System and Organisational Health Literacy

Delivering improved population health outcomes, tackling health inequalities & improved health and care performance

For further information or guidance please contact Dr Mike Oliver
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Executive Summary

This document targets System and Organisational Health Literacy.

Health literate organisations support:

- The key policy priorities of Integrated Care Systems
- Organisational effectiveness and efficiency in healthcare systems
- The Public Sector Equality Duty

Taking action on health literacy is one of the easiest ways for Integrated Care Systems and providers to contribute to their core purpose. It supports:

- **Improved health outcomes** for patients and others by having better understanding and engagement with their care. It should underpin all day-to-day healthcare interactions. Those with lower levels of health literacy have poorer health outcomes.[1]
- **Tackling health inequalities** by acknowledging and responding to the fact that different groups have different health literacy levels and have differing abilities to access and act on healthcare information. Almost half of UK adults find it hard to understand written health information, and this rises to over 60% when numbers are included.[2]
- **Improved productivity** through reducing waiting lists by improving attendance or improved self-management. A health literate organisation helps service users to find, understand, and use information and services to inform their health-related decisions and behaviours for themselves and others.[3]

Health literate organisations that make it easier for people to find, understand and act on health information will further support:

- Personalised care, choice, shared decision-making and informed consent
- Increased self-management and preventative health behaviour
- Improved patient safety and reductions in preventable deaths
- Reductions in unnecessary treatments and prescribing, improved adherence to treatment advice and protocols, improvements to medication and health-behaviour compliance, and a reduction in wasted medication

The first part of this document provides a strategic steer for inequality Senior Responsibility Officers and others.
<u>The second part of this document</u> provides case studies to illustrate the challenge and examples of where it is being addressed.
<u>The third part of this document</u> provides the detail behind the strategic drivers outlined in part one.

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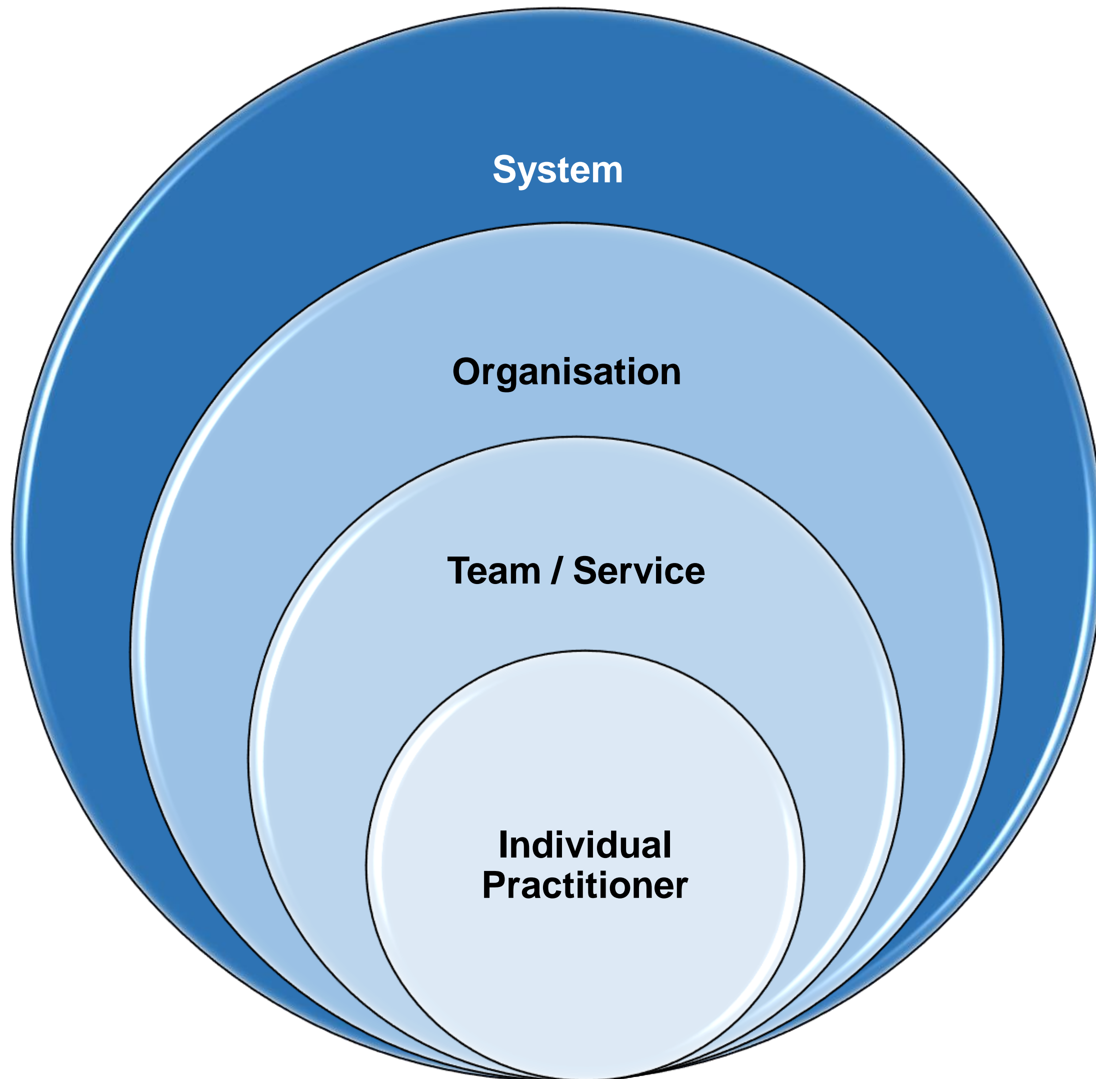
Part 1: A mature health literate system



The healthcare system locally/nationally recognises the importance of health literacy as a component of addressing health inequities. The system provides leadership, resources and support to enable healthcare organisations to become more health literate.

Organisations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. They are supported in this by the healthcare system within which they operate.

Teams put health literacy at the heart of the way they support their service users. Team leaders actively encourage team members to become confident and capable of becoming more health literate in how they support service users. Teams are supported by their organisation in doing this.

Healthcare practitioners know what health literacy is and how important it is. When they communicate, whether verbally or in writing, they do so with health literacy in mind. Practitioners are supported in doing this by their team and organisation.

