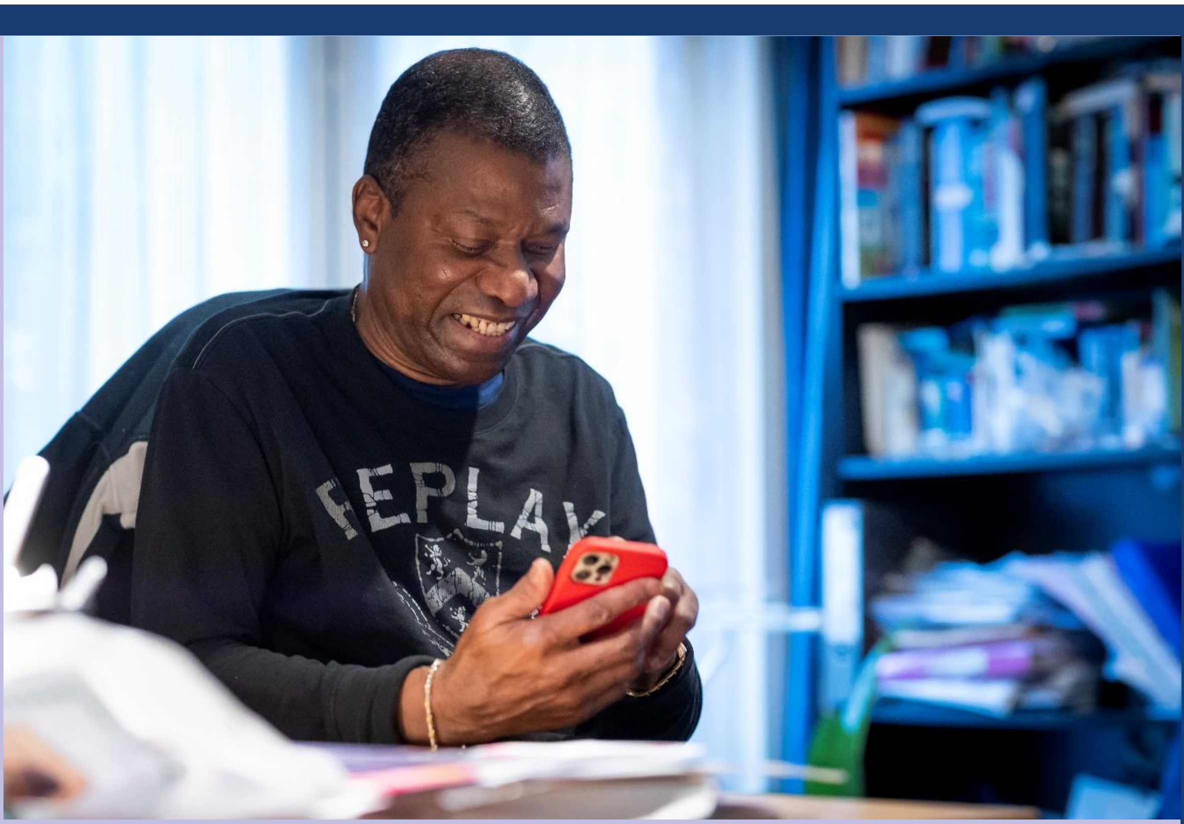
NIHR | Policy Research Unit Older People and Frailty



Full Report

Experiences and views of older adults of South Asian background and Black African or Caribbean background about digitalisation of primary care services since the COVID-19 pandemic

Alex Hall, Nisar Ahmed, Brenda Poku,
Jane McDermott, Jayne Astbury, Chris Todd

August 2023

Experiences and views of older adults of South Asian background and Black African or Caribbean background about digitalisation of primary care services since the COVID-19 pandemic

Full Report

August 2023

Alex Hall, Nisar Ahmed, Brenda Poku, Jane McDermott,
Jayne Astbury, Chris Todd

NIHR Older People and Frailty Policy Research Unit
School of Health Sciences, Faculty of Biology, Medicine and Health, The University of
Manchester, Manchester, M13 9PL, UK.

This report presents independent research funded by the National Institute for Health Research Policy Research Unit in Older People and Frailty. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Policy Research Unit Programme Reference Number PR-PRU-1217-21502

Contents

Summary briefing

The study

The COVID-19 pandemic of 2020-23 led governments worldwide to mandate lockdowns and social restrictions, accompanied by rapid implementation of many digital health and care services. As older age is the single main predictor for digital exclusion, there are concerns that older adults are being disadvantaged and excluded. Other barriers to digital inclusion include literacy levels and ethnicity. There is a lack of robust evidence that focuses on the experiences of older adults from minority ethnic groups in accessing health and care services since the start of the pandemic.

This study aimed to explore the experiences of older adults from South Asian backgrounds and Black African or Caribbean backgrounds in the use of digitalised primary care services since the beginning of the pandemic. This report summarises the views of 27 older adults from these two minority ethnic groups, obtained from face-to-face and online focus groups held in April and May 2023.

Main findings

Four main themes were identified in the data:

Accessibility

- Participants reported strong concerns of language barriers for older people in their communities where English is not spoken as a first language.
- Participants were critical of a perceived increase in gatekeeping by GP receptionists and inappropriate questions about reasons for appointments.

Importance of visual contact with clinicians

- Participants felt that visual contact with clinicians is important to allow patients to feel confident that their problems are understood, and to develop a therapeutic relationship.
- Participants preferred face-to-face consultations but saw video consultations as an acceptable alternative in maintaining visual contact.

Stresses of shift to remote access

- Some participants highlighted frustrations and distress at being unable to make appointments via technologies available, and that this has led to a deeper fear of becoming ill in the first place.
- Some participants of Black African Caribbean background reported discrimination and racism when trying to make appointments.

How far is technology the answer?

- Participants recognised that digital is here to stay and can bring many benefits but cautioned against seeing it as a panacea and advocated for choice of access.
- There were suggestions that simple queries may be appropriately addressed remotely, but certain issues (e.g., sexual/reproductive health; mental health) are more appropriately addressed face-to-face.

Key recommendations

- Design of digital health services must involve in-depth consultation and user experience research with older adults from diverse backgrounds, including those who have limited English language ability.
- Visual/in-person contact with clinicians is perceived as very important. The use of video technology is seen as an acceptable alternative to in-person consultations.
- It is imperative to maintain choice in how to access health services, including offline options.

Executive summary

Background

For at least a decade, the World Health Organization (WHO) has been encouraging use of digital technology to improve health and social care services.[1] The NHS Long Term Plan outlines a 'digital first' vision that prioritises digital access to services[2] and the 'Empowering the Person' roadmap outlines milestones for 'digital first' services.[3] The COVID-19 pandemic of 2020-23 led governments worldwide to mandate lockdowns and social restrictions; both in UK and internationally, this was accompanied by rapid implementation of many digital health and care services.[4,5] In June 2022, the UK government affirmed its policy position for the continued digitalisation of health and social care, focusing on the NHS app as the 'front door' to NHS services, greater use of electronic care records, and digital self-management of long-term conditions.[6] There is a growing role for digital technologies to access health and care services, but as older age is the single main predictor for digital exclusion, there are concerns that older adults are being disadvantaged and excluded.[7] Other barriers to digital inclusion include socioeconomic status, literacy levels and ethnicity; the latter may include digital, literacy and language barriers for people from minority ethnic groups but may also be compounded by a lack of trust in authoritative institutions like the NHS.[8]

Prior to the COVID-19 pandemic, there is a lack of evidence for technologies to facilitate older adults' access to health and care services. In the evidence collected since the start of the pandemic, there are two major shortcomings: (a) a dearth of qualitative evidence in the UK peer-reviewed literature that focuses specifically on older adults' perceptions and experiences of digitalisation of health and care services since the start of the pandemic; (b) a lack of analytical focus on personal characteristics related to health inequalities, including ethnicity.

Aims and approach

The present study provides a qualitative exploration of the experiences of older adults from South Asian backgrounds and Black African or Caribbean backgrounds in the use of digitalised primary care services. These two groups were chosen as they are the two largest minority ethnic groups in England and Wales.[9] Twenty-seven people took part in four focus groups held in-person or online using video conferencing software. Patient and public involvement and engagement (PPIE) was sought in two ways: (1) through a participatory approach with community organisations for the recruitment and arrangement of focus groups; (2) through feedback on the focus group topic guide. Data were analysed via framework analysis.

