YOUTH HEALTH PARLIAMENT

HANDING BACK CONTROL

REDUCING DEMAND THROUGH PATIENT EMPOWERMENT

DECEMBER 2016

YOUTH HEALTH PARLIAMENT

CONTENTS

1 EXECUTIVE SUMMARY

As the gap between demand and supply within the NHS grows unsustainably, both financial and clinical targets continue to be missed. The NHS is in need of a strategic rethink to identify new sources of efficiency. It is well known that patients with health literacy skills are able to better navigate healthcare systems and make healthier choices. Therefore, this report presents novel recommendations to help empower patients using community resources and technology, thus enabling them to take greater control over the delivery of their own healthcare.

Through identifying problem areas along the entire patient journey, seven policies are proposed to ensure that patient empowerment does not remain a platitude. The proposals are intentionally innovative and challenging. They draw upon existing successes to suggest new creative routes to healthcare, whilst striving to avoid the mistakes of past attempts. Four sequential steps along the healthcare journey have been identified as areas for improvement.

STEP ONE:
HEALTHCARE EDUCATION

Patients are underprepared from the very start of their journey. There is no formal process for learning how to use the health service appropriately.

RECOMMENDATION 1:
A FOUNDATION EDUCATION IN HEALTH

Compulsory health education in schools, focusing on healthy living, common health conditions, and when and where to access appropriate services in the NHS.

STEP TWO:
HEALTHCARE INFORMATION

Motivated patients can turn to online health information for assistance, although many have difficulty discerning its quality and trustworthiness.

RECOMMENDATION 2:
THE REGULATION OF HEALTH INFORMATION

NHS to promote websites containing high quality healthcare information by providing an NHS accreditation logo, or kitemark, that is easily visible and well recognised as a stamp of reliability.

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RECOMMENDATION 3:
AN IMPROVED ONLINE DIAGNOSTIC TOOL

NHS to partner with a major search engine to provide an accessible diagnostic tool that can direct patients to the most relevant local health services, without them having to access a health specialist website such as NHS Choices.

STEP THREE:
HEALTHCARE PROVISION

In spite of online information, health issues can remain unresolved due to stigmatisation or delayed clinical visits. Furthermore, as the demand for health services continues to increase, traditional methods of delivering healthcare are being challenged.

RECOMMENDATION 4:
NON-TRADITIONAL COMMUNITY HEALTHCARE EXPERTS

Central and local government to make funding available for the training of non-traditional sources of healthcare information, such as hairdressers, teachers and tattoo artists, who can be engaged to support local communities by using their positions in society to help recognise health symptoms and direct patients to appropriate sources of care.

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RECOMMENDATION 5:
PROMOTING AND UPSCALING THE USE OF TELEHEALTH

NHS to incentivise healthcare professionals to utilise and upscale telemedicine to engage and communicate with patients outside of the clinic and spearhead a culture shift towards the acceptance of the technology.

STEP FOUR:
HEALTHCARE INVOLVEMENT

Regardless of the provider, healthcare information discussed with patients is often not understood at the time, or else quickly forgotten. This increases patients' reliance on healthcare professionals for the day-to-day management of their condition.

RECOMMENDATION 6:
THE APP'Y PATIENT

NHS to create a safe and user-friendly consultation app that provides the patient with specific information about their consultations, condition and medication.

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RECOMMENDATION 7:
THE EQUIPPED PATIENT

NHS to empower patients to take control of their health and chronic conditions through tailored education, joint care planning and by giving them the tools to measure, monitor and manage their conditions.

Although challenging, this strategy aims to ensure that individuals take ownership of their health, access reliable health information and find the most appropriate provider. Such an approach aims to improve individual patient experience of healthcare whilst ultimately reducing avoidable demand for health services.

2 INTRODUCTION

The NHS exists in a state of turmoil, at a time when demand for services is growing far more quickly than the system can afford. Referrals to hospital have risen by 20% since 2010, three times faster than spending (The Economist, 2016), whilst the number of people waiting in Accident and Emergency is at its highest point in decades (The King's Fund, 2016). The impact of these pressures is clear: in 2015 nearly 90% of NHS trusts were in deficit (The Economist, 2016). All the while, vital indicators, such as cancer survival rates, show the NHS lagging behind comparable countries (Walters et al., 2015).