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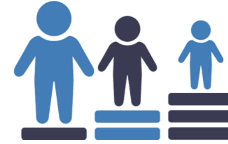
System and Organisational Health Literacy: Drivers for key outcomes and priorities



Promoting health equity & tackling health inequalities

Enabling the core purpose & features of ICSs

Improving organisational effectiveness and efficiency (finances)

Improving patient safety & reducing preventable deaths

Tackling waiting lists

Reducing inappropriate use of A&E

Improved health outcomes for service users & patients

Reducing DNAs

Increasing medicine compliance and reducing wastage

Enabling personalised care

Underpinning shared-decision making & informed consent

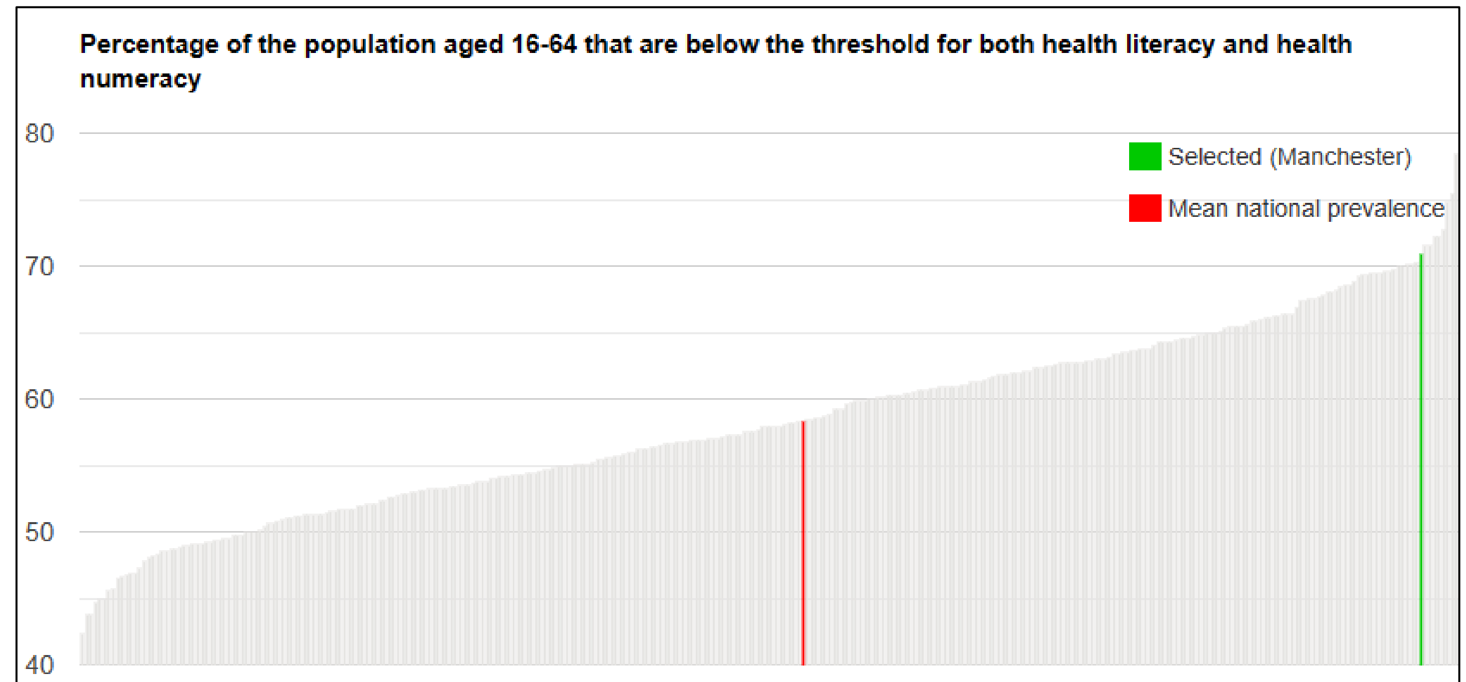
Underpinning behavioural science

Increasing self-management & preventative health behaviour

The scale of the issue

- **43% of UK adults find it hard to understand written health information,** and this number rises to 61% when numbers are included.[2] In some cities this is as a high as 70% (e.g. Manchester & Birmingham)
- Health literacy is more than pure literacy skills, but it is still important to note **that 1 in 6 adults (7.1 million) in England read and write at or below the level of a nine-year-old.**[4]
- The Government's content and publishing team are aware of the way people read and take in information, and advise people on GOV.UK websites to write for a **9-year-old reading age.**[5]

The http://healthliteracy.geodata.uk/[6] shows the health literacy levels across England. Built in partnership between NHS England and the University of Southampton, it provides an estimate of the percentage of a local authority population with low health literacy and numeracy or with just low health literacy. You may wish to explore this for the areas that you are most interested in. It indicates that, on average, 38.7% of the population aged 16-65 do not understand written and spoken health information and 58.3% do not understand when numbers are included in the information.