Findings

The findings are organised around four key themes:

Accessibility

This theme explores the extent to which people feel that online/remote access to health services is accessible. Many participants referred to trying (and often failing) to telephone GPs at 8am to get an appointment. Some participants felt that the role of the receptionist has become more of a gatekeeping role, in which receptionists ask what are perceived to be sometimes inappropriate, personal or sensitive questions about symptoms and reasons for wanting a GP appointment.

There was a strong sense that language difficulties made remote access to health services difficult for older people who do not speak English as a first language, both in terms of attempting to use online means to access appointments or health information, but also if they needed to explain medical symptoms over the telephone. Some participants suggested that it might be useful if information and interactive services were available in different languages. However, others were mindful that poor first-language literacy among some older people in their communities meant that this would not suit everybody.

There was a perception that online systems and technology-facilitated access are designed for predominantly ‘white people’ or those who are proficient in English, with concerns expressed with the lack of consultation during the development stages. Participants talked extensively about (a lack of) digital skills among older people in their communities.

Overall, the role of (usually younger) relatives and members of community organisations to support people digitally (both in general and around health appointments/prescriptions) was cited as being important. However, it is not clear how appropriate this might be in the context of health care in upholding privacy, e.g., in the case of women making gynaecological appointments.

Importance of visual contact with clinicians

This theme highlights the extent to which people feel it is important to be able physically to see (and be seen by) a health professional. There was a strong preference for in-person appointments as participants queried how well GPs might understand a problem if they cannot see the patient. Others suggested that a face-face consultation with their GPs was important at an inter-personal level for the purposes of ‘connectiveness’ which was described as ‘uplifting’ and ‘healing’. This was also related to some of the feelings about language challenges and the feeling that some older people may be able to explain problems much better in person rather than online or over the telephone.

Although there was limited experience of video consultations with GPs, some participants were positive about this mode of consultation and perceived it to be the next best thing to an in-person appointment. Video consultation was seen as a familiar mode of communication as participants were able to relate it to remote interaction with relatives during the pandemic.

Stresses of shift to remote access

This theme identifies psychosocial impacts for participants attempting to access health services remotely. There were multiple examples of fear of using technology to make health appointments, which caused stress, agitation, frustration and high levels of anxiety at not being able to make health appointments. These experiences were felt by some to contribute to a deeper fear of becoming ill in the first place.

Some participants felt that digital access to health care has been ‘thrown at them’ and that it will take time for them to adjust to this new way of working. There were concerns about consent and the ‘small print’, with the sense that people may be very confused about what is happening with their data when engaging with the health service digitally. This sense of fear and confusion of using technologies to access health care was cited within a wider narrative of fear and lack of confidence in using technologies more generally (e.g., fear of online banking and scams).

The topic of institutional racism and discrimination within the health service was raised by participants in the Black African Caribbean groups, with some feeling that they are not treated with sympathy, empathy or respect when making appointments. There were descriptions of being treated differently, both over the telephone and in person, because of being identified as Black or ‘not British’.

There were some reflections on cultural gender differences, with examples of digitally excluded Asian men possibly being further excluded because they are more reluctant to seek health care than women. However, these reflections were made with the caveat that the vast majority of study participants were women.

How far digital is the answer

This theme explores the extent to which participants view digital access to health and care services as acceptable and appropriate. Participants accepted that digitalisation is the way forward but cautioned against seeing it as a panacea. There was recognition that one size does not fit all and there were calls for offline alternatives. Choice was seen as very important, and participants felt that people should be given options about mode of consultation, with some suggesting adopting a ‘hybrid approach’ as a way forward. Some participants were sceptical about the potential benefits of technology-based access to the health service if there was a fundamental lack of clinical workforce to deliver care.

Implications/Recommendations for policymakers

A number of suggestions arise from this work for policymakers to consider regarding the future of digitalised health and care services:

- Design of digital health services must involve in-depth consultation and user experience research with older adults from diverse backgrounds, including those who have limited English language ability.
- It is important not to underestimate the impact of language barriers and the challenges this can pose for digital literacy and engagement. Simply offering translation functions within digital technologies may be insufficient.
- Although older adults may be able to ask friends or family for support in using digital technologies and may be willing to learn how to use digital technologies, there are times when this will not be appropriate as people need privacy to raise intimate health issues.
- More simple queries may be addressed online or via telephone, but face-to-face/visual contact with clinicians is important to allow patients to feel confident that their problems are understood, and to develop a therapeutic relationship. This may be particularly important for older people who have limited or no English language skills, and particularly important for certain health issues such as sexual/reproductive health and mental health. The use of video technology is seen as an acceptable alternative to in-person consultations.
- It is imperative to maintain choice in how to access health services, including hybrid and offline options.
- The use of buddies or champions at a practice level may warrant further consideration and evaluation to help support people who are having difficulty accessing services.

1. Background

1.1. Policy issue

For at least a decade, the World Health Organization (WHO) has been encouraging use of digital technology to improve health and social care services.[1] The NHS Long Term Plan outlines a 'digital first' vision that prioritises digital access to services[2] and the 'Empowering the Person' roadmap outlines milestones for 'digital first' services.[3] The COVID-19 pandemic of 2020-23 led governments worldwide to mandate lockdowns and social restrictions; both in UK and internationally, this was accompanied by rapid implementation of many digital health and care services.[4,5] In June 2022, the UK government affirmed its policy position for the continued digitalisation of health and social care, focusing on the NHS app as the 'front door' to NHS services, greater use of electronic care records, and digital self-management of long-term conditions.[6] There is a growing role for digital technologies to access health and care services, but as older age is the single main predictor for digital exclusion, there are concerns that older adults are being disadvantaged and excluded.[7] Other barriers to digital inclusion include socioeconomic status, literacy levels and ethnicity; the latter may include digital, literacy and language barriers for people from minority ethnic groups but may also be compounded by a lack of trust in authoritative institutions like the NHS.[8] It is therefore important to understand how digital access to health and care services is experienced by diverse groups of older people across society.

1.2. Evidence scope

A previous Older People and Frailty Policy Research Unit review synthesised evidence published pre-pandemic on the impact of digital technologies on older adults' (age 65+) access to health and social care services.[10,11] Overall, the review concluded the evidence was unclear, low-quality and lacked evidence for technologies to facilitate older adults' access to services. Our other recent reviews of mHealth and eHealth for activity promotion and strength and balance exercise delivery also revealed major evidence gaps but were more positive about the role of technologies in the delivery of such interventions. However, this positive view came with a warning about the risks of exacerbating health inequalities if digital access is not available to all, especially disadvantaged groups in society.[12–14] A systematic review of evidence on inequalities in general practice remote consultations (published pre-pandemic), focusing on any age of patient, found that telephone consultations were used by younger people, the very old and non-immigrants, and internet-based consultations were used more by younger people.[15] There are several recent reports suggesting that health inequalities have been widened because of the pandemic, driven at least in part by the digital divide.[16–18]

Since the pandemic encouraged rapid moves towards remote access to health and care services, in the first work package of the present project we conducted a systematic mapping review to map evidence on the impact of digitalisation of health and social care services for older adults since March 2020.[19] We identified two major shortcomings in the pandemic-related evidence base: (a) a dearth of qualitative evidence in the UK peer-reviewed literature that focuses specifically on older adults' perceptions and experiences of digitalisation of health and care services since the start of the pandemic; (b) a lack of analytical focus on personal characteristics related to health inequalities, including ethnicity. Longitudinal mixed methods work in the first few months of the pandemic suggested that while GPs maintained consultation rates with older patients (aged 70+), practitioners in some practices with a large older, deprived or immigrant population felt that remote telephone consultations were more challenging than face-to-face consultations because of the importance of non-verbal cues.[20] This finding was echoed by work with older patients with musculoskeletal conditions, who felt that while remote consultations may be appropriate for simple queries or follow-up and offered convenience in terms of lack of travel, they were unsatisfactory for new diagnoses or in-depth discussions because of the importance of a face-to-face approach for seeing and feeling joints, and for visual cues in developing the therapeutic relationship.[21] Video consultations may provide a window for some visual cues, but their usefulness for some patient groups, e.g., dementia services, has been questioned as they do not offer the same sensory experience as face-to-face consultations.[22] Other work suggests that GP practices with greater numbers of older patients perceive a lower digital confidence in their patients which may negatively influence the digital readiness of practice staff.[23]

Some qualitative evidence in the UK grey literature, particularly reports by Healthwatch, highlights challenges for digitally excluded people in accessing health services during the pandemic, including age-related unfamiliarity with technology and language barriers for people with limited levels of English.[24–28] However, findings relating specifically to older people from minority ethnic groups are unclear. Overall, there is a need for much more detailed focus on the impacts of pandemic-driven digitalisation of health and care services on older adults with attention paid to potential health inequalities among minority ethnic groups.

