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BMJ Open Barriers and facilitators to use of digital health tools by healthcare practitioners and their patients, before and during the COVID-19 pandemic: a multimethods study

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ABSTRACT

Objectives To explore how healthcare practitioners (HCPs) made decisions about the implementation of digital health technologies (DHTs) in their clinical practice before and during the COVID-19 pandemic.

Design A multimethods study, comprising semistructured interviews conducted prior to the COVID-19 pandemic, supplemented with an online survey that was conducted during the pandemic with a different sample, to ensure the qualitative findings remained relevant within the rapidly changing healthcare context. Participants were recruited through HCP networks, snowballing and social media. Data were analysed thematically.

Setting Phone interviews and online survey.

Participants HCPs represented a range of professions from primary and secondary care across England, with varied socioeconomic deprivation.

Results 24 HCPs were interviewed, and 16 HCPs responded to the survey. In the interviews, HCPs described three levels where decisions were made, which determined who would have access to what DHTs: health organisation, HCP and patient levels. These decisions resulted in the unequal implementation of DHTs across health services, created barriers for HCPs using DHTs in their practice and influenced HCPs' decisions on which patients to supply DHTs with. In the survey, HCPs described being provided support to overcome some of the barriers at the organisation and HCP level during the pandemic. However, they cited similar concerns to pre-pandemic about barriers patients faced using DHTs (eg, digital literacy). In the absence of centralised guidance on how to manage these barriers, health services made their own decisions about how to adapt their services for those who struggled with DHTs.

Conclusions Decision-making at the health organisation, HCP and patient levels influences inequalities in access to DHTs for HCPs and patients. The mobilisation of centralised information and resources during the pandemic can be viewed as good practice for reducing barriers to use of DHTs for HCPs. However, attention must also be paid to reducing barriers to accessing DHTs for patients.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ To ensure our qualitative study conducted just prior to the COVID-19 pandemic was relevant and informative in a 'post-COVID-19' landscape, we developed and disseminated a questionnaire that explored whether COVID-19 had changed the way that healthcare professionals used DHTs.
- ⇒ Double-coding of a subset of interviews by five members of the team and ongoing discussion about coding structure ensured the coding scheme was robust.
- ⇒ Challenges recruiting participants for both the interviews and the survey may limit the generalisability of the findings.
- ⇒ As patients were not included in this study, reflections about the barriers patients experience accessing digital health technologies are from the healthcare practitioner's perspective.

BACKGROUND

In recent years, primary care practice has rapidly increased the use of digital health technologies (DHTs).¹ DHTs include smartphone apps, digital tools for diagnosing or treating conditions (including those that use artificial intelligence²), wearable devices (eg, pedometers) and platforms that provide remote healthcare.³ This has been accelerated by the COVID-19 pandemic, in which the majority of face-to-face appointments were suspended and healthcare practitioners (HCPs) were required to encourage the uptake of digital self-management tools for patients, including using remote consultations and mobile health apps.⁴⁻⁶ DHTs have the potential to increase access to health interventions, while reducing demand on an overstretched healthcare system.⁷⁻⁹ The National Health Service (NHS) Long Term Plan has outlined the role of DHTs in transforming 'healthcare

in the digital age', to achieve the goal of delivering world-class personalised medicine in primary care practices and social care.¹ However, the successful implementation of DHTs relies on both the patients and HCPs being willing and able to engage with these interventions,^{10 11} and there are ongoing concerns about the impact of DHTs on health inequalities.¹²

DHTs have been found to be effective in supporting patients to self-care for a range of health conditions.^{8 13–16} Health interventions designed specifically to support disadvantaged groups can be more effective for those groups, thus reducing inequalities.^{8 15 17 18} However, recent evidence has found that such benefits may be limited for people from lower socioeconomic groups, who do not have the resources (such as time, finances, technical proficiency) to access and use DHTs.^{19–21} Less is known about how HCPs use DHTs for helping patients to manage their own health and wellness, the barriers they face doing so and the implications this may have for the access to DHTs for their patients.^{2 10 20 22} There are indications that HCPs face challenges incorporating DHTs into their existing systems and practices,¹⁸ and establishing risk and rapport with patients in remote consultations.^{10 22} Patients have also reflected that they feel HCPs have limited knowledge of what self-care DHTs are available and effective.²⁰

Our multimethods study was designed to explore how HCPs (eg, general practitioners (GPs), nurses, pharmacists) used and made decision about DHTs in their clinical practice before and during the COVID-19 pandemic. We aimed to (1) understand barriers and facilitators to the use of DHTs by HCPs, and the implications for the access patients have to DHTs, and (2) whether these changed during the pandemic.