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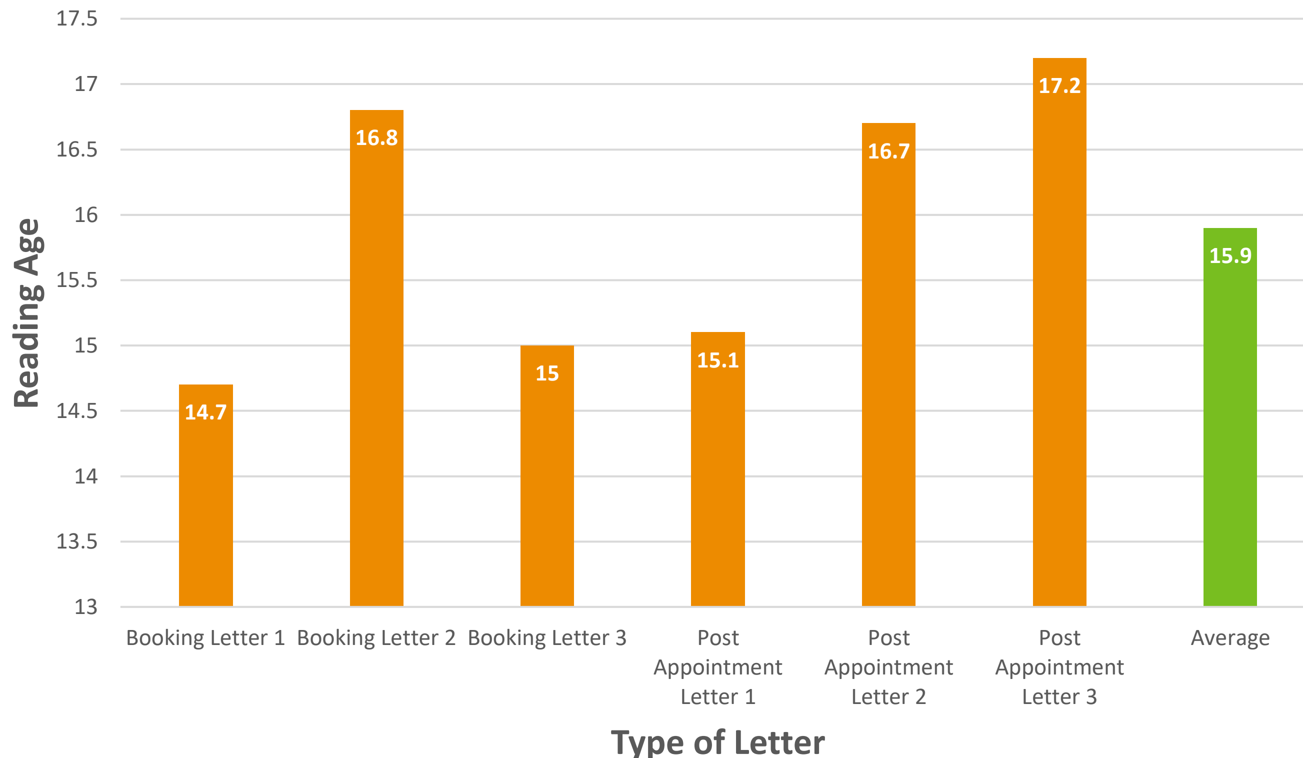
Healthcare organisations can put barriers in the way

A large NHS Trust audited their communication in 2023 and found that the average reading age for letters and patient information leaflets provided by their services was 16 years old. Given that the reading age of so many UK adults is below this[4], large numbers of people are excluded from being able to understand and act on the information.



Below is an example of a recent letter from a hospital to a patient, copied to the patient's GP.

The complexity and technical language are a barrier to understanding. **It has a reading age of 18.**

, I hope this letter finds you well.

We have now the results of your CT Cardiac coronary angiogram done on 23/10/2023 which showed Two identifiable grafts, namely LIMA to LAD and SVG to OM. The LIMA graft appears to be mildly diseased distally, however there is optimal opacification of the anastomosis and the target vessel distally. Severe stenosis of the dominant RCA with no appreciable graft to it.

Overall, the CT-scan showed two patent grafts to the left coronary system but no identifiable graft to the right coronary artery which itself has diffuse disease with area of severe stenosis.

In my opinion both tests, ECHO and cardiac CT scan were reassuring and we recommend to continue on medical treatment. If you have further questions, please let us know. Thanks

Yours Sincerely

Dr

Health literacy barriers may also exist in terms of:

- Verbal communication with patients
- Signage and physical access to healthcare settings

A health-literate organisation works to address these barriers.

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The process underpinning organisational health literacy

Organisational Change Management

+

Health Literacy Best Practice

→

Health Literate Organisation

- Leadership commitment & policies
- Co-production & service user engagement
- Staff awareness & ways of working
- Written communication
- Verbal communication
- Physical layout
- Evaluation & continuous improvement

Health Literate Organisation

The case studies later in this document provide examples of where this is happening.

The NHS Health Literacy Toolkit[7] is also a valuable resource to support this parts of this process.

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Document history and acknowledgements

Intended audience

This document is primarily intended for senior leaders within the health and care system who have a responsibility for **tackling health inequalities.** It will also be of interest to those involved or interested in how improved system and organisational health literacy can support improved population health and patient outcomes.

Commissioners note

This document was commissioned by Natasha Koerner, Portfolio Manager, Midlands Region, WT&E, NHS England:

"Embedding public health core skills, including health literacy, across the NHS workforce is necessary to improve population health. By improving what, how and when we communicate, we can support people to manage their health needs and prevent poor health.

Additionally, a focus on good practice organisational health literacy results in a more inclusive NHS, opening up employment opportunities and enabling the NHS to become representative of the communities it serves.

Improving health literacy at individual, organisational and system level, contributes to both the NHS Long Term Plan and the NHS Long Term Workforce Plan."

Document author

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Jonathan Berry	Steering Group Member, Health Literacy UK Former NHS national lead for Health Literacy and Shared Decision Making

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Part 2: Health Literacy in Action: Case Studies

In this section, there are two types of case study.

Firstly, case studies which highlight the serious consequences of low levels of health literacy – both organisational and personal:

1. Missed appointment
2. Safety implications of patient communications
3. Health Check communication
4. Communication and health behaviour during the Covid-19 pandemic

Secondly, case studies showing where work is underway to create Health Literate Organisations:

5. Midlands Region
6. Manchester University NHS Foundation Trust
7. Joined Up Care Derbyshire
8. Herefordshire and Worcestershire ICB
9. Dorset Health & Care System

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Case Study 1: Missed appointment

A practising GP recounts the story of a patient in a deprived inner-city practice. The patient was a lifelong smoker with a persistent cough and worrying chest signs. The GP was concerned so she gave him a form (the system for X-rays in that area) and advised him to go to X-ray as soon as possible. She arranged to see him 2 weeks later by which time she would have expected to have received the X-ray report. The patient attended 2 weeks later as planned, and the GP asked him if all had gone ok with the X-ray as she was surprised not to have seen a report.

The patient then looked very embarrassed, shuffling his feet and said that he had gone to the hospital, had not found X-ray department but was too embarrassed to ask, so he went home without having the X-ray.

Considering both personal and organisational health literacy:

1. Should we expect the patient to have known that the radiology department is where you go for an X-ray? Should we have expected him to have had the confidence to ask for directions?

   Or

2. Should the hospital have had clear, understandable signage? Should the hospital have trained people (whether employed or volunteers) to routinely help people to navigate their way around the hospital?

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Case Study 2: Safety implications of patient communications

"A child of Romanian ethnicity was referred for an MRI scan, which required a general anaesthetic. The scan was booked, and a letter was sent to the child's parents including the appointment details and pre-appointment instructions.