1.3. Research aims and objectives

The work presented in this report is part of an existing project that aims to advance the understanding of how health and care services have been digitalised during the COVID-19 pandemic, to learn what has worked well and what has not, with a specific lens on the digital divide and health inequalities among older people from two different minority ethnic communities. The present study provides a qualitative exploration of the experiences of older adults from South Asian and Black African or Caribbean groups in the use of digitalised primary care services. We focused on these two groups as the two largest minority ethnic groups in England and Wales.[9]

Our research objectives were to explore:

(1) the experiences of older adults from a South Asian background or a Black African or Caribbean background in accessing/using digitalised primary care services;

(2) the views of older adults from these groups about digitalised primary care services;

(3) the expectations of older adults from these groups regarding future digital primary care services.

2. Approach

2.1. Study design, participant criteria and recruitment

The study adopted a qualitative approach using focus groups. Participants were eligible to take part if they were aged 65+ and from either a South Asian background or a Black African or Caribbean background. There were no requirements for English language proficiency as we intended to facilitate interpreter support, if necessary; community group members who arranged the focus groups and facilitators were also available during the sessions to help with translation. Digital engagement may be thought of on a spectrum ranging from people who are highly engaged and digitally literate through to those who are digitally excluded. This can be a function of a range of material and psychosocial factors such as skills, self-confidence, appropriate technological resources and available support.[29] We applied a combination of purposive and convenience sampling approaches to identify and recruit participants. Within each minority ethnic group, we aimed to recruit older adults of varying levels of digital engagement across this spectrum.

To recruit digitally engaged older adults, we advertised the study via the Valuing Our Intellectual Capital and Experience (VOICE) platform, a national community of people interested in health and care research for older people (https://www.voice-global.org/). Those interested in taking part were emailed further information about the study and a consent form. To recruit older adults who are less digitally engaged or digitally excluded, we used participatory methodology, which is particularly pertinent for working with potentially socially disadvantaged groups.[30] This involved continued engagement with an established public and community advisory group of members of the Greater Manchester Older People's Network (GMOPN). We used our existing links with the Caribbean and African Health Network (CAHN; based in Manchester) and liaised with the GMOPN to contact a South Asian community group in Greater Manchester. Community leaders were asked to share information about the study among their communities and to coordinate expressions of interest, which were then followed up by the research team.

2.3. Data collection

Participants were invited to attend a focus group to discuss their views and experiences of digitalised primary care health services. The discussion focused on experiences of accessing primary care services via digital technologies, and views and expectations about the future of primary care services and digital health technologies. Focus groups were organised according to ethnic group, i.e., groups for participants from South Asian groups and for participants from Black African or Caribbean groups. Within each ethnic group, we ran one online and one in-person focus group, based on participants' self-perceived level of digital engagement and confidence.

We opted to undertake focus groups rather than interviews as focus group methodology allows researchers to collect diverse views from multiple people at once. Focus groups are considered more flexible and provide a more general overview of the topic.

Focus groups were facilitated by two researchers (NA and BP, supported by AH and JM) and lasted up to two hours (including breaks). Online groups were held via Zoom. In-person groups were held on premises used by the community group through which they were recruited. For the in-person groups, we offered participants support via a gatekeeper from that community group with interpretation, but this was unnecessary as all participants had good levels of English. Community groups were reimbursed for the costs of arranging and hosting the focus groups on their premises. Participants were offered a shopping voucher as a thank you for their time. Data were collected in April and May 2023.

2.4. Data analysis

Four focus group sessions were recorded within Zoom (online groups) or on an encrypted digital recording device (in-person groups). We analysed the data using a framework approach:[31] (1) recordings were professionally transcribed verbatim; (2) we read the transcripts for familiarity and rendered them anonymous; (3) two researchers (AH and NA) coded the same transcript; (4) we agreed upon a coding framework; (5) two researchers (NA and JA) applied the framework to the remaining transcripts; (6) we charted the data into a framework matrix using MS Excel; (7) three researchers (AH, NA and JA) interpreted the data to identify higher-order themes, and similarities and differences.

2.5. Ethics and consent

Ethics approval was granted by the University of Manchester Proportionate Research Ethics Committee (27/01/2023; ref. 2023-15589-26902). Participants provided written informed consent.

2.6. Patient and public involvement and engagement (PPIE)

In addition to the participatory approach to recruitment described above, from the onset of this project we engaged with the GMOPN Equalities lead along with other key members of the network who advised us on how we might best recruit and engage participants from these communities. We sought feedback from members of the GMOPN on our recruitment adverts, interview topic guide and questions, and consulted with a Project Lead and Health Coordinator from a South Asian community group outside Greater Manchester (Firvale Community Hub, Sheffield, UK) for advice on the practicalities of conducting in-person focus groups within this community.

3. Findings

3.1 Participants and qualitative themes

In total, we recruited 27 participants. Participant characteristics and distribution across focus groups are shown in **Table 1**.

Table 1: Participant characteristics (n=27)

Age	
Median (IQR)	69 (66.5-72.5)
Sex	
Female	22
Male	5
Ethnicity	
Asian/Asian British Indian	11
Asian/Asian British Pakistani	4
Black/African/Caribbean/Black British African	6
Black/African/Caribbean/Black British Caribbean	5
Any other Black/African/Caribbean background – not described	1
Focus group distribution	
In-person – South Asian	10
In-person – Black African/Caribbean	8
Online – South Asian	5
Online – Black African/Caribbean	4

Findings are organised around four key themes:

1) Accessibility, exploring the extent to which people feel that online/remote access to health services is accessible.
2) Importance of visual contact with clinicians, highlighting when people feel it is important to be able to physically see a health professional.
3) Stresses of shift to remote access, which identifies psychosocial impacts for participants attempting to access health services remotely.

4) How far digital is the answer, which explores the extent to which participants view increasing digital technology as acceptable and appropriate.

In the quotations provided, participants are identified by their unique identifier, their ethnicity, and the mode of focus group in which they took part (e.g., P1, SA/I = Participant 1, South Asian/in-person focus group; P24, BAC/O = Participant 24, Black African or Caribbean/online focus group).

3.2 Accessibility

This prominent theme covers the extent to which participants felt that online/remote access to health services is accessible. It covers procedural issues about booking appointments, issues relating to language and culture, issues relating to digital skills, and access to dentists, pharmacies, and other community services. These issues emerged consistently across all four focus group sessions.

3.2.1 Appointment booking

Many participants referred to trying (and often failing) to telephone GPs at 8am to get an appointment.

> *"I needed to see my GP and I wanted to see a female GP for specific reasons. So, I used to ring them up, just like everybody else, you know, in the morning, 7:30/8 o'clock, continuously… I remember one day I must have made about 20-odd phone calls… When I rang in the afternoon they said, oh try again tomorrow… [I] did exactly the same, nothing again." [P1, SA/I]*

> *"…at the medical centre you have to phone about half past 8 and you can be waiting, and after maybe 30 minutes, every appointment is gone to see your own GP, so they will direct you to other services and they did ask me do I want a video call with another GP locum, or a telephone call…" [P11, BAC/I]*

Some participants said that they were more successful in making an urgent appointment after waiting outside the doctor's surgery.

> *"…one of the receptionists turned round to me and said, Mrs [name], why don't you come and wait outside the surgery at 8 o'clock and you might be able to get an appointment. Bob's your uncle. I went in and hence I got myself an appointment. Now since then… I've sat outside the doctor's surgery before 8 o'clock. There's always a queue." [P1, SA/I]*

> *"…if I can't get the appointment online, on the phone, I'll go down to the surgery... it means getting there before 8 o'clock, so as soon as it opens you can step in and get an appointment." [P24, BAC/O]*

Participants felt that digitalisation has meant that some people struggle to make a GP appointment via the phone or the NHS app, leading to more people going to A&E, a situation which got worse during the COVID-19 pandemic.

> *"What's happening is people who cannot access their GPs end up going to A&E, which is costing a lot more, which is impacting on the ambulances not getting out to people and not being able to deal with people who have got real emergencies… it's a broken system." [P23, SA/O]*

Some participants felt that the role of the receptionist has become more of a gatekeeping role, in which receptionists ask what are perceived to be sometimes inappropriate, personal or sensitive questions about symptoms and reasons for wanting a GP appointment. This was illustrated by a discussion mainly in the South Asian in-person focus group.

