that people in Leeds can expect in relation to holding of data, etc.	All PVG members, in partnership with health and care organisations and 100% Digital
4	To develop a quarterly report that highlights people's experiences of that quarter and highlights good practice as well as gaps where digital exclusion is being experienced.	The PVG in coordination with Healthwatch Leeds
5	Identify any gaps in hearing the voices of people and commission specific pieces of targeted engagement, potentially using the Big Leeds Chat branding.	Include digital inclusion on the agenda for the Big Leeds Chat meetings and ensure that it features in upcoming initiatives.

8. Appendix

a. 100% Digital Leeds approach

The fundamental principles of the 100% Digital Leeds approach include:

- Convening community- based assets to ensure that no-one is 'hard to reach';
- Working flexibly and responsively;
- Moving to a whole system approach that enables people to independently look after themselves and improve their lives;
- Connecting people to their communities and a wider circle of care and support;
- Co-designing the right interventions with professionals and practitioners, staff and volunteers and people with lived experience.

First and foremost, COVID-19 is a health crisis and the digital response has strengthened the 100% Digital Leeds team's relationships with NHS partners, Leeds Community Healthcare and the third sector to embed digital inclusion within health and care settings.

COVID-19 further highlighted the digital divide through the implementation of video appointments, online consultations and the greater need for patients in the shielded cohort to self-manage health conditions. During the pandemic, 100% Digital Leeds has worked alongside communities to enable more people and organisations to get online. Working together has increased the delivery of Digital Health Champion training, utilised the equipment lending scheme and shared tools and resources to enable health professionals and staff in health and care settings to embed digital inclusion in their approach. Work has been targeted in priority wards and areas with the highest health inequalities.

Support for third sector organisations has included the provision of data, equipment and devices, grant funding, technical support, Digital Champions training, plus advice on how to tackle digital inclusion issues particular to their own organisation.

How 100% Digital Leeds can support the recommendations and next steps for the PVG group

100% Digital Leeds will continue to:

- Deliver Digital Health Champion training with all staff across Health and Care supporting the digital ready workforce programme.
- Support the Digital Health Champion training to be embedded within the Health and Care staff skills development programmes for new and existing staff, increasing opportunities for digital inclusion to be embedded within clinician to patient communication.
- Work with third sector organisations to embed digital inclusion within community settings, adapting a person-centred approach, coproducing digital inclusion to meet the needs of service users.
- Implement and develop the Digital Health Hub model across Leeds partnering third sector organisations with local Health and Care providers.
- Engage with each LCP to develop a localised plan and approach to tackle digital inclusion in supporting health inequalities.
- Use the 100% Digital Leeds evaluation framework to highlight case studies and impact of digital inclusion across Health and Care, and share these across organisations to promote sharing best practice increase tools and resources.

b. Members of the Digital Inclusion Subgroup

Members based in health and care organisations:

- Samantha Hirst (LCHT)
- Neil Maguire (LCHT)
- Suzanne Slater (LCHT)
- Heather Thrippleton (LCHT)
- Joanne Twigger (LCHT)
- Angela Medd (NHS England)
- Sophie Edwards (NHS England & NHS Improvement)
- Leisa Batkin (NHS Leeds CCG)
- Alison Best (NHS Leeds CCG)
- Chris Bridle (NHS Leeds CCG)
- Angela Collins (NHS Leeds CCG)
- Caroline Mackay (NHS Leeds CCG)
- Patricia McKinney (NHS Leeds CCG volunteer)
- Sharon Moore (NHS CCG Leeds)
- Natasha Noor (NHS Leeds CCG)
- Rosemary Horsman (LTHT)
- Krystina Kozlowska (LTHT)
- Caroline Otieno (LTHT)
- Jennifer Wilson (LTHT)
- Sayed Ahmed (LYPFT)
- Amy Hirst (LYPFT)

- Rachel Pilling (LYPFT)
- Helen Thompson (LYPFT)
- Jennifer Fletcher (St Gemma's)
- Clare Russell (St Gemma's)

Members from Leeds City Council:

- Anne Arnold (Health Partnerships Team)
- Kuldeep Bajwa (consultation and involvement officer)
- Rachel Benn (100% Digital Leeds)
- Bebhinn Browne (health improvement specialist)
- Richard Cracknell
- Lisa Gibson
- Hannah Lamplugh
- Hannah McGurk
- Ade Winterburn
- Lelir Yeung

Members from the community sector:

- Wendy Cork (Advonet)
- Karen Fenton (Forum Central)
- Lucy Graham (Forum Central)
- Karl Witty (Forum Central)
- Anna Chippindale (Healthwatch Leeds)
- Hannah Davies (Healthwatch Leeds & People's Voices Group Digital Inclusion Subgroup chair)

- Dex Hannon (Healthwatch Leeds)
- Stuart Morrison (Healthwatch Leeds)
- Jonathan Phillips (Healthwatch Leeds volunteer)
- Karl Proud (Leeds BID)
- Jagdeep Passan (Leeds Involving People)
- Emily Turner (Leeds Women's Aid)
- Lucy Graham (Forum Central)
- Karen Fenton (Forum Central)
- Karl Witty (Forum Central)
- Sarah Fox (Touchstone)
- Jim Leyland (Touchstone)
- Alison Lowe (Touchstone)
- Sally Poyser (Touchstone)
- Iona Lyons (Voluntary Action Leeds)

Members from academic and research organisations:

- Ruth Coulthard (Leeds Academic Health Partnership)
- Roz Davies (mHabitat)
- Amy Rebane (NIHR Leeds Biomedical Research Centre)

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