The Trust's booking system was only able to produce appointment letters in English, and there were no Trust processes or policies to routinely translate written appointment information.

The family recognised key details in the written information, including the time, date and location of the scan. However, they were not able to understand the instructions about the child not eating or drinking (fasting) for a certain amount of time before the scan.

When the family attended the appointment for the scan, the child had eaten. This meant the MRI scan could not be completed and it was therefore cancelled. The radiology booking team did not receive confirmation of the need to rebook the scan, and 11 weeks passed before it was identified that the scan had not taken place. When the scan was rebooked, a letter was again sent to the family with the appointment details and information about the need for fasting. The letter was sent in English. The child arrived at the scheduled scan appointment but had again eaten prior to arrival. The scan was cancelled and rebooked for the following day, when it was carried out and cancer was diagnosed.

The child received treatment, but sadly the disease progressed, and they were placed on a palliative care pathway and died. There was no suggestion that identifying the cancer at an earlier point would have affected the child's outcome."

Link to the reference event (Health Services Safety Investigations Board Website)[8]

Whilst there are clearly system and process issues relating to this incident, there is also a health literacy angle.

Considering both personal and organisational health literacy:

1. The report says "they were not able to understand the instructions…"
2. But did anyone at the Trust check for understanding?

Clearly this is a complex, multi-faceted and tragic case, but might organisational health literacy i.e. checking for understanding, or a letter in a suitable language, have made a difference?

Health Services Safety Investigations Body

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Case Study 3: Health check communication

A 53 year-old male attended his NHS health check. A cholesterol test was part of this. The patient was given the summary sheet shown. There was a short discussion about the results, but no check to find out whether he understood them, or to confirm the actions he would take.

Considering both personal and organisational health literacy:

Should we expect the patient to understand this – and know what to do as a result?

Should we expect the provider to issue a clear, easy-to-understand document? Should the healthcare practitioner have asked the patient to 'teach back' (a core health literacy technique) to them what they were going to do with the information?

There is considerable evidence to show that clearer communication, combined with the "teachback" health literacy technique, leads to improved health outcomes.[9,10]

Date of Birt un-1969 (53y)

Report Path: Local Record

NHS Number: Usual GP:

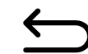
Values and Investigations (Latest Value)

24-Apr-2023 ! Serum lipids - (MF) - Make/Keep Appointment
Random (non-fasting) sample.
HDL Cholesterol increased: may be "protective".
Total/HDL chol ratio for use in primary prevention only
to estimate overall cardiovascular risk.

! Serum total cholesterol level	7.2	mmol/L	2.50 - 5.00mmol/L
Serum triglycerides	1.6	mmol/L	0.40 - 1.70mmol/L
! Serum HDL cholesterol level	2.74	mmol/L	1.00 - 1.90mmol/L
! Non-HDL Cholesterol	4.5	mmol/L	1.50 - 4.00mmol/L
Serum cholesterol/HDL ratio	2.6		2.00 - 6.00

5 target

Healthy Hearts + raised cholesterol



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Case Study 4:Communication & health behaviour during the Covid-19 pandemic

Antigen or antibody? UK adults confused by Covid terminology

Almost half the population unclear what 'antigen' or 'epidemiologist' mean, while two in five would struggle to explain 'circuit breaker'

Almost half the population is unclear what "antigen" or "epidemiologist" mean[11]

Two in five admit they would struggle to explain "circuit breaker" or "flatten the curve".

Just 20% said they could confidently explain a PCR (polymerase chain reaction) test

While 88% had heard of the "R number", only 42% said they could confidently explain it, compared with 46% who could not.

Many people would struggle to explain "herd immunity" (39%), "support bubble" (34%), and "stay alert" (29%)

"There are even disagreements among experts as to what some of these terms mean. Given that, it's not surprising that so many lay people get confused by so many of these words and phrases." Paul Hunter, a professor of medicine and expert in infectious diseases at the University of East Anglia[11]

In practice, it can be tempting to reduce explanations of health literacy to pure literacy, but whilst pure literacy (and numeracy) skills do have a part to play in understanding health literacy, it "is more than just reading, writing and counting".[12]

It also applies to the environment we provide for people. Again, this example from the pandemic brings this to life – combining both a complicated (and long) word (asymptomatic), with a somewhat confusing sign.

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Case Study 5: NHS Midlands Health Literate Organisation Programme

Health Literate Organisation

Leadership commitment & policies

Co-production & service user engagement

Staff awareness & ways of working

Written communication

Verbal communication

Physical layout

Evaluation & continuous improvement

Health Literate Organisation

The HLO programme, commissioned by HEE (Midlands) and subsequently supported by NHS England (Midlands) aims to support health and care organisations to become health literate in the way they support their service users. Health Literacy Matters delivered this programme. It has been made available to all NHS, Local Authority and many other health and care organisations across the Midlands. It recognises that to achieve its aim, two core components are required.

Firstly, it provides health and care practitioners with health literacy awareness supported by tools, techniques and expert advice. Secondly**, it places this in the context of an organisational change management approach**. It requires a commitment and prioritisation of this work – both at the system and organisational level. It will not happen simply by ‘awareness raising’ alone.

The HLO Programme aims to address the enablers and barriers organisations face and to provide support during their process towards becoming Health Literate. The support offered includes:

1. Health Literacy Awareness Training
2. Health Literate Organisation Workshop
3. Access to the Health Literacy Group on the Knowledge Hub
4. Receive support and guidance from an experienced health literacy expert
5. Community of Practice Workshops