> *"They ask you [P1, SA/I]. That's right. [P5, SA/I]. They say what is the symptoms… [P6, SA/I]… That's true, sometimes it's private and confidential things… now reception wants to know before you see the doctor [P8, SA/I]. Yes, that's right. Yeah. [P5, SA/I]… Sometimes we have to say if we don't want to tell them… I just say it's my personal… then she would say… what is the symptoms." [P9, SA/I]*

> *"… they ask you all these questions. I mean I know they have to ask it. But my name, my date of birth and why do you want the appointment and do you need to see a doctor today… And I'm thinking don't ask me my personal business, because you're sat in an office, I know where the reception is, and you've said my name out… you've said that publicly that everybody can hear… And then the fact when I mention what the ailment is… other people might be in the reception that know who I am. And they're talking very loud. It's not quiet… you feel embarrassed... So, in a way I think that's wrong. I think that they need to change that." [P24, BAC/O]*

There were also concerns about the flow of communication from the receptionist to the doctor, delayed appointments, and lack of continuity of care, i.e., not being able to see the same doctor, particularly after hospital discharge. These concerns emerged consistently across all four focus groups, but predominantly among the South Asian participants (both in-person and online groups).

> *"…reception's not passing a message… that doctor told me that soon as you come out [of hospital], ring me, and I'll come and see you. And the reception never put back to the doctor. Doctor doesn't know and up to now, last… I phoned again and… they did give me appointment after three weeks. But I was seeing a different doctor, which… the doctor who told me my GP won't see me. She never mentioned to him and I never saw him after." [P2, SA/I]*

Participants in the Black African Caribbean online group raised concerns about primary and secondary care services not being 'joined up' or connected, with this leading to a breakdown in continuity of care.

> *"Because the hospital prescribed it. So, they have to give it to the doctor for the doctor… They don't seem to be working together. You're not getting the medication, I don't think, the necessary medication. And you're not getting their help quick enough. It's hard, isn't it? …. and when you do get the medication…like I said, the doctors are still… they're not joined up, that's what I think. It needs to be more joined up [P27, BAC/O]".*

Some South Asian participants highlighted how booking appointments online may be beneficial if it ensured rapid triage and bypassed receptionists who are perceived to be intrusive or uncaring.

> *"…these apps are good, but I mean, my experience of it is, the only plus point is that you don't have to speak to the receptionist – who has got*

> *about as much interest in the patient so whether you tell her, I'm just about to die she'll tell you, sorry, computer says no. So, the only advantage is that at least we don't have to speak to the receptionist, I can type my problem." [P23, SA/O]*

Participants felt that as appointments get booked up quickly, GP services should have a dedicated telephone line for very vulnerable people who are seriously ill or for carers of seriously ill older people.

> *"I was a carer for many years to my mum and dad, right, I'm now a carer to my brother. So, if they have complex medical conditions and they are very frail I can't wait in the queue behind you because you are a fit able young man, you can look after yourself. Now, our situation is not comparable at all therefore the GP can't give one number to everybody. There should be a hotline, an SOS number that you… But don't misuse the service. There should be a warning that if you misuse this service, we will take action against you." [P22, SA/O]*

Participants raised some concerns about older people being unable to access dental services, which was reported as having become more prevalent during COVID-19.

> *"Some of them are really, really suffering with the pain, especially if they've got infections or gum problems. And they couldn't go because of the COVID… now they are trying to go private, aren't they… unless you have been registered and if you've not been using the service, then they take your name off, right… And there is a lot of elderly are going through… especially when they have loose tooth, they can't afford it, they want to pay privately, there's so many issues with that." [P4, SA/I]*

Some participants did not know how to make an online dental appointment to see a dentist or were unsure about who to telephone.

> *"…so if you can't find a dentist, how would they know to… who to ring, how to go online and have a look? People don't know, they just assume that I haven't got a dentist, I can't do anything about it, I've got to put up with that." [P19, SA/O]*

The quote above also illustrates how there may be a sense of people feeling that they have no choice but to tolerate an unresolved dental issue.

3.2.2 Language and culture

There was a strong sense that language difficulties made remote access to health services difficult for older people who do not speak English as a first language, both in terms of attempting to use online means to access appointments or health information, but also if they needed to explain medical symptoms over the telephone.

> *"And what about people who are not English? And when I say not English, like Jamaican, African, not… the English language, it's second for them. There're loads of problems really that nobody's bothering about. What about uneducated people?" [P27, BAC/O]*

Participants particularly from the South Asian groups identified that people in their communities may have difficulties in understanding and communicating medical, difficulties in spelling and pronouncing or describing symptoms and problems, and difficulties in reading or writing.

> *"Another thing is there's a language barrier. That is the biggest problem... because they can't pronounce, they can't explain, they can't say what symptoms they're having, so this is why I think there's a lot of issues with Asian communities… It's the English, isn't it. How are you going to… if you don't know… proper English to explain what is happening to you, you don't know the words, you don't know how to type it, you don't know how to say it… understand. You know, like, if you spell it wrong… or if you put a sentence, it might… doesn't make sense because your English is not first language. So, you're trying to explain your symptom on a piece of paper or on the computer. And if you don't know how to express that, how are you going to make them understand what's happening to you?" [P4, SA/I]*

Some participants suggested that it might be useful if information and interactive services were available in different languages. However, others were mindful that poor first-language literacy among some older people in their communities meant that this would not suit everybody and pointed out the different levels of literacy within and across the different communities.

> *"…that South Asian community which came here in 1950s onwards, the majority are from small towns and villages and now they are as a first generation – so literacy is only 23 percent. Most of them cannot even read and write their own language so how they can use… and how many people have a smart phone or internet access?... that's another question… So, even if they want to do digital technology they should have digital literacy courses in the community, where these courses are giving a chance for older people especially to learn how to use the digital technology." [P20, SA/O]*

The role of interpreters was discussed and was highlighted as not straightforward, as families cannot interpret for relatives because of conflict of interest, family pressures, impartiality, and confidentiality issues.

> *"…at the moment, I think this is a new thing that family cannot interpret because I have to go with my mum many times and because I live with her, I'm official carer, but family can put pressure and it has to be the interest of the person. So, I cannot interpret. They have to get an outside interpreter." [P7, SA/I]*

There was an overall belief across all four focus groups that some older people were missing out on access to essential services and health care provision because of language barriers which compounds digital exclusion.

> *"I personally think you are [missing out] because… they've not been able to access those things because they don't understand. Because in the house their first language is either Punjabi or whatever it is that they speak, yeah. But it's not been able to access that… like I said before, you could have somewhere where there's, like, some, sort of, translation that can be done… And I'm sure that they're all willing. They're capable." [P1, SA/I]*

> *"… there's so much flaws in the system and there are people at home now suffering endlessly, you know? So, something has to be done. Every GP or whatever has to have a questionnaire, can you read and write, have you got support, things like that. We are in a multicultural society and the assumption that we can read, write, understand technology, it's not…" [P15, BAC/I]*

There was a perception that online systems and technology-facilitated access have been designed for predominantly 'white people' or those who are proficient in English, with concerns expressed about a lack of consultation during the development stages.

> *"Now, when NHS or these health ministers, if they are giving the contract to somebody to design the app for this kind of thing, they must give them first and make sure they have a cultural competence training before they design anything. They should know whom they're designing for. They are not just designing for white people, those who can speak English or Asians who can speak English, it is for everybody." [P20, SA/O]*

> *"But the thing about these things is, you know, where does the consultation happen? Because I've not ever seen any consultation… [they're] not reaching out to the whole community then. And I wonder if they've become… and biases have been developed then because they've not thought about, you know, this community might have this need and they've just thought, well, let's just base it on the white, you know, majority population." [P19, SA/O]*

Participants here also raised concerns about 'rolling out' of technology and the lack of public awareness and access to the various options available.

3.2.3 Digital skills and training

Participants talked extensively about (a lack of) digital skills and the kind of training that might be beneficial. Many reported that they and other older people in their communities often needed support from friends and family to undertake online interactions with health services. Some participants had support from community groups in accessing online health services as part of wider programmes of digital skills training that included use of Zoom to facilitate exercise sessions, healthy living and contact with families.

> *"We have gone out of our way to help these 15 families, supported them. And the one big thing that came out of the COVID for the digital side, when we got our licence for the Zoom, right, we were connected with the members and then… start a Zoom exercise session… we provide a service as well." [P10, SA/I]*

However, this was not always straightforward, as some participants struggled with online medication orders and repeat prescriptions.