METHODS

Design

This study adhered to the Consolidated Criteria for Reporting Qualitative Research guidelines on the reporting of qualitative research.²³ It was a multimethods study, comprising semistructured interviews and an online survey with HCPs working in English primary and secondary care services. The primary study was the semistructured interviews that were conducted prior to the pandemic (November 2019–March 2020). This was supplemented with the survey, a secondary study that was conducted during the pandemic (July 2020–August 2020) with a different sample. Both studies explored how HCPs accessed and used DHTs. However, the survey also explored how the COVID-19 pandemic affected HCP attitudes to and usage of DHTs. The qualitative findings from the survey were compared with the findings from the interviews, in order to explore similarities and differences in DHT use that occurred due to the COVID-19 pandemic, and to ensure that the qualitative findings remained relevant within a rapidly shifting healthcare context. The methodological orientation of the study was a mixed inductive and deductive approach.^{24 25}

Interviews

Participants

Participants for the interviews were recruited through a range of networks, including National Institute of Health and Care Research School of Primary Care Research, community networks, social media (snowballing) and Academic Health Service Networks across England. We recruited HCPs who represented primary and secondary care health professionals from a range of backgrounds from across England, working in locations that varied in their level of socioeconomic deprivation (table 1). Socioeconomic deprivation was determined by collecting the postcode of the health service where the HCP worked, and mapping it to the England Indices of Multiple Deprivation (IMDs).²⁶

Procedure/data collection

The topic guide (see online supplemental material) was developed through author collaboration, consultation with qualitative experts, and input from patient and public involvement representatives. The topic guide was piloted and revised for clarity following feedback from two GPs.

All interviews were semistructured and conducted over the telephone by the same researcher (JL). All participants were provided with written information via email about the study before agreeing to be interviewed. Participants were informed that the purpose of the study was to explore which DHTs are used by healthcare professionals in their clinical work, how these tools were used to support their daily tasks (both client and non-client facing) and their experiences with different DHTs. At the beginning of each interview, participants were given the opportunity to ask questions, were assured of their voluntary participation, and could withdraw their data until anonymisation and analysis. Participants provided informed consent using an online form before the interview. Interviews were conducted via phone at a mutually convenient time, lasted 17–51 min (mean=32 min; median=30 min), and took place in private, quiet settings, often participants' offices or homes. HCPs received a £70 payment as compensation.

Each participant took part in one interview, with no repeat interviews. Short field notes were taken during the interviews. All interviews were audio-recorded, transcribed, anonymised and imported into NVivo software (NVivo qualitative data analysis software; QSR International, V.1.6.2). Transcripts and findings were not returned to participants for comment or correction. Interviews were undertaken with all willing participants, with the sample size guided by principles of information power rather than data saturation.²⁷

Data analysis

Analysis of qualitative data began shortly after data collection started and was ongoing and iterative. Corrected, anonymised transcripts were coded using NVivo software. An inductive thematic analysis approach was used for

Table 1 Participant demographics

Demographic characteristics	Qualitative interview sample N=24	Survey sample N=16
Gender (n)		
Male	9	6
Female	15	10
Age range (n)		
21–30	5	4
31–40	14	7
41–50	3	2
51–60	2	2
61–70	0	1
Place of work (n)		
Medical school and GP practice	1	0
GP practice	11	9
University	1	0
Hospital	5	3
Turning Point	1	0
Community pharmacy	2	4
NHS trust	2	0
Integrated urgent care service	1	0
Length of time in role (n)		
<1 year	7	0
1–5 years	14	11
6–10 years	0	2
>10 years	3	3
Time using digital health tools (n)		
‘The whole time’	1	Not collected
‘Not long’	1	
<1 year	3	
1–5 years	16	
6–10 years	2	
>10 years	1	
Socioeconomic deprivation of practice area, median (IQR)		
Practice IMD decile (1 most deprived and 10 least deprived)	4 (3–8)	Not collected