This situation is clearly unsustainable. The Nuffield Trust (2012) estimates that the NHS will face a budget gap of £30 billion by 2020, with the Department of Health pledging less than a third of this amount in additional funding. As demand continues to grow, the NHS will need to identify fresh sources of efficiency. New models for managing demand have become an unavoidable area of focus for the NHS, and will continue to direct the quest for efficiency.

Preventable demand for health services is found at every step along the patient journey. Patients with poor health literacy are at greater risk of avoidable conditions. This is exacerbated by the existence of inaccurate health sources, which have the potential to cause patients harm. A lack of education about the health system itself means patients often use inappropriate channels to access care. Often at the point of need, the most appropriate channels are not accessible, or difficult to navigate (Royal College of General Practitioners, 2014). This presents a risk to patient safety and can lead to worsening of health problems, which increases the burden on the NHS. Finally, after diagnosis, patients do not always have the tools to self-manage their conditions, adding to the demand faced by clinicians. Technological solutions to these problems are still underutilised (Digital Health, 2006), making it ever more difficult for patients to be involved in their own care.

These are the consequences of a health service not yet equipped to meet the coming challenges. Each shortfall curtails the process of patient empowerment. An empowered patient is defined here as a health literate individual who is able to obtain, process and understand basic health information (Morgan, 2016). This enables them to think critically and act more autonomously by effectively navigating the healthcare system while making contributions to decisions about their healthcare and the services they require (Morgan, 2016).

Patients who are not empowered cost up to 21% more than those that are (Purdy, 2010), as they are more likely to make unhealthy choices and use emergency care (The King's Fund, 2016). Despite strong evidence supporting patient empowerment, there is a lack of focus on this initiative.

This report outlines how the empowerment of patients can be achieved. This will provide patients with the tools to better manage their health, reduce inappropriate use of services and ultimately, help curtail the rise in demand. Such an approach aligns closely with a novel model of partnership envisioned by the NHS through its 50 new 'care model vanguards' (NHS England, 2016). This paper sets out the route to achieving patient empowerment amidst an evolving healthcare environment, thus ensuring the long-term survival of the NHS.

3 OPPORTUNITIES TO EMPOWER PATIENTS AND REDUCE DEMAND

3.1 HEALTHCARE EDUCATION

Patient education is teaching individuals about their conditions and encouraging them to have greater understanding so they are better placed to make decisions about their care plan while coping better in everyday life (WHO, 2009). This can improve decision making, promote healthy behaviour and empower patients to participate in the delivery of their own healthcare. Numerous trials have demonstrated the benefits of patient education across several chronic diseases, including asthma (Couturaud et al., 2002) and diabetes (Khunti et al., 2012).

Although there are education programmes for adults with chronic illnesses, there is no formal education on prevention and early intervention in schools. Currently, 'Personal, Social and Health Education' (PSHE), which covers the broad topics of substance misuse, sexual health, healthy lifestyles and mental health, is taught in some UK primary and secondary schools. However, PSHE is largely non-compulsory and Ofsted have noted that '40% of PSHE teaching is less than good' (Morgan, 2016).

Teaching around self-management of health conditions and appropriate use of healthcare services is not in the PSHE Guidance. Targeted education in these areas, particularly around conditions commonly seen by GPs – such as upper respiratory tract infections, back conditions and depression – could help to reduce the burden on the health service.

A cultural and educational shift is required to encourage the use of non-GP and A&E sources of health information and support. For example, 91% of patients think that pharmacists only dispense medications; the majority do not appreciate that pharmacists can also be a source of advice, a view held particularly by younger people (East Berkshire Primary Care: Out of Hours, 2015).