> *"I found out it wasn't user-friendly for me, maybe my fault because you know when you are requesting a repeat prescription or trying to access the GP on behalf of somebody… I just put the information in where there's space and said this is not concerning me, you know? So, I found it unfriendly. I don't know about anyone's experience, but you know, when you're doing it for someone else in the same household, and with ours there was a limited time, so if you are not able to complete it, it goes back*

> *again, throws you out and then you have to start all over again... I don't find it helpful. I struggle with it." [P15, BAC/I]*

For other participants, using the telephone instead of online was also challenging because of hearing difficulties.

> *"So we done it online but it doesn't accept us to order our medication. Why's that? Because we've been asking this question and nobody's answering us better. And now we're learning to do it by phone but we're having a problem because my husband can't hear it properly." [P2, SA/I]*

Participants were positive about the role of local digital champion schemes and endorsed the idea of befrienders, buddy systems, volunteer and patient participation groups to help deliver training sessions to older people.

> *"I think there should be what I call an app buddy or a technological buddy or, you know, a tech champion at our GP surgery so that they can take the pressure away from the GP, all this negative angst and bitterness that we have because we can't cope. And the job of that person will be to take over the burden of the technological deficit, which obviously is prolific in, and be the intermediary between all these problems. So, if I can't do something technologically or, like, my brother can't, then we don't have to panic. The tech buddy at the GP surgery or, you know, whichever hub they place them at, can initially sort us out." [P22, SA/O]*

> *"I am part of the digital championship scheme in Manchester where we help the older people to [be]come au fait with their gadgets. And we do it in places where they have spaces like community centres, libraries. And we have the cooperation of the people who work there. And people do come and people are helped to work out… We're doing Learn My Way…. And Good Foundation... And we're teaching that to help people to just… get used to the keyboard. Just to get used to the keyboard is an advantage." [P24, BAC/O]*

Some participants felt the NHS app has been helpful because patients do not have to wait for telephone calls about appointments or test results and can receive reminders which they find helpful.

> *"I'm okay, we have got the NHS app so any messages they send me online and I can order my repeat prescription as well on there, so I'm okay with that... It's been okay, yes… It's like when you have a blood test, when I phoned the next day, the results go on the app. You don't need to wait for them to ring you… For me, going back to the appointments, I find the NHS app helped me. If you've got an appointment, they send you on your phone and a letter and then it reminds us two days before. I find this helpful." [P12, BAC/I]*

However, there were other examples of people being unaware that test results were communicated via the app and thought that they were left waiting. There were also concerns over how results would be interpreted on apps compounded by an unfamiliarity with medical terms.

> *"… some of us don't even know we go there and then you have your bloods done and then you're sat at home waiting for the results, and the*

> *next time you go they say, what happened to my tests, they say, oh, it's on the app. I said which app? They said you have not downloaded the app? So, they come up with apps without raising awareness. I'm like how am I even going to interpret those results on the app? I mean, it's just taking over the world, like some of them are not really… probably it's my own thing, it's not necessary, like how would I interpret results on an app? I don't know the medical terms. And they say, oh, your results are on the app, just like that." [P17, BAC/I]*

Others indicated that the NHS app use has proved problematic, either because of issues with downloading or with password issues, e.g., forgotten passwords and a lack of knowledge about how to request a new one.

> *"…she told me about the NHS app because at the time I was waiting for results, so she said I could go to my NHS app and look for it. When I got there, when they asked me for the password, I forgot and I didn't know how to get the password again, so I left that. I had to wait for the results to come... So now I have an NHS app but I don't know how to do it because I don't know my password. I only had it during…COVID, when I needed to travel, but I don't know how to regain it." [P13, BAC/I]*

Overall, the role of (usually younger) relatives and members of community organisations to support people digitally (both in general and around health appointments/prescriptions) was cited as being important. However, it is not clear how appropriate this might be in the context of health care in upholding privacy, e.g., in the case of women making gynaecological appointments.

> *"…if she has got any gynae issue it is very hard for that Asian mother to ask her son to put that something into this app. Because it's… like cultural wise it's kind of a private things when it comes to gynaecological or sexual issues. Parents do not talk. Maybe mother is easy to talk with the daughter but not with the son, it's out of the question. So, these things they have to consider." [P20, SA/O]*

3.3 Importance of visual contact with clinicians

This theme highlights the extent to which participants felt that having a visual aspect to their interaction with clinicians (particularly a GP) is important. There were multiple quotes emphasising the importance of the GP being able to see patients, and scepticism of telephone appointments.

> *"…and if they are doing some face-to-face, the relationship with the doctor has been real, they will be able to recognise that very quickly. And at least identify the problem much quicker than being on the phone." [P3, SA/I]*

There was a strong preference for in-person appointments as participants queried how well GPs might understand a problem if they cannot see the patient.

> *"…how can they diagnose something when they don't see you… my husband can't hear it properly… 'cause we can't pronounce things… like to see face-to-face that we can say it. How to speak… I don't know how to spell everything." [P2, SA/I]*

> *“The other advantage of face-to-face, somebody could be suicidal, depressed, you talk to somebody over the phone, to the doctor, they can’t see your face.” [P12, BAC/I]*

Others suggested that a face-to-face consultation with their GPs was important at an inter-personal level and was considered to be ‘uplifting’ and ‘healing’. This was also related to some of the perspectives about language challenges and the feeling that some older people may be able to explain problems much better in person rather than online or over the telephone.

> *“…because you have connected with somebody who’s got experience, who knows your symptoms, who knows you well. And you can release all your pressures. Sometimes it could be just talking. And now because we’re not connecting with people, we are connecting with this electric gadgets… but I prefer seeing them personally because then I feel confidence that you're seeing me, you're seeing my symptoms, my diagnoses and giving me the right medicine or whatever.” [P4, SA/I]*

> *“We are not [confident], so we want that line that will connect with our GPs, because really to be honest, when you go to your GP, you see that GP face-to-face, you feel already better, whereas when you’re online, there’s no connection, there’s no relationship for us. It’s just machine noise. But the person-to-person thing, so yes, the two of them, I think. We’re not saying they shouldn’t be, but the two of them can go together side-by-side.” [P18, BAC/I]*

Although there was limited experience of video consultations with GPs, some participants were positive about this mode of consultation and perceived it to be the next best thing to an in-person appointment.

> *“…well for a start, I think there’s nothing better than having face-to-face communication, right. But talking about FaceTime or video call, we’ve had this experience where my father-in-law fell, and when the sister-in-law rang the doctor, obviously the doctor came on video call, it was over…due to COVID, and because she was on a video call, the doctor wanted to see exactly what happened, and the doctor was able to diagnose to say that he’s actually fractured his hip, because she could actually see exactly what was happening. And she called the ambulance and everything. And he was taken to hospital. But if you can't contact or have communication with doctor, face-to-face, at least having video call would probably be another best thing.” [P5, SA/I]*

However, the following quote highlights the importance and usefulness of an in-person face-to-face approach for ‘seeing and feeling’ patients; this seems to be the preferred method for undertaking regular patient reviews and for monitoring purposes.

> *“…you cannot have regular reviews online because they need to see you, they need to monitor you, you need to take those tests, they need to see your grip, they need to see your stand, they need to see your position...they need to smell your breath, you known what I mean? Just need to know what you're like. Because sometimes people's breath smells of pear drops and that's a sign of diabetes or some kind of ailment I think. But they need to be there. And if it smells of almonds you know… there's something wrong with them and whatever.” [P24, BAC/O]*

Participants also acknowledged advantages of using video conferencing technology for some people (e.g., if they live far away), as many older people may have transportation issues.

> *"But this is what would be useful, if the GPs use the FaceTime. If they use the FaceTime with the patients… the patient doesn't have to worry about transport, which the majority… of them have the problem. If the GP… they don't even really need the receptionist, they just say, right…this is the doctor, I want to see you, can you give me time. That's all they have to say. And if the FaceTime… it can be… not hundred per cent but near enough to face-to-face conversation. So that would be a very big asset." [P10, SA/I]*

Video consultation was seen as a familiar mode of communication as participants were able to relate it to remote interaction with relatives during the pandemic.

3.4 Stresses of shift to remote access

This theme captures (often negative) psychosocial impacts reported by people arising from a shift to remote appointments and appointment booking.

There were multiple examples of fear of using technology to make health appointments, which caused stress, agitation, frustration and high levels of anxiety at not being able to make health appointments.

> *"For me, it's scary, technology, because it changes so fast, you can't cope and like they've said, the person-to-person thing, you get connected with your doctor and you've got answers when you go there, you've got answers. But the machine will go on, you keep carrying on half an hour, 40 minutes, you're next in the line, you're next in the queue, you're number three, whatever, you wait and wait and wait, and then you lose patience… so, technology is scary because we get also anxious… I'm scared of the machine. I'm not able to grasp it… it's so stressful." [P18, BAC/I]*

These experiences were felt by some to contribute to a deeper fear of becoming ill in the first place.