GP, general practitioner; IMD, Index of Multiple Deprivation; NHS, National Health Service.

the analysis of the qualitative interviews,²⁴ subsequently, a deductive approach was taken to investigate similarities and differences between themes emerging from the surveys.²⁵ Initial codes were developed by JL. Five members of the multidisciplinary research team also coded a sample of transcripts and then met to discuss and develop significant broader patterns of meaning

(potential themes). SLT organised the codes into final themes, which were agreed upon by the core team (SLT, BA and CD).

Research team and reflexivity

Personal characteristics

JL, a female PhD student in clinical and developmental psychology during data collection, conducted all interviews. JL received postgraduate training in qualitative methodology and had experience with semistructured interviews and thematic analysis. She was supervised by senior academics experienced in qualitative research (CD and BA).

Relationship with participants

There was no prior relationship between the research team and study participants. The participants knew that the study was about the use of DHTs in primary health-care, and that JL was a student researcher. The position taken by JL was that DHTs have the potential to empower people in self-monitoring and care and facilitate HCPs to share wider range of resources with patients from diverse backgrounds. However, JL felt that there may be barriers to assessing the quality of different DHTs by HCPs, and accessibility regarding both hardware and software issues for patients from more disadvantaged backgrounds.

COVID-19 survey

As interviews occurred before the first UK COVID-19 lockdown in March 2020, we developed an online survey to capture evolving healthcare delivery, ensuring continued relevance to the changing context. The survey sought to understand general views on DHTs and specifically how the COVID-19 pandemic affected their usage. The survey (see online supplemental materials) included free-text responses, multiple choice questions and Likert scales. Feedback from three GP stakeholders informed the optimisation of the survey.

Participants were invited to complete the survey through advertisements on social media (Twitter) and email, disseminated through academic primary care research networks and departments. English-speaking HCPs who use DHTs were included in the study, with no further exclusion criteria used for participant recruitment. Data collection took place between July 2020 and August 2020. Informed consent was obtained before survey participation. Participants were given the option to enter a prize draw for a £50 Amazon gift voucher as an incentive.

SLT analysed the free-text responses thematically by using the coding structure developed during the analysis of the qualitative interview data (included in the coding tree in the online supplemental material). Themes emerging from the survey were discussed and refined by SLT, CD and BA.

Patient and public involvement

The topic guide for the interviews was revised following input from the patient and public involvement group.

RESULTS

In total, 24 HCPs were interviewed: 10 GPs, 4 nurses, 8 pharmacists, 1 psychologist and 1 systems manager; their characteristics are outlined in [table 1](#). Participants approached the study if they were interested; there were no participants who dropped out of the interview study. Most of the HCPs were women (63%), in the 31–40 age range (58%), worked in a GP practice (46%), had been in their role for 1–5 years (58%) and had 1–5 years' experience using digital health tools in their practice (67%). The median practice IMD decile was 4 (IQR 3–8),²⁶ indicating the participants worked in more deprived areas than average for England.

22 HCPs consented to take part in the survey; however, three participants were excluded as they did not report their job title and an additional three participants were excluded as they did not finish the survey. We do not have information on the completion rate of the surveys, as we only received surveys that were completed. This left a total of 16 HCPs: 7 GPs, 4 pharmacists, 2 nurses, 1 dietitian, 1 clinical psychologist and 1 cardiac surgeon ([table 1](#)). There were nine women and seven men, with an age range of 28–66 years (M=41, SD=11.6) and the years of experience ranging from 1 year to 43 years qualified.

Digital healthcare tools used

HCPs discussed a range of technologies that they considered to be a DHT, including: treatment algorithms, digital self-care behavioural interventions, email, text and video call consultations, correspondence with patients (eg, practice text message systems) and data storage systems.