Evidence shows that well-designed and executed programmes can lead to long term health benefits, with examples including the 'Friends for Life Program' (Briesch et al., 2010). Interactive

curricula with a similar focus have been explored in the US (U.S. Food and Drug Administration, 2013), and current education in the UK surrounding oral healthcare has been successful. These could be replicated across other healthcare domains, and by pairing pupils' education with parent education, benefits may be enhanced.
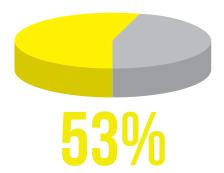
3.2 HEALTHCARE INFORMATION

People are increasingly using the internet to find healthcare information; roughly 1% of all Google searches globally are related to a health symptom or concern (Pinchin, 2016). However, information accessed online is often unregulated and a number of studies have shown that accuracy and reliability is poor (Lissman and Boehnlein, 2001).

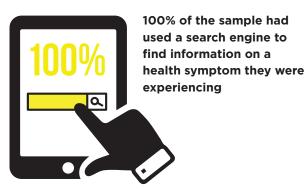**One study revealed that only**

43.5%

of the first 1300 results of a health search provided information that was consistent with national health guidelines, such as those of the National Institute for Health and Care Excellence (NICE) (Rehman, 2012). In light of this, it is worrying that
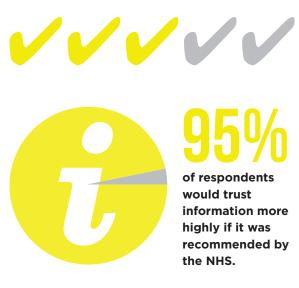

53%

of the general population use information online to influence decisions about their health.

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To support the existing literature, we conducted a survey of 100 people which showed:

100% of the sample had used a search engine to find information on a health symptom they were experiencing

On average, users rated the trustworthiness of information found online 3 out of 5 (with 5 being complete trust and 0 being no trust at all).

95%

of respondents would trust information more highly if it was recommended by the NHS.

Although there are specialist health information websites such as 'NHS Choices', which provides comprehensive health information to help patients make the best choices about their health (NHS Choices, 2016), only 13% of the general public will start an online search by using such sites (PMGroup, 2014). By contrast, 77% of the general population will access a major search engine to look up health symptoms (PMGroup, 2014), something that one third of the population admit to doing in order to self-diagnose (Gann, 2012).

Despite possible dangers of the internet, it is a potentially powerful healthcare tool. In a review conducted in 2015 there were found to be 23 "Online Symptom Checkers" (OSCs), the term given to computer algorithms that enable patients to self-triage or self-diagnose (NHS Choices, 2015). In these OSCs, triage appropriateness was found in 80% of emergency cases and 55% of non-emergency cases (Semigran et al., 2015). While low accuracy can risk unnecessary patient mortality or the cost of unnecessary appointments (Semigran et al., 2015), high accuracy OSCs can lead to beneficial outcomes by quickly signposting patients who require care and reassuring patients who do not (Saczynski et al., 2008; Poote et al., 2014). OSCs combined with Global Positioning Systems (GPS) can also be used to help patients locate their closest and most appropriate health service, based on their symptoms.

The Anthem Blue Cross in Virginia has created an online map of health clinics and urgent care centres to direct patients to the appropriate care provider. This feature has assisted more than 60% of patients who would have otherwise unnecessarily attended the emergency department.

(Clarke, 2010).

3 OPPORTUNITIES TO EMPOWER PATIENTS AND REDUCE DEMAND

The benefits of internet-based health information and OSCs are enhanced through structured, personalised tools such as shared decision aids, which present the risks and benefits of treatment options in formats patients can understand (Bessière et al., 2010).

The reality is that patients will continue to search their symptoms online through major search engines. While certification such as the Information Standard, introduced by NHS England in 2009, already exists (NHS England, n.d.), the application process is voluntary and often complex; moreover, certification is not visible to the public until they actually open a webpage. Consequently, it is not possible to easily and conveniently identify reliable sites from the search results page of a major search engine. Therefore, in order to enhance the potential benefits of the internet whilst minimising dangers, there needs to exist a tool that guides and empowers patients to make use of the most appropriate health services available, as well as an instantly visible system that highlights trustworthy online health tools and information.