Health Literacy Matters
Clear Communication For Better Health

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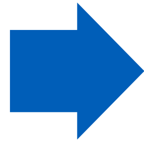
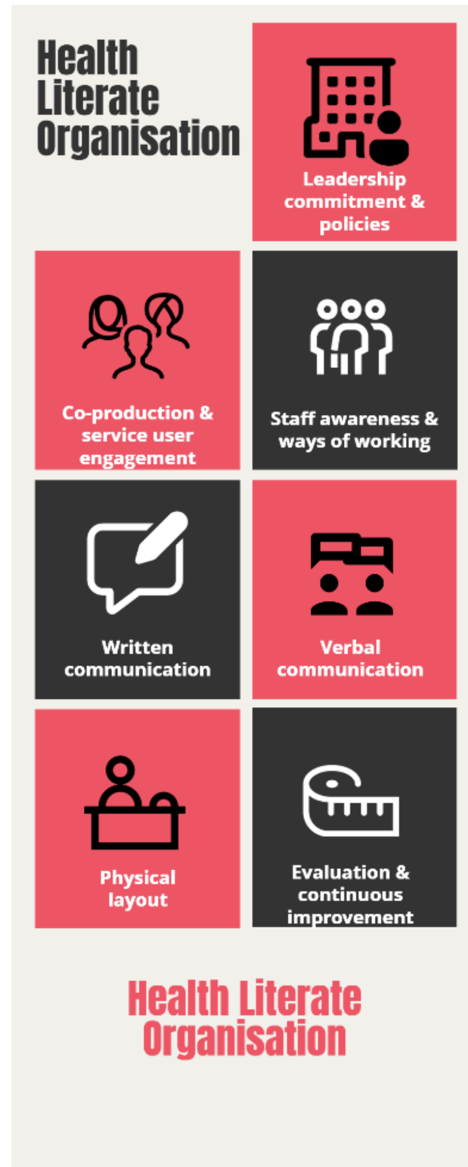
Case Study 5 (cont): NHS Midlands Health Literate Organisation Programme

Organisational Change Management

Health Literacy Best Practice





Inspired by the seminal work of Brach et al. (2012),[13] this model consists of:

A key **leadership** role(s) has been identified. The person(s) will be accountable for ensuring that the organisation becomes health literate in the way it supports its service users. There is as specific health literacy **policy** in place to embed health literate ways of working across the organisation.

Service users are directly involved (often referred to as **co-production**) in the creation of documents, online resources or processes that the organisation delivers. As a minimum, service user feedback on materials is sought and acted upon. C**o-production is a fundamental value underpinning this approach** – particularly to involve underserved communities.

People in this organisation know what health literacy is (both "people" and "organisational"). Leadership and other influential roles have attended training. Key service-user facing roles have had **training tailored to their role** (which includes practical techniques for effective health literate communication).

Written communication is appropriate for the people it is intended for. Plain language (whatever the language) is used. Appropriate words and images are used to aid understanding. Ideally, the people whom the communication is intended for have been involved in its creation. If not, those creating the materials are aware of the importance of health literacy and how to use health literacy tools and techniques.

Verbal communication is prioritised so that service users feel more confident in being able to act on the health information that is shared with them. Service users also feel part of the decision-making process regarding their health. Those people who have interaction with the public know how to, and feel confident to, use health literacy techniques such as teachback and chunk and check.

Where applicable the **physical (and virtual / online) layouts of the organisation support people** in finding and accessing services. Service users feel as comfortable and confident as possible when using the service to support their understanding, and ability to act on, health information.

There is a conscious effort made to **evaluate the impact** of the actions taken to become a health literate organisation. Where possible , 'before' and 'after' measurements are made. Successes are publicised. Areas for improvement are identified.

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Case Study 6: Manchester University NHS Foundation Trust

Manchester University NHS Foundation Trust has:

- Run dedicated sessions with teams from across all sites, reaching over 500 staff so far from various clinical and non-clinical roles.
- Over 30 health literacy champions and set up its own community of practice.
- Monthly health literacy training now available to all staff.
- Made a long-term commitment to health literacy, which now forms a key part of an organisational wide programme focused on improving patient communication.

The impact the work is having:

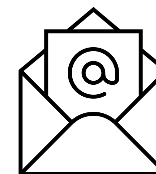
- Clearer and simpler communication with patients, both in writing and verbally. E.g. changed induction of labour information from a 5-page document with a reading age of 17 to an easy-to-read infographic.
- Multiple projects being led by services to improve communication, complemented by new Trust processes that ensure literacy is a consideration e.g. in new letters/leaflets.
- Leaders across the Trust acknowledging that getting health literacy and communication right is fundamental to everything the organisation wants to do.

Professor Jane Eddleston, Group Joint Medical Director and Senior Responsible Officer for Health Inequalities:

“Moving towards being a health literate organisation is central to the work we are doing to tackle health inequalities at the Trust. Our Health Literacy training and workshops have helped our teams recognise how changing how we communicate can improve access, outcomes and experience for our patients who are experiencing inequalities.

Colleagues at the Trust have been energised by this work; it feels like we are making a real difference.”

Manchester University
NHS Foundation Trust



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Case Study 7: Joined Up Care Derbyshire

Joined Up Care Derbyshire (the Integrated Care System in Derby and Derbyshire) has:

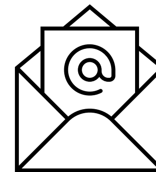
- Commissioned, delivered and continues to develop a range of health literacy training sessions reaching over 1000 staff so far.
- Recognised that Health Literacy supports an established Quality Conversations approach.
- Invested in a Health Literacy Officer to support services to become more health literacy friendly (e.g. Wound Clinic Service).

The impact the work is having:

- Services are making changes to the way they communicate by having clearer conversations and writing information that is easier to read.
- Health literacy is starting to become embedded across the healthcare system, helping to reduce health inequalities.
- Taking part in an external research project will help us to further evaluate what impact our work is having on health outcomes.

Jayne Needham, Director of Strategy, Partnerships and Population Health/Consultant in Public Health, DCHS NHS FT:

"Evidence shows that people most at risk of limited health literacy have the poorest health outcomes.[1] This is why it is hugely important we build in strategies to increase health literacy levels within our local populations. Improving the ability for people to read, understand, navigate, access and act on health information is a key priority. If we work together to achieve this, we will improve healthy life expectancy and reduce inequalities within our communities."



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Case Study 8: Hereford & Worcestershire ICB

The HLO Programme Team in Herefordshire & Worcestershire has:

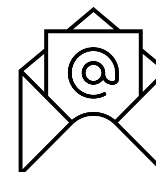
- Gained commitment from ICB Senior Responsible Officers to become a health-literate organisation
- Engaged with the local population via focus groups and a HL survey (>250 survey responses)
- Launched system-wide training offer for staff and volunteers
- Recruited Health Literacy Champions
- Focused on COPD service for quick wins

The impact the work is having:

- Governance established to ensure health literacy is considered at senior levels – All ICS programme-boards have a Health Inequalities Ambassador trained in Health Literacy Awareness.
- Fuelled other projects– "Ensuring people affected by stroke are provided with the information they need, when they need it" as part of the system-wide Stroke Transformation project
- People are being provided with information that is easier to understand, for example, reading age for a Pulmonary Rehabilitation booklet reduced from 15.8 to 11.7.
- Video library being integrated with patient resources to provide alternative, easy to understand health information

David Mehaffey, Executive Director: Strategy, Health Inequalities and Integration:

"We know that poor health literacy contributes significantly to unequal health outcomes for people. This project is therefore a critical part of our drive to tackle these and help us realise our ambition to make tackling health inequalities everyone's business".