> *"I think it's [the current health system] more stressful. Because you feared to become ill. You fear to become ill because doctors and national health doors are closed now. Those who can be… you know, get to their… they… we don't know the digital, we can't get any Internet and we can't call them, then every… all the doors are closed for us, so it's a fearful life." [P9, SA/I]*

Several participants commented on how the 'old days' were better, where they could walk up to their GP surgery and sit in a queue to be seen by a GP, with some reflecting on their experiences before and after the pandemic.

> *"In my opinion, yeah, it was better before. During COVID and after COVID it's gone worse, you know, in my experience, you know. Because when you need an emergency care, you know, you need to see your GP, you need to see the professional, you know, and if you don't get the chance to see them, you know, it will affect your mental health as well." [P23, SA/O]*

Some participants felt that digital access to health care has been ‘thrown at them’ and that it will take time for them to adjust to this new way of working.

> *“I think because we were used to the old system of doing things, this one has just been thrown at us, and as we keep saying, it’s scary. It will take time for us to move into there and then it has to be simplified as well for us because if you ask me about getting in touch online to my GP, I personally don’t like it.” [P15, BAC/I]*

There were concerns about consent and the ‘small print’, with the sense that people may be very confused about what is happening with their data when engaging with the health service digitally.

> *“…but also there’s a thing about consent. And, you know, with the NHS it’s that you’re all opted in but you have to opt out, so you know, this is where your data is shared. And a lot of it they’re unaware of this. To me it should’ve been communicated to them in their own language.” [P19, SA/O]*
>
> *“I don't like to go online because of all the information… actually I don't trust the online services because things get leaked and so forth online. Personally, why it's a bit unfair, is that most older people will not read the small print of anything that's put online. They will just complete the form and they don't know if they're signing their life away. And because they haven't read the small print anything can happen. You know what I mean? And when it comes to your health and the national health, imagine if that small print said if you fill in this form, that you've agreed to your organs being donated, when they don't want to do that.” [P24, BAC/O]*

This sense of fear and confusion of using technologies to access health care was cited within a wider narrative of fear and lack of confidence in using technologies more generally (e.g., fear of online banking and scams).

> *“…there's too many scams going about now. The older people, they are really getting scared of that. And not even the older, the younger people… The scams are so sophisticated to do with computers that I couldn't imagine what could go wrong if some person had all the national health number, this number, that…” [P27, BAC/O]*

Participants describe their fear of missed opportunities, late diagnosis and neglect which they felt were creating more health inequalities for older people because of digitalisation of services.

> *“…people, especially with South Asians, if they can't access their GPs and they can't use the app what’s happening is, if they’ve got a condition, they’re going to let it fester until it gets to a point where they have to go into hospital. So, it’s actually going to cost you more and really, you know, there should be other pathways that people… like we've said, you know, that they can't get into the GPs but there should be at least somewhere. Some health professional, you know, triaging this and saying, you know, let’s get you seen by a nurse or see what is the issue? And I don't think you can just rely on apps and online technology, I think there’s always going to be a percentage of people who are not going to be able to access,*

> *and that's, you know, in a way you're creating more health inequalities."*
> *[P19, SA/O]*

The topic of institutional racism and discrimination within the health service was raised by participants in the Black African Caribbean groups, with some feeling that they are not treated with sympathy, empathy or respect when making appointments. For example, there were descriptions of being treated differently, both over the telephone and in person, because of being identified as Black or 'not British'.

> *"We're living in a very stressful society now and the assumption that it's easy to access the GP or NHS, it's not. It's not… They look at you, institutional racism, so the one at the counter is going to deal with you the same way. They're not going to deal with you with sympathy, empathy, with respect. I've seen it. I've seen, I'm not assuming, you know? I know there are challenges because they look at you, she's old, no disrespect, she's Black, they don't know the technology, they don't understand it... they hear your voice, oh no, this one is not British, okay, I'm going to treat that person differently. And she gets angry at that because to take a phone to make a call to a person you don't know to express what you're feeling and what you want, it takes some courage, that has to be respected."*
> *[P15, BAC/I]*

The above quote also highlights how it can be intimidating for people to express their concerns and feelings over the telephone to somebody they do not know, and the sense that this is not always respected by health professionals.

There were some reflections on cultural gender differences, with examples of digitally excluded Asian men possibly being further excluded because they are more reluctant to seek health care than women.

> *"I think the frustration is higher in the end, it's higher for me, because initially… in general, men find it difficult to talk about their problems and they're not getting to be able to see the GP gets them even more frustrated. And then the combination of everything together…"[P3, SA/I]*

However, these reflections were made with the caveat that the vast majority of study participants were women.

3.5 How far digital is the answer

This theme captures the extent to which participants feel that digital access and delivery of health services is appropriate. There was recognition that one size does not fit all and there were calls for offline alternatives. Participants accept that digitalisation is the way forward but cautioned against seeing it as a panacea. Relating back to the theme about accessibility, there were some concerns that more personal/private health issues (e.g., sexual/reproductive health and mental health) would be better suited to in-person discussion. Choice was seen as very important, and participants felt that people should be given options about mode of consultation, with some suggesting adopting a 'hybrid approach' as a way forward.

> *"I think we should be given options. Do you want to come face-to-face? Do you want telephone consultation? Do you want this? We are different, we all have different strengths and weaknesses." [P15, BAC/I]*

> *"I think there should be a hybrid approach, you know, there should be options for those people who can't access technology. There should be somewhere that they are either supported in the GP surgery to be able to do that. And whether that's… I don't know, I don't want to go back to community pharmacies because they're already busy doing everything else. So, whether… those people that can do it online or through other ways..." [P19, SA/O]*

Some participants were sceptical about potential benefits of technology-based access to the health service if there was a fundamental lack of clinical workforce to deliver care.

> *"And the other thing is also I think that Britain…left the Common Market a lot of people went back, you see, so we don't even have the chance of, say, even a reasonable nurse seeing you at the GP practice. Even if a specialist nurse saw us it would be okay, you know, but they haven't even…they can't even manage to have specialist nurses. Where will they get the nurses from? You know, the borders are closed, aren't they?" [P22, SA/O]*

> *"I think the technology was to help improve the system, but the problem has been you've got a reduced workforce, so you haven't got the staff there to actually deal with all these… online technology and the requests coming through. I don't think it's just been from COVID; I think it's been over the last 10 or 12 years it's been reduced, the staff and the workforce…" [P23, SA/O]*

The above quotes show that participants recognised workforce challenges as a longer-term issue that predated the pandemic and that affected all members of society, not just specific ethnic groups.

4. Discussion

4.1 Key issues from findings

The finding that many participants reported trying and failing repeatedly during, and since, the pandemic to get through to their GP to make an appointment is unsurprising. It is widely recognised by the public and by policymakers; ending the '8am rush' of telephoning on the morning is a central ambition of recent NHS England guidance for recovering access to primary care.[32] This guidance proposes implementing 'Modern General Practice Access' via digital telephony and online requests as a key approach to realising this ambition. Although this may be helpful for many people, our study reveals strong concerns of language barriers for older people who do not speak English as a first language, both in attempting to use online means to access appointments or information and in using the telephone to book appointments or speak with clinicians. Qualitative research conducted before the pandemic (with white British participants mainly under the age of 60) highlighted that while participants felt that online consultation tools could increase access for certain groups (e.g., people who have difficulties in communicating verbally), they also struggled with the laborious nature of structured questionnaires and with articulating their problems independently.[33] Such challenges are exacerbated by language barriers. Other work exploring the impact of pandemic-driven digitalisation with migrants (under the age of 50) found that digitalisation has aggravated existing inequalities in access to health care because of challenges in digital literacy and access to technology which are augmented by language barriers.[34] In our study, the role of (usually younger) relatives and members of community organisations to support older people to overcome digital and language barriers around health appointments was highlighted as being important, but a reliance on this support may be inappropriate in some contexts that are deemed to be more personal, e.g., women seeking gynaecological appointments. It is also not clear that simply offering digital services in different languages will be helpful for everyone, as participants in our study cautioned that literacy levels among some older members of their communities are poor.

Some challenges are more general to an ageing population e.g., hearing loss, and others are specific to minority ethnic groups, e.g., language difficulties. General challenges may be exacerbated by specific challenges, e.g., an older adult from a minority ethnic group who has hearing loss may experience further difficulties in hearing in a language that is not their first language.