3.3 HEALTHCARE PROVISION

As the demand for health services continues to increase, traditional methods of delivering healthcare are being challenged. The increasingly interactive role that community members and technology can play in healthcare has the potential to create positive change that can help the NHS efficiently meet growing demand.

Health information delivered in a group setting, or by other individuals suffering from similar conditions, has been shown to be particularly beneficial to patients and cost effective for the NHS, especially as such programmes are often run by volunteers. These volunteers are examples of "non-traditional healthcare advisors" who, if trained, are able to improve patient outcomes (Eakin et al., 2002). This idea aligns with the concept of Asset Based Community Development (ABCD), which implies that communities themselves can drive development by identifying and mobilising existing, but often unrecognised assets, notably local individuals and established networks.

In the UK, North Bristol NHS Trust has run educational events for local tattoo artists to teach them how to spot potential signs of melanoma and signpost patients to seek further advice. This has also been seen to work in other professions such as hairdressers, barbers and podiatrists (North Bristol NHS Trust, 2016). Another successful example is provided by the Camden Clinical Commissioning Group, which funded mental health training for local barbers, helping them to identify, signpost and manage mental health difficulties (NHS Camden CCG, 2016). These schemes help identify health problems early, thus reducing long-term social and health care costs. There is mounting evidence to suggest that empowering patients through the use of non-traditional healthcare advisors would help reduce demand and improve health outcomes for specific conditions (Perfetti, 2013).

Commitment from local and central government is necessary for non-traditional healthcare advisors to become a reality, and resources to train these individuals need to be considered. However, research suggests that supporting patients through non-traditional means could save over 31 million GP appointments, easily offsetting the additional costs (Clay and Stern, 2015).

There is also a growing body of evidence to suggest that healthcare services could be made more efficient through the use of telehealth (Cruickshank et al., 2010). The WHO defines telehealth as 'The delivery of healthcare services, where distance is a critical factor, by all healthcare professionals using information and communication technologies'. This includes email, telephone/video consultations and mobile messaging.

Telephone and video consultations are forms of telehealth that have been used for several years. Research has shown them to be hugely successful in terms of patient satisfaction, with 95% of patients saying they would use the service again (Central London Clinical Commissioning Group, 2014). The Airedale NHS Foundation Trust is realising savings

3 OPPORTUNITIES TO EMPOWER PATIENTS AND REDUCE DEMAND

of around £5 million per year predominantly through a 45% reduction in hospital admissions from care homes and prisons (NHS Providers, 2015). Investment into (online) e-consultations has been part of the Prime Minister's Challenge Fund, with six pilots providing access to 250,000 patients (NHS England, 2015). Several individual GP practices have also demonstrated the feasibility of telehealth on a local scale with reduced patient demand (NHS Networks, n.d.).

Due to these advantages and the increase in internet use by the general population, telehealth is an appealing solution. However, as many as 90% of patients are unaware of, or have yet to experience, telehealth, which is likely contributing to poor uptake (Nijland et al., 2009). And while the engagement of healthcare professionals with telehealth services is critical for success, clinicians are not obligated to recommend the use of telehealth and receive no formal training on reliable and optimal options (National Assembly for Wales, n.d.).

For telehealth to be successful there needs to be improved patient awareness and development of a culture that is accepting of these changes. Telehealth also requires a coherent national plan for its implementation, to create a service familiar to all patients. The use of technology to help patients engage and communicate better with the health service provides opportunities for increased patient empowerment.

3.4 HEALTHCARE INVOLVEMENT

Approximately 15 million people in the UK are currently living with at least one chronic health condition (Department of Health, 2012). These conditions place a huge resource burden on the NHS and account for £7 out of every £10 spent on health and social care (Department of Health, 2012). There are extensive opportunities to improve patient experience and reduce expenditure by engaging these patients in better self-care and ensuring they have a holistic understanding of their condition.