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Case Study 9: Dorset Health & Care System

Public Health Dorset has:

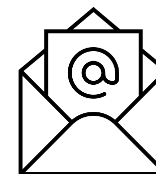
- Worked across the health and care system in Dorset to deliver a structured programme to support organisations to become health literate.
- After taking part in the programme, Dorset County Hospital's Pulmonary Rehabilitation Team decided to re-write their leaflet about the service.
- The leaflet contained complex sentences and medical terminology like "pulmonary function tests" and "exercise prescription.“ The team knew that they needed to co-produce a new version with people who use the service.

The impact the work is having:

- The leaflet now has simpler language. It is less likely to overwhelm readers who are already dealing with their lung conditions. For example:
- Simplified language: ‘pulmonary function tests’ was replaced with ‘breathing test’
- Pictures were added to explain how the programme works
- Quotes were included from real programme users about how it had benefited them

Claire Peak, Specialist Physiotherapist:

“Start by truly understanding your audience - who your patients are, their education levels, their cultural backgrounds, and their language preferences. Always test your materials with patients to gather feedback and make necessary improvements”



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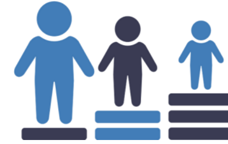
Part 3: Click on the icons for supporting evidence and rationale for becoming a Health Literate Organisation

Enabling the core purpose & features of ICSs



Promoting health equity & tackling health inequalities

Improving organisational effectiveness and efficiency (finances)

Improving patient safety & reducing preventable deaths

Tackling waiting lists

Reducing inappropriate use of A&E

Improved health outcomes for service users & patients

Reducing DNAs

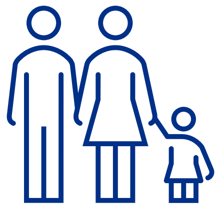
Increasing medicine compliance and reducing wastage

Enabling personalised care

Underpinning shared-decision making & informed consent

Increasing self-management & preventative health behaviour

Underpinning behavioural science



Improved health outcomes for service users & patients

A **health literate organisation** makes it easier for people to access, appraise and act on health information.

It **helps people** to:

- Access the right services at the right time
- Navigate health services
- Attend appointments (right time, right place, prepared for the appointment)
- Engage with disease prevention e.g. cancer screening, immunisation
- Understand when they need help and feel confident accessing it on time
- Communicate better with health staff (as a result of better shared decision-making discussions)
- Avoid unhealthy behaviours (e.g. abuse of alcohol, unhealthy eating, smoking)
- Engage in healthy behaviours (follow a good diet, strive for a healthy weight, take part in physical activity)
- Understand labelling and how to take medicines correctly

Which all contribute to reducing pressure on health and care services and improving patient flow.

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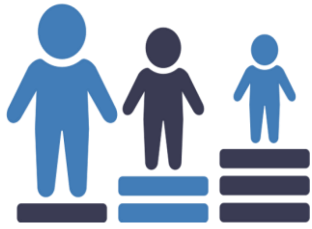

Promoting Health Equity & tackling Health Inequalities

"**Living in communities served by health care organisations that lack organisational health literacy can affect the quality of health care delivered and, consequently, health outcomes.** People residing in the catchment areas of organisations with limited health literacy may be more likely to suffer from miscommunication and have difficulty accessing services. Even people with high personal health literacy can suffer ill effects from low organisational health literacy.

Personal health literacy is associated with racial/ethnic minority status, age, poverty, educational attainment, language spoken before starting school, and self-reported health. Strategies to increase personal health literacy disproportionately benefit populations that have been marginalized and therefore have the potential to decrease health disparities.

Similarly, improving organisational health literacy may reduce disparities. For example, one aspect of being a health-literate organisation is meeting the needs of populations with a range of health literacy levels. By ensuring that everyone, regardless of their abilities, can make use of health information and services, health-literate organisations advance health equity." [14]

Health literate organisations operating in health literate systems will support the delivery of statutory duties relating to health inequalities and population health.

There is strong correlation between the groups identified in the **Core20, PLUS** groups and people who have lower levels of health literacy.

- Our approach to reducing healthcare inequalities[15]
- Publication of NHS England's statement on information on health inequalities[16]
- Core20PLUS5[17]
- The Public Sector Equality Duty[18]

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Improving organisational effectiveness and efficiency (finances)

By contributing to all of the priorities outlined in this document (especially improved health outcomes at the population level) the health and care system will be more effective, efficient and save money. Some examples are included here.

Nationally the NHS paid on average £155.46 per registered patient to GP Practices in 2019/20.[19]

The use of the "teachback" health literacy technique has been shown to increase medication compliance and improve health behaviours. Fewer unnecessary return appointments to GP appointments will save money.[23,24]

Data from 2019 showed that patients who miss GP appointments are costing NHS England £216m a year (15 million consultations missed, 1.2 million GP hours being wasted every year.)[20] NHS England reports each missed appointment costs, on average, £30. The overall expense of missed appointments could pay the annual salary of 2,325 full-time GPs.

Clear, understandable appointment communication (based on best practice health literacy approaches) can contribute to tackling this issue. The Director of Primary Care for NHS England pointed out that £216m could also fund about 58,000 hip operations or 220,000 cataract operations[20], highlighting the opportunity cost of poor organisational health literacy.

Using cost collection data for 2020/21, the unit cost per day of NHS hospital beds is as follows: Elective - £2,349, Non-elective - £901, Critical care - £1,881, Standard bed - £345.[21]

By communicating with the public in a health literate way, health and care organisations can support people with preventative health behaviours, personalised care and shared decision making.