Some participants felt that the role of the GP receptionist has changed over the pandemic to become more gatekeeping and queried the appropriateness of some of the questions they had been asked about why they wanted an appointment. Some of the Black African and Caribbean participants raised concerns about racism and discrimination in the health service during both face-to-face and remote access, which have been reported in other qualitative work by the Older People and Frailty Policy Research Unit exploring access to palliative and end-of-life care during the pandemic for people of Black African and Caribbean backgrounds.[35] The issue of receptionists as gatekeepers has long been highlighted, for example, in work over 20 years ago which found challenges for receptionists in managing patient appointments but also revealed that receptionists showed discriminatory behaviour about certain groups of patients.[36] It is concerning that some participants in our study reported that these issues are still occurring.

Several participants emphasised the importance of visual interaction with clinicians and a strong preference for in-person appointments, linked to some of the concerns raised around language barriers and the ability to explain problems over the telephone. There were also positive comments about video consultations as a next-best-thing to in-person consultations. These findings reinforce earlier work that highlights that there may be times when visual or face-to-face interaction with clinicians may be felt to be more appropriate.[20–22]

Some participants reported negative impacts of struggling to get appointments, including stress, frustration and a deeper fear of becoming ill in the first place. Policy and research have long focused on mitigating missed appointments, primarily through the lens of improving resource efficiency. A recent evidence review of non-attendance in the NHS shows a clear age, socioeconomic and health inequalities gradient as older people from lower socioeconomic groups with multiple long-term conditions are most likely to miss appointments.[37] The review suggests that addressing inefficiencies in the appointment booking system and enhanced patient involvement in the booking process may help address the problem. Our study suggests that the impacts on older people’s wellbeing of being unable to arrange appointments in the first place may need further investigation. The recent Major Conditions Strategy emphasises early diagnosis, early intervention and quality treatment.[38] Our findings raise concerns that people may not be able to make appointments and get timely GP treatment, resulting in use of hospital resources, either at A&E or longer term when diseases have not had timely treatment in primary care.

Participants generally accepted that digital is the way forward and could see benefits of digitalised access for many people (e.g., time and convenience). However, they cautioned against seeing technology as a panacea and called for offline alternatives and choice of ways to access health care. It is therefore encouraging to see that this is reflected in the NHS primary care recovery plan’s emphasis that patients will ‘always have the option of visiting their practice in person’.[32] The plan also emphasises increasing knowledge and confidence in the use of the NHS app and other digital access routes. Although participants in our study called for more support to increase digital skills and confidence among older people, and indicated willingness to learn, it is important to highlight that they raised concerns about the extent to which they felt digitalised services have been designed in consultation with older people from minority ethnic groups and for whom English is not a first language. Such considerations are a fundamental aspect of digital UX design methodology, which aims to understand the needs, behaviours, motivations and preferences of users.[39,40] Participants urged policymakers to consider this more carefully. Our findings suggest that there are numerous barriers for engagement of minority ethnic older people in digital technologies that must not be ignored or overlooked. Some participants expressed a wider scepticism about the potential of digital access to arrange health appointments if there is a more fundamental lack of clinical workforce and a lack of continuity of care and relationship with the same clinician.

4.2 Strengths and limitations

The strength of the study included the sample size (n=27) and our use of a participatory approach for the in-person focus groups, with extensive engagement with two community organisations in Greater Manchester to support recruitment of diverse older people from two different minority ethnic groups. Five of the 27 participants were aged at least 75; the involvement of people over 75 in research—particularly about digital technologies—is often lacking.[41]

Despite this participatory approach, the main limitation of the study is the extent to which we reached older adults from the two ethnic groups who are digitally excluded. We aimed to recruit participants from across the spectrum of digital engagement, but the qualitative data suggest that the levels of engagement appeared to be similar across the in-person and online groups. We had hoped to recruit people who may not have been proficient in use of English given the impact that language has on digital exclusion, and we did not include any quantitative measure of participants’ levels of digital health literacy (e.g., via the eHealth Literacy Scale (eHEALS)[42,43] because it has not been translated into appropriate languages). However, all participants had a good level of English and therefore it is likely that we did not reach people from these minority ethnic groups who may be the most digitally excluded. Despite this limitation, participants offered some valuable insights into the dual nature of digital and language exclusion when attempting to access health services via digital or remote means. The vast majority (22/27) of participants were women so we are unable to say much about gender-based norms and expectations within each ethnic group.

4.3 Implications/Recommendations for policymakers

A number of suggestions arise from this work for policymakers to consider regarding the future of digitalised health and care services:

- Design of digital health services must involve in-depth consultation and user experience research with older adults from diverse backgrounds, including those who have limited English language ability.
- It is important not to underestimate the impact of language barriers and the challenges this can pose for digital literacy and engagement. Simply offering translation functions within digital technologies may be insufficient.
- Although older adults may be able to ask friends or family for support in using digital technologies and may be willing to learn how to use digital technologies, there are times when this will not be appropriate as people need privacy to raise intimate health issues.

- More simple queries may be addressed online or via telephone, but face-to-face/visual contact with clinicians is important to allow patients to feel confident that their problems are understood, and to develop a therapeutic relationship. This may be particularly important for older people who have limited or no English language skills, and particularly important for certain health issues such as sexual/reproductive health and mental health. The use of video technology is seen as an acceptable alternative to in-person consultations.
- It is imperative to maintain choice in how to access health services, including hybrid and offline options.
- The use of buddies or champions at a practice level may warrant further consideration and evaluation to help support people who are having difficulty accessing services.

Acknowledgements

We would like to thank the study participants and community organisations we worked with for their support with this study, including John Mulvenna, Facilitator, GM Older People’s Equality Panel; Gertrude Wafula and Percy Akudo from the Caribbean and African Health Network; and the Gujarati community group Dipak Dristi (Light of Vision).

We also acknowledge the contributions of Ukachukwu Abaraogu, former Research Fellow within the Older People and Frailty Policy Research Unit, during the early stages of the study; Saima Ahmed, Project Lead and Health Coordinator from a South Asian community group (Firvale Community Hub, Sheffield) for advice on the practicalities of conducting in-person focus groups within this community; and Katie Brittain, Professor of Applied Health Research and Ageing, Newcastle University/Older People and Frailty Policy Research Unit, for comments on this report.

References

1. World Health Organization. *Global Strategy on Digital Health 2020-2025*. Geneva, World Health Organization; 2021. https://www.who.int/docs/default-source/documents/gs4dhdaa2a9f352b0445bafbc79ca799dce4d.pdf?sfvrsn=f112ede5_42

2. National Health Service. *NHS Long Term Plan*. London, National Health Service; 2019. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

3. National Health Service. *Empowering the Person: Roadmap for Digital Health and Care Services*. London. National Health Service; 2019. https://indd.adobe.com/view/119c9ee5-6acb-4f52-80c2-d44fc03fdc91

4. UK Government. *COVID-19 Response - Spring 2021 (Summary)*. London, UK Government; 2021. https://www.gov.uk/government/publications/covid-19-response-spring-2021/covid-19-response-spring-2021-summary

5. Gasser U, Ienca M, Scheibner J, Sleigh J, Vayena E. Digital tools against COVID-19: taxonomy, ethical challenges, and navigation aid. *Lancet Digit Heal*. 2020;2(8):e425-e434. doi:10.1016/S2589-7500(20)30137-0

6. Department of Health and Social Care. *A Plan for Digital Health and Social Care*. London, Department of Health and Social Care; 2022. https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care

7. NHS Digital. What we mean by digital inclusion. Published 2023. Accessed July 31, 2023. https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/digital-inclusion/what-digital-inclusion-is

8. Stone E. *Digital Exclusion and Health Inequalities: Briefing Paper*. Sheffield, Good Things Foundation; 2021. https://www.goodthingsfoundation.org/wp-content/uploads/2021/08/Good-Things-Foundation-2021-–-Digital-Exclusion-and-Health-Inequalities-Briefing-Paper.pdf

9. UK Government. *Population of England and Wales*. London, UK Government; 2022. https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest

10. Kunonga P, Spiers GF, Beyer F, et al. *Can Digital Technologies Enhance Older People's Access to Health and Social Care? A Rapid Review of Reviews*. NIHR Older People & Frailty Policy Research Unit; 2020. https://documents.manchester.ac.uk/display.aspx?DocID=67157

11. Kunonga TP, Spiers GF, Beyer FR, et al. Effects of Digital Technologies on Older People's Access to Health and Social Care: Umbrella Review. *J Med Internet Res*. Published online November 2021. doi:http://dx.doi.org/10.2196/25887