Several studies show that patients forget approximately two-thirds of information discussed during consultations, and a large number do not fully understand the information received (Makaryus and Friedman, 2005). If patients have poor understanding of their treatment plan or diagnosis it can affect their medication compliance; this is estimated to cost the NHS £500 million annually (Hagan, 2015). Patients who are engaged with their treatment reduce NHS costs in other ways; physician supported self-management has been shown to increase patient satisfaction, improve the patient-doctor relationship and reduce hospital admission rates in a broad range of conditions (O'Kane et al., 2015).

There have been several efforts to ensure patient self-management is widely adopted:

- The 'Co-Creating Health' programme aimed to embed self-management into all standard UK health services. The Long Term Conditions Year of Care Commissioning programme was a handbook published to help commissioners achieve this (The Health Foundation, n.d.).

- Self-Management UK is a leading charity providing generic and disease-specific courses for patients with chronic diseases (Self Management UK, n.d.).

- The Expert Patients' Programme demonstrated reductions in patient pain, disability and fatigue (Foster et al., 2007) and was considered very likely cost effective (Richardson et al., 2008).

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Despite the compelling case for patient self-management, primary and secondary care services have not fully engaged with the programme (Kennedy et al., 2007). For self-management to be effective it needs to be seen as a priority by clinicians, and implemented sensitively to avoid unnecessary patient anxiety.

Research shows that the best methods of delivering information to patients are designed around their needs and change in accordance with their situation (Mathers and Paynton, 2015). The information should also be available at the right time and in the correct format. Technological progress enables patients to now receive "tailored information that is contextualised and personalised e.g. directly relevant and easily comprehensible to the person's own health situation" (Kennedy et al., 2014). The rise in smartphone ownership provides an opportunity to develop a regulated, permanent and patient specific information source. However, it is vital that patient privacy and data protection is maintained throughout this process in order to instil public confidence in the system (Huckvale et al., 2015).

A systematic review of the use of mobile phone apps by Coronary Heart Disease patients showed significant improvements in patient outcomes with minimal usability issues (Beatty et al., 2013). Other technologies such as activity, heart rate and blood pressure monitors have also been successful in supporting self-management (Zheng et al., 2010). Decision support systems can help to detect abnormal activity based on monitor readings enabling early, well informed treatment alterations (Zheng et al., 2010). Research suggests patients are supportive of the introduction of this technology (Vanhoof et al., 2015).

Empowering patients to understand and co-manage their condition, in conjunction with their physician, has been shown to have wide-ranging benefits. However, implementation of these strategies has not yet been effective. NHS England could realise savings of at least £4.4 billion a year from reduced A&E attendance, hospital admission, and outpatient attendance if they were fully adopted (NESTA, 2013).

4 RECOMMENDATIONS: THE BEST OPPORTUNITIES TO REDUCE DEMAND ON THE NHS

4.1 RECOMMENDATION 1: A FOUNDATION EDUCATION IN HEALTH

Compulsory health education in schools, focusing on healthy living, common health conditions, and when and where to access appropriate services in the NHS.

There are no modules within schools that develop the capabilities of future health service users to navigate the NHS and assess when their needs require specialist clinical support. We propose that a module is introduced within schools, possibly through PSHE, that covers topics such as healthy living, basic health conditions and, most importantly, when as well as where to access appropriate services in the NHS. For this education module to succeed it must be a compulsory component of the curriculum and taught throughout all school years, ensuring that sufficient time is allocated to guarantee accurate and continuous learning. This should be an examinable subject to highlight its importance and allow progress to be measured. Pooled funding for the module should originate from the Department of Education and the Department of Health. The module must be run collaboratively with universities, GPs and community healthcare professionals to actively help develop and deliver the programme. Teaching of pupils should be partnered with parent health education sessions to guarantee consistent messages are delivered and demonstrated outside of the classroom. This recommendation represents a sustainable and long term solution to help reduce the growing demand on the NHS.

4.2 RECOMMENDATION 2: THE REGULATION OF HEALTH INFORMATION ONLINE

NHS to promote websites containing high quality healthcare information by providing an NHS accreditation logo, or kitemark, that is well recognised as a stamp of reliability.