An attendance at A&E costs the NHS four times as much as a visit to the GP. An emergency ambulance costs four times as much as an attendance at A&E.[22]

People with lower levels of health literacy find it hard to navigate the health and care system. By being easier to navigate, and by helping people to "use the right part of the system" health literate organisations can contribute to cost saving.[2,25]

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Tackling waiting lists

Organisational health literacy can play its part in tackling waiting lists by making the information shared with people **before, during and after** the waiting list experience **easier to understand and act on**.

There is a strong health inequalities link as people with lower levels of health literacy are more likely to experience delays in getting health care because of long waiting lists for appointments[26]

NHS Monthly operational statistics (January 2024): waiting lists at 7.6 million in November 2023[27]

New analysis by the Health Foundation shows that, if current trends continue, the waiting list for routine hospital treatment ('elective care') in England could rise to over 8 million by next summer, regardless of whether NHS industrial action continues.[28]

In "**Improving the NHS waiting list experience**"[29] Mace and Menter suggest seven principles for any service that currently operates a waiting list, all of which should be underpinned by health-literate ways of working:

1. Provide more information about what patients can expect
2. Cater for access needs
3. Provide guidance around things people can do while waiting
4. Provide regular reassurance on waiting list progress
5. Help patients to feel cared for while they wait
6. Provide options for immediate support
7. Give guidance on ways to prepare for an appointment / procedure

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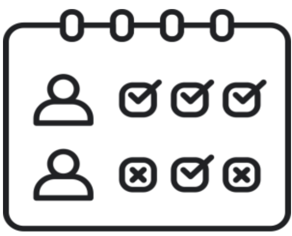

Reducing DNAs

Whilst recognising the complexity and scale of the issue, organisational health literacy can play its part in reducing DNAs.

Of the 103 million outpatient appointments booked in 2021/22, 7.6% ended in a 'Did Not Attend'; this equates to an average of 650,000 monthly appointment slots.[30]

Collectively, in England from June 2022-December 2022, it is claimed that an estimated £290,323,500 of NHS funds has been wasted due to people not attending their appointment slots. This figure is a result of 4.9% of total appointments being missed during this time period.[31]

The two most commonly cited reasons are patients forgetting and clerical errors or communication failures, which mean that the patient was unaware of the appointment.

From the Online library of Quality, Service Improvement and Redesign tools (Reducing DNAs):[32] communication – appointment letters should be easy to read and understand.
Multiple sources of support are available on how to do this e.g. the NHS Document Readability Tool.[33]
Additional guidance is included in the NHS Health Literacy Toolkit[7]
It can be useful to ask the patient to repeat back the information in appointment letters to ensure they have understood it correctly.

In addition to DNAs, there is an issue of people not being prepared for appointments (i.e. not bringing required information or items with them, or not having followed pre-operation instructions), leading to the need for more appointments. Case study 2 provides a stark example of this.

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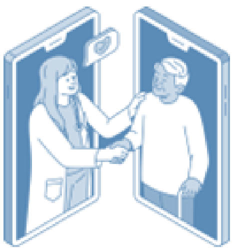

Enabling personalised care

Because a health literate organisation makes it easier for people to access, appraise and act on health information, it helps to involve patients, carers, citizens and their representatives to be involved in decision-making about their own care and how to support themselves and others.

Effective organisational health literacy is integral to the implementation of the personalised care model.[34] The NHS Implementing the Comprehensive Model for Universal Personal Care [35] reflects this. It requires that:

- Clinicians are trained in shared decision-making skills, including risk communication and appropriate decision support for people at all levels of health literacy and groups who experience inequalities or exclusion.
- Staff develop health-literate decision support materials and tailor their conversations to take account of low health literacy by using specific techniques, such as "teachback", building on the health literacy toolkit.
- Communication strategies take into account the communication needs of people who experience health inequalities, including, for example, people with learning disabilities and those with lower levels of health literacy

The World Health Organisation[36] states: "Developing more integrated [personalised] care systems has the potential to generate significant benefits to the health and health care of all people, including improved access to care, improved health and clinical outcomes, better health literacy and self-care, increased satisfaction with care, improved job satisfaction for health workers, improved efficiency of services, and reduced overall costs."

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Underpinning behavioural science

The understanding and application of behavioural science to health behaviours is widespread. It can be applied to organisations as well as people. Health literacy is a building block for behavioural science. More health literate healthcare organisations will help people by supporting their capability, motivation and opportunity to follow health behaviour.

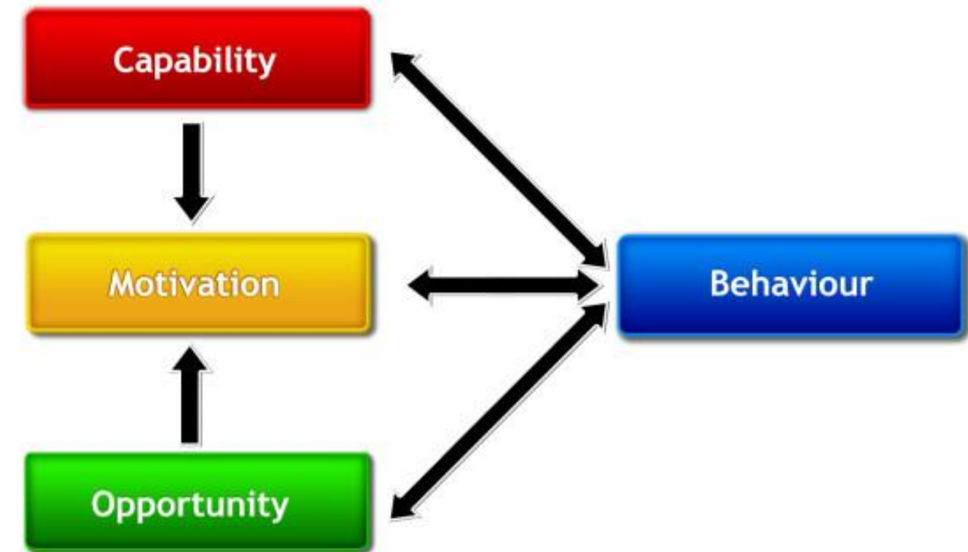
The COM-B model of behaviour change provides an accessible way of understanding this concept.[37]

Behaviour: such as taking medication safely, preventative actions such as healthy eating or exercise

Capability: having the psychological or physical ability to enact the behaviour

Motivation: Reflective and automatic mechanisms that activate or inhibit behaviour

Opportunity: Physical and social environment that enable the behaviour



Michie (2011)

A health-literate organisation will:

- Let people know why the health behaviour is important and how to do it, in a clear and understandable way
- Help develop plans for following the health behaviour with people
- Provide an accessible and easy-to-navigate environment

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Supporting prevention and self-management

Health and care organisations can enhance outcomes for their patients by addressing health literacy in how they interact with their service users. Addressing organisational health literacy is associated with improved health outcomes.