12. McGarrigle L, Todd C. Promotion of Physical Activity in Older People Using mHealth and eHealth Technologies: Rapid Review of Reviews. *J Med Internet Res*. 2020;22(12):e22201. doi:10.2196/22201

13. McGarrigle L, Boulton E, Todd C. Map the apps: a rapid review of digital approaches to support the engagement of older adults in strength and balance exercises. *BMC Geriatr*. 2020;20(1):483. doi:10.1186/s12877-020-01880-6

14. NIHR Older People & Frailty Policy Research Unit. *Delivery of Strength and Balance Exercises for Falls Prevention amongst Older People Using Digital Technologies*. NIHR Older People & Frailty Policy Research Unit; 2020. https://www.opfpru.nihr.ac.uk/our-research/covid-19-research/technology-for-strength-and-balance/

15. Parker RF, Figures EL, Paddison CA, Matheson JI, Blane DN, Ford JA. Inequalities in general practice remote consultations: a systematic review. *BJGP Open*. 2021;5(3):BJGPO.2021.0040. doi:10.3399/BJGPO.2021.0040

16. Centre for Ageing Better. *COVID-19 and the Digital Divide: Supporting Digital Inclusion and Skills during the Pandemic and Beyond*. London, Centre for Ageing Better; 2021. https://ageing-better.org.uk/resources/covid-19-and-digital-divide-supporting-digital-inclusion-

and-skills

17. Phillipson C, Lang L, Yarker S, et al. *COVID-19 and Social Exclusion: Experiences of Older People Living in Areas of Multiple Deprivation*. University of Manchester; 2021. https://www.micra.manchester.ac.uk/muarg/research/publications/

18. McGarrigle L, Todd C. Falls prevention in a digital age: addressing the digital divide. In: *On Digital Inequalities*. University of Manchester; 2021. https://www.policy.manchester.ac.uk/publications/on-digital-inequalities/

19. Eost-Telling C, Hall A, Beyer F, et al. *Digitalisation of Health and Care Services for Older Adults: What Can We Learn from the COVID-19 Pandemic?* NIHR Older People & Frailty Policy Research Unit; 2022. https://documents.manchester.ac.uk/display.aspx?DocID=66892

20. Murphy M, Scott LJ, Salisbury C, et al. Implementation of remote consulting in UK primary care following the COVID-19 pandemic: a mixed-methods longitudinal study. *Br J Gen Pract*. 2021;71(704):e166-e177. doi:10.3399/BJGP.2020.0948

21. Paskins Z, Bullock L, Manning F, et al. Acceptability of, and preferences for, remote consulting during COVID-19 among older patients with two common long-term musculoskeletal conditions: findings from three qualitative studies and recommendations for practice. *BMC Musculoskelet Disord*. 2022;23(1):312. doi:10.1186/s12891-022-05273-1

22. Bradwell H, Baines R, Edwards KJ, et al. Exploring Patient and Staff Experiences With Video Consultations During COVID-19 in an English Outpatient Care Setting: Secondary Data Analysis of Routinely Collected Feedback Data. *JMIR Form Res*. 2022;6(3):e30486. doi:10.2196/30486

23. Hammerton M, Benson T, Sibley A. Readiness for five digital technologies in general practice: perceptions of staff in one part of southern England. *BMJ Open Qual*. 2022;11(2):e001865. doi:10.1136/bmjoq-2022-001865

24. Healthwatch. *Locked out: Digitally Excluded People's Experiences of Remote GP Appointments*. Healthwatch; 2021. https://www.healthwatch.co.uk/report/2021-06-16/locked-out-digitally-excluded-peoples-experiences-remote-gp-appointments

25. Healthwatch Salford. *Remote Appointments during COVID-19 Report*. Healthwatch; 2021. https://www.healthwatchsalford.co.uk/report/2021-05-24/remote-appointments-during-covid-19-report

26. Healthwatch Darlington. *Digital Exclusion: Understanding the Impact on Primary Care Services and Patients in Darlington during the Covid-19 Pandemic*. Healthwatch; 2021. https://www.healthwatchdarlington.co.uk/sites/healthwatchdarlington.co.uk/files/Digital Exclusion Report Final June 2021.pdf

27. Healthwatch Suffolk. *Digital Health & Care: A Report on Local Experiences in Suffolk and North East Essex*. Healthwatch; 2021. https://healthwatchsuffolk.co.uk/wp-content/uploads/2021/06/Digital-Health-and-care-FINAL.pdf

28. Healthwatch Derbyshire. *Experiences of Virtual Appointments during Covid-19*. Healthwatch; 2020. https://democracy.derbyshire.gov.uk/documents/s4318/Healthwatch Derbyshire Virtual Appointments Report October 2020.pdf

29. Kebede AS, Ozolins L-L, Holst H, Galvin K. Digital Engagement of Older Adults: Scoping Review. *J Med Internet Res*. 2022;24(12):e40192. doi:10.2196/40192

30. Bonevski B, Randell M, Paul C, et al. Reaching the hard-to-reach: a systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BMC Med Res Methodol*. 2014;14(1):42. doi:10.1186/1471-2288-14-42

31. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol*. 2013;13(1):1. doi:10.1186/1471-2288-13-117

32. NHS England. *Delivery Plan for Recovering Access to Primary Care*. London, NHS England;

2023. https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/

33. Turner A, Morris R, Rakhra D, et al. Unintended consequences of online consultations: a qualitative study in UK primary care. *Br J Gen Pract*. 2022;72(715):e128-e137. doi:10.3399/BJGP.2021.0426

34. Knights F, Carter J, Deal A, et al. Impact of COVID-19 on migrants' access to primary care and implications for vaccine roll-out: a national qualitative study. *Br J Gen Pract*. 2021;71(709):e583-e595. doi:10.3399/BJGP.2021.0028

35. Dewhurst F, Tomkow L, Poole M, et al. *Palliative and End of Life Care Experiences of People of African and Caribbean Descent during COVID-19 (PEACE)*. NIHR Older People & Frailty Policy Research Unit; 2022. https://www.opfpru.nihr.ac.uk/our-research/projects/peace/

36. Offredy M. Access to primary care:decision making by GP receptionists. *Br J Community Nurs*. 2002;7(9):480-485. doi:10.12968/bjcn.2002.7.9.10660

37. Wilson R, Winnard Y. Causes, impacts and possible mitigation of non-attendance of appointments within the National Health Service: a literature review. *J Health Organ Manag*. 2022;36(7):892-911. doi:10.1108/JHOM-11-2021-0425

38. Department of Health and Social Care. *Major Conditions Strategy: Case for Change and Our Strategic Framework*. London, Department of Health and Social Care; 2023. https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2

39. Wilson J, Heinsch M, Betts D, Booth D, Kay-Lambkin F. Barriers and facilitators to the use of e-health by older adults: a scoping review. *BMC Public Health*. 2021;21(1):1556. doi:10.1186/s12889-021-11623-w

40. Blanchard M. User experience research in the development of digital health products: Research letter. *Heal Policy Technol*. 2023;12(2):100753. doi:10.1016/j.hlpt.2023.100753

41. Eost-Telling C, Hall A, Harris D, et al. *What Factors Have Impacted on Older People's (75+) Access/Experience of Public Services during Covid-19? Phase 2: Qualitative Report*. NIHR Applied Research Collaboration Greater Manchester; 2022. https://arc-gm.nihr.ac.uk/media/Resources/ARC/Healthy Ageing/Digital Inclusion/phase 2 Digital Inclusion Report_Phase II_27-06-22.pdf

42. Norman CD, Skinner HA. eHEALS: The eHealth Literacy Scale. *J Med Internet Res*. 2006;8(4):e27. doi:10.2196/jmir.8.4.e27

43. Oh SS, Kyoung-A K, Kim M, Oh J, Chu SH, Choi J. Measurement of Digital Literacy Among Older Adults: Systematic Review. *J Med Internet Res*. 2021;23(2). doi:http://dx.doi.org/10.2196/26145

NIHR | Policy Research Unit Older People and Frailty

This document is available in large print.

Please contact the NIHR Older People and Frailty PRU for assistance.

Email: pru-manager@manchester.ac.uk

Telephone: 0161 306 7797

Front Cover Image
From Centre for Ageing Better image library
Licensed under CC0 1.0 Universal (CC0 1.0)

MANCHESTER 1824 The University of Manchester

Newcastle University

CPEC CARE POLICY AND EVALUATION CENTRE Research at LSE