We propose that the current Information Standard (which indicates a reliable source of health and social care information) should be made more visible and easily identifiable. Firstly, the logo must be viewable on the search results page when looking for websites rather than only once the website has been visited. Secondly, the Department of Health should partner with Google to ensure that websites meeting the standard appear at the top of the search page. This must be combined with changes to practice whereby healthcare professionals actively direct patients to verified sites, and where the Information Standard actively seeks health information sites to accredit, especially those that have been shown to be highly popular resources based on usage figures.

4.3 RECOMMENDATION 3: AN IMPROVED ONLINE DIAGNOSTIC TOOL

NHS to partner with a major search engine to provide an accessible diagnostic tool that can direct patients to the most relevant local health services, without them having to access a health specialist website.

The majority of online health searches are via major search engines rather than specialist websites like NHS choices. We propose that when patients search symptoms online using a major search engine, they be immediately presented with simple follow up questions from an NHS triage tool. This would help individuals easily identify whether they need to access professional support without necessarily having to visit a specialist health website first. The triage tool must be enhanced by global positioning systems technology so that individuals can be directed to appropriate local health services, for example a pharmacist, community nurse, GP or local patient group.

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4.4 RECOMMENDATION 4: NON-TRADITIONAL COMMUNITY HEALTHCARE EXPERTS

Central and local government to make funding available for the training of non-traditional sources of healthcare information, such as hairdressers, teachers and tattoo artists, who can be engaged to support local communities by using their positions in society to help recognise health symptoms and direct patients to appropriate sources of care.

We propose that 'lay' individuals in the community have access to training and support related to specific local health needs to become non-traditional healthcare advisors. This would be voluntary training, focused on individuals with regular contact with the general public (such as teachers, hairdressers, tattoo artists) or those who themselves live with chronic conditions. The proposed system would harness these advisors' unique position to identify individuals who may be experiencing health difficulties and correctly signpost them to appropriate services. In some instances, this would act as a form of early intervention and would lead to clinician's time being used more effectively. National and local government funding would need to be allocated to this system.

4.5 RECOMMENDATION 5: PROMOTING AND UPSCALING THE USE OF TELEHEALTH

NHS to incentivise healthcare professionals to utilise and upscale telemedicine to engage and communicate with patients outside of the clinic and spearhead a culture shift towards the acceptance of the technology.

We propose that telehealth should be expanded and promoted by healthcare professionals through the use of government funded incentive programmes. These programmes must reward healthcare providers that actively engage patients through the use of telehealth to improve the efficiency of healthcare delivery. The use of telehealth must become a routine alternative to being seen in person, thus healthcare professionals need to take an active role in promoting and building the capacity of patients to utilise the technology. Telephone clinics and video conferencing appointments already exist and must be expanded upon to allow patients to send data collected on a smartphone relating to their health, such as photos of visible symptoms. Increased use of telehealth offers the chance to reduce the number of patients needed to be seen in clinic, promotes regular contact with healthcare teams and reduces disruption to work or family life, potentially improving treatment outcomes for patients whilst reducing the long-term burden on the NHS.

4.6 RECOMMENDATION 6: THE APP'Y PATIENT

NHS to create a safe and user-friendly consultation app that provides the patient with specific information about their consultations, condition and medication.

There is an increasing prevalence of patients with more than one chronic condition. These patients often require multiple forms of treatment and are at greater risk of medical complications. Management of their conditions must be made simple and easy so they can take greater control of their own health. We recommend the creation of an NHS Choices app as a simple resource for storing generic information about personal conditions and medications. Specific information, such as medication regimen, could be added onto the app by the healthcare professional. Although information contained in this app would not be transmitted and remain private to the patient's device, patients would consent to this scheme and the app would be password protected to ensure privacy and data protection was maintained. This would enable quick and secure access to health information, while potentially increasing medication adherence and personal knowledge of relevant health conditions.

4 RECOMMENDATIONS: THE BEST OPPORTUNITIES TO REDUCE DEMAND ON THE NHS

**4.7   RECOMMENDATION 7:
         THE EQUIPPED PATIENT**

NHS to empower patients to take control of their health and chronic conditions through tailored education, joint care planning and by giving them the tools to measure, monitor and manage their conditions.