Clearer and more understandable communication for all can help with explaining the importance and benefits of:

- **screening** for self and family[38]
- **immunisation**, for self and for family[38]
- **self-examinations**[39]
- explaining the benefits of **healthy behaviours**[40] in relation to
  - **alcohol**
  - **diet**
  - **smoking**
  - **physical activity**
- Increasing the response to **public healthy living campaigns**[40]
- Adherence to **medication protocols**[38]
- Managing **long-term conditions**[40]

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Underpinning shared decision-making and informed consent

Organisational health literacy helps people make decisions for themself based on their values, preferences and circumstances

Shared decision-making is enshrined as a principle in the NHS Constitution[41], with principle 4 stating that, 'Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment'. Involving people in decisions about their care, in a health-literate way may result in:

- greater satisfaction with the decisions made
- greater understanding about the risks and benefits of the available options
- better communication between people and their healthcare professional, including people feeling that they have 'been heard'
- improved trust between people and their healthcare professional
- better concordance with an agreed treatment plan
- people reporting a better experience of care, including more satisfaction with the outcome.

Improving health literacy is a key influence on people's health behaviours and, therefore, their health and wellbeing. This in turn has a benefit for the NHS as it reduces the demand each individual places on the health service. Effective shared decision making[42] has a greater impact on those with lower health literacy or who are more disadvantaged so can also reduce health inequalities.
One technique that is helpful in ensuring that patients have understood the information given to them, including risk information, is known as teachback. This is a health literacy evidence-based communication technique, and the Personalised Care Institute (login required) has developed a helpful resource showing Teachback in action.

Following the **Montgomery Judgement**[43]**,** shared decision making must comply with national legislation and policy.
Health professionals now have to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments".

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Increasing medicine compliance and reducing wastage

By communicating more clearly – and checking for understanding - healthcare organisations will:

- Help people to avoid unnecessary treatments and prescriptions
- Help people to adhere to treatment advice
- Save money by wasting less medication

It has been estimated £300 million of NHS prescribed medicines are wasted each year.[44]

The Pharmaceutical Waste Reduction in the NHS report[44] contains numerous case studies outlining improved patient outcomes and cost savings by focusing on reducing wasted medication.

Teachback is one of the most useful techniques available to the healthcare system and workforce. Research shows that using the teachback technique works to improve patient understanding, leading to better patient compliance with medication and health behaviours, improved patient safety and ultimately improved health outcomes[24,25]

It is simply done by asking a patients to explain—in their own words—what they need to know or do. It is a way to check for understanding and, if needed, re-explain and check again.

Educational resources to demonstrate this are widely available, such as those hosted by the Personalised Care Institute.[45] As with all changes to workforce behaviour and processes, organisational commitment is required to make the changes stick.

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Reducing inappropriate use of A&E

People with lower levels of health literacy are more likely to use A&E.[2] Systems and organisations that are more health literate can support people to understand which part of the system to access and when.

NHS Digital defines unnecessary emergency department attendance as a “first attendance with some recorded treatments or investigations all of which may have been reasonably provided by a GP, followed by discharge home or to GP care.”

Sixteen percent of emergency department attendances in 2015-17 were defined as unnecessary.

Inappropriate attendances may account for up to 40% of presentations at accident and emergency (A&E) departments.

There is considerable interest from health practitioners and policymakers in interventions to reduce this burden.[46]

In an analysis of the reasons for emergency department (ED) attendances across Yorkshire and the Humber, ED staff highlighted the need to re-educate the public about what is an appropriate attendance at the ED.[47] Examples of these types of education-based demand-management interventions included:

- Patient leaflets
- Poster campaigns
- Advertising in the press
- TV campaigns
- Advertising on Facebook
- Lobbying the government to educate the public
- Including health literacy in the school curriculum

In 2020/21, the estimated average cost of a patient being taken to A&E by ambulance was £367. Ambulance call-outs that didn’t result in a trip to A&E cost an estimated average of £276.[23]

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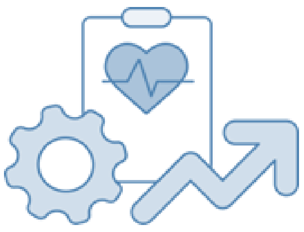

Improving patient safety & reducing preventable deaths

Healthcare that is designed to be understandable and useable by all, regardless of health literacy levels is likely to improve patient safety. This is also an issue of health inequalities. Lower levels of health literacy are associated with lower socio-economic status and worse health outcomes.[2]

A key finding of the NHS England Public Report into health service failings at the Mid-Staffordshire NHS Trust outlined the key role that patient concerns should have played in highlighting safety issues.

A health-literate approach to informed consent, with materials designed to be understood by all patients regardless of health literacy, and staff trained in explaining information clearly and checking comprehension, is thus key to patient safety and quality of care.[48]

NHS England » The NHS Patient Safety Strategy[49] sets out how the NHS will support staff and providers to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety. Getting this right could save almost 1,000 extra lives and £100 million in care costs each year.

Strategies to promote health literacy by helping patients more easily obtain, process, and understand health information to be able to make informed decisions ultimately support patient safety. The health system must promote better communication of health information while also simplifying the demands it places on patients.[50]

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Enabling the Core Purpose & Features of ICS's

The Integrated Care Systems: design framework[51] states that the core purpose of an ICS is to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

The Integrated Care Systems: design framework[51] states that the common features that every system is expected to have and develop are:

- they make decisions closer to and in consultation with the communities they affect, leading to better outcomes.
- collaboration between partners, both within a place and at scale, in order to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity

System and organisational health literacy provides a way to support the adoption of improved ways of working and pathways that align with population health needs and address health inequalities. Evaluation of programmes to implement Organisational Health Literacy will also allow ICBs to fulfil their duty to facilitate and promote research.

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