Results from thematic analysis

There were two main themes that emerged from the interviews conducted prior to the pandemic: the role of

DHTs in HCPs' clinical practice, and decision-making at three levels that determined who got access to what DHTs. There was an additional theme from survey, where HCPs described changes in access to and the use of DHTs during the pandemic. An outline of the themes and subthemes is available in [table 2](#).

Pre-pandemic interviews

Role of digital healthcare tools

In the interviews that were conducted prior to the COVID-19 pandemic, HCPs generally viewed DHTs as having the potential to make information and services easier for patients to access. However, some HCPs felt that DHTs were not suitable for everyone under every circumstance, and that remote consultations could not replace the 'human side and that caring side' (ID P5) and they 'shouldn't be done at the expense of face-to-face consultations' (ID P8).

Decision-making at three levels that determined who got access to what digital health tools

Prior to the pandemic, three levels were identified where decisions were made about who should have access to what DHTs and what support they would receive to access them. These were the (1) health organisation, (2) HCP and (3) patient levels.

Health organisation level

Influence of strategic decisions and incentive structures

HCPs described how strategic decisions made by individual health services and incentive structures created challenges for the adoption and implementation of DHTs. There was generally a perception that there was no cohesive digital strategy across healthcare services with '...all practices are doing slightly different things' (ID P2). An

Table 2 Themes and subthemes

Theme	Subtheme
Role of digital healthcare tools	None
Levels of access to digital health tools: health organisation level	▶ Influence of strategic decisions and incentive structures
Levels of access to digital health tools: healthcare practitioner level	▶ Healthcare practitioners' digital skills ▶ Healthcare practitioners' knowledge of what DHTs were available and effective ▶ Healthcare practitioners' perceptions about digital health tools ▶ Healthcare practitioners' access to training and informal support within the organisation or practice
Levels of access to digital health tools: patient level	▶ Healthcare practitioners' perceptions of which patients can use and benefit from DHTs ▶ Healthcare practitioners making judgements about who to use DHTs with
Changes in access to and use of DHTs during the pandemic	▶ How healthcare practitioners adapted to a remote-led model of care during the pandemic ▶ Barriers and facilitators to providing care through DHTs during the COVID-19 pandemic ▶ Barriers and facilitators for patients accessing care through DHTs during the COVID-19 pandemic
DHTs, digital health technologies.	

HCP felt that it was challenging for practices to prioritise the adoption of DHTs because they were not supported by traditional incentive structures, which would compensate for the time involved in managing the new digital treatments and services:

... [digital health is] not one of the key performance indicators (...) it's not yet at the point where commissioners are saying, look, you know, you said to us, you're going to offer digital interventions. Show us by March that you've offered 2500. (...). it's often commissioners that drives practice because obviously commissioners are the ones that actually pay for the services. (ID P15)

HCP level

The uptake of DHTs by HCPs and their decision to recommend them to patients were influenced by: the HCP's digital skills, their knowledge of what DHTs were available and effective, their perceptions of the quality of DHTs, and the availability of training and informal support for HCPs to use DHTs.

HCP digital skills

HCPs' use of DHTs in their practice and their ability to recommend them to their patients were reliant on their digital skills. Some HCPs described finding technology 'intuitive and quite basic' (ID P17). Others felt a lack of digital skills was a barrier to them supporting patients: 'I've actually found that simple things [using DHTs] I don't know how to do, it means that I can't do my job, just because I've not had the training' (ID P22).

There was a perception by some of the participants that older HCPs would struggle to learn about and use new DHTs, because they 'were not responsive to learning the new ways of doing things...' (ID P30).

HCPs' knowledge of what DHTs were available and effective

HCPs were aware there were lots of DHTs available that may be able to support their practice and patients, but many felt they did not have specific knowledge of what they should use or how they worked. One participant spoke about how multiple different digital systems were being introduced in their practice, that 'have got amazing functionality but we don't know about it and we don't know how to use it' (ID P10). Another described how there were 'websites and apps that I've got experience of using and are very happy to recommend', while other DHTs they had heard of but 'don't know how good they are' which impacts how they 'sell' DHTs to their patients (ID P8). A participant described how the high workload for HCPs presented challenges for them to remember what DHTs are available and how to use them in a short consultation:

...people will do the training and then they've got loads of other things do it. They'll forget about it. So at the point (...) I'm thinking this client could maybe

do digital, but I can't remember how to log on. (ID P15)

HCP perceptions about the quality of DHTs

HCPs made judgements about what DHTs to use or recommend to patients based on their perceptions of the quality or reliability of DHTs. They talked about the challenges in determining which DHTs were trustworthy, and which were 'flawed and quite risky' (ID P10). Some HCPs talked about being happy to recommend government-led online sources of information, like the National Institute of Clinical Excellence website, because it was a 'reputable source' (ID P13).