It is well known that patients with chronic health conditions put considerable demand on the NHS. As such, we propose that patients with a chronic condition should be offered the basic tools to measure, monitor and manage their own health, where they have suitable capacity, so they can take a more active role in their health condition. The healthcare professional must therefore have dedicated time to educate the patient, to agree goals and co-create a care plan. Education will include how to use simple tools and available technology that can measure vital signs and take other condition-relevant readings. This data should be inputted by patients into an interactive portal that clinicians can access. Education will be followed up by patient surveys that assess the individual's understanding of their condition, when and where to seek clinical support, and whether they would be able to give advice to a friend with a similar condition. In the long term, this could significantly reduce avoidable appointments.

5 CONCLUSION

The empowerment of patients is not an overnight task. Implementing the principles of patient education and support requires a long-term investment of focus, and the use of new technology will be crucial to bringing about this change. However, it is not just technological innovation, but cultural innovation, which will determine the success of the policies recommended here. The major challenge will be ensuring that an increase in access to services does not bring with it an increase in demand.

It is for this reason that an original combination of policies is proposed, which are nonetheless supported by a robust evidence base. Thus, policy makers can build a future in which demand for health services is more manageable, patients are more able to take ownership of their healthcare, and the healthcare system is sustainable once again.

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HANDING BACK CONTROL
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HANDING BACK CONTROL
REDUCING DEMAND THROUGH PATIENT EMPOWERMENT

The following insights come from interviews and research conducted by the Youth Health Parliament, a group of highly motivated and passionate future leaders determined to shape the future of the NHS.

YOUTH HEALTH PARLIAMENT
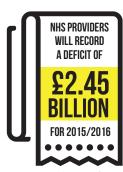
PATIENT EMPOWERMENT:

Is the process of helping patients gain greater control over their own healthcare...Patient empowerment has the potential to improve health outcomes and reduce costs on the NHS by:

1. Improving health literacy, which is shown to increase healthy lifestyle choices.

2. Giving patients the confidence to be more involved in decisions about their care, thus increasing compliance.

NHS PROVIDERS WILL RECORD A DEFICIT OF
£2.45 BILLION
FOR 2015/2016

Source: King's Fund 2016

1. IMPROVE HEALTHCARE EDUCATION

We must better prepare patients for navigating the NHS by providing basic mandatory education on healthcare services and health topics within schools.

92% OF PEOPLE
did not receive formal health education in schools

Source: YHP 2016 survey

100%
OF PEOPLE
in our survey had used Google to find health information

Source: YHP 2016 survey

2. SHARE AND PROTECT HEALTHCARE INFORMATION

We must ensure that the information that patients access online is trustworthy and safe by accrediting high quality reliable sources and providing links to local services.

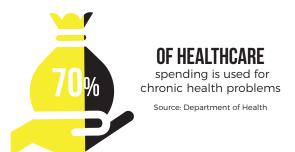## 3. INVENT NEW METHODS OF HEALTHCARE PROVISION

We must find new and innovative ways of using the resources already available to us, such as telehealth and local community members, to improve the provision of health care and improve patient access.

45%
REDUCTION
in hospital admissions from care homes with the introduction of telehealth

Source: Airedale Trust

70%
OF HEALTHCARE
spending is used for chronic health problems

Source: Department of Health

4. EQUIP PATIENTS FOR HEALTHCARE INVOLVEMENT

We must enable patients to be more involved in their long-term healthcare by ensuring they have access to tools that allow them to measure, monitor and manage agreed health goals with their healthcare professional, thus helping them become more actively involved in their care planning.

PATIENT EMPOWERMENT IS ESSENTIAL FOR THE SURVIVAL OF THE NHS.

Educate, Inform and Involve patients in their own care so that the NHS can continue to be a key provider of healthcare in the UK. Without innovative change there can be no progression, so we encourage you to support our movement and help us in

HANDING BACK CONTROL