There was a sense from some of the HCPs that DHTs could not always be trusted to manage or deliver patient care. One participant felt that if there was something important that needed to be communicated with a patient 'someone needs to phone as well, we can't totally trust the technology' (ID P20). Another recalled incidences where 'systems have just gone down and then you're completely stuck', making it impossible to access essential patient information (ID P7).

Access to training and informal support within the organisation or practice

HCPs described how the provision and quality of formal training to use DHTs were variable across health services, and consequently it was 'learn by using' (ID P4). Some felt formal training for DHTs was not accessible for HCPs because they had to 'take time out of your practice' (ID P1), which they did not have. For those who had attended training, some HCPs felt it was useful, while others felt they did not 'meet a broad range of people's learning needs' (ID P13).

Many of the HCPs described how they learnt about DHTs and their features through other HCPs in the health service where they worked. The availability and quality of this support were not consistent across practices or organisations, and were determined by the level of digital skills of the people working in the individual health service:

...someone in the practice has either figured it out or seen it elsewhere and then they show someone else and so some people know how to do it. Some people don't. It's all a bit patchy... (ID 10)

Patient level

HCPs made judgements about which patients would benefit from DHTs. Their perceptions often influenced whether they recommend DHTs or used them with patients.

HCPs' perceptions of which patients can use and benefit from DHTs

HCPs generally believed that DHTs were most suitable for digitally literate, 'young, fit' (ID P2) individuals, and those who were 'able bodied and mentally able' (ID P32).

HCPs identified patient groups who they thought faced barriers accessing and using DHTs. This included patients with ‘very low literacy’ (ID P10), ‘whose language is not English’ (ID P5), and those who ‘never embraced the internet or any digital tech’ (ID P32). Some patients were viewed as more isolated, lacking support from a ‘team or family or carers’ to help them access DHTs (ID P12).

Some DHTs placed criteria that excluded vulnerable and underserved groups. For example, an HCP also spoke about the Babylon app that has: ‘excluded a ridiculous number of people from being able to use its service (...) like no woman can become pregnant, no one with social service needs, no one with mental health problems, so there’s many exclusions for people with the highest needs’ (ID P9).

There were conflicting opinions about digital health accessibility for people who lived in lower-income areas. Some felt most people with lower incomes ‘have phone access now anyway, so they will rely on their phones and online’ to access health information and support (ID P4). However, concerns were raised that the ‘disadvantage of the digital stuff is potentially exacerbating health inequalities’ (ID P8). A participant described the intersection between age and deprivation being particularly problematic:

...we work in a relatively deprived area and most of our particularly younger patients do have Internet access and you know have mobiles, but a lot of our older patients don’t. (ID P8)

Although many HCPs spoke about how the elderly could be excluded from using DHTs, some had their presumptions about age-related technology uptake challenged by experiences with older patients being adept at using DHTs:

... a chap who was 80 years old, he came into my clinic room (...), he opened his tablet and he logged on to his own umm... personal page on his own practice to give me information. (...) I was like oh gosh that’s really impressive can I have a look. (ID P20)

Conversely, an HCP had found that ‘...a lot of young people don’t want treatment digitally’ (ID 15), because they were concerned around inadvertent disclosure of stigmatised health conditions:

...they’re saying, actually, I don’t want something on my phone that my mates going to see. And it’s got something about anxiety on it or it’s got something like I’m a family member of somebody with an alcohol problem. (ID P15)

HCPs making judgements about who to use DHTs with

The perception of HCPs about the appropriateness of DHTs for a specific patient group influenced their decisions regarding DHT use. HCPs described how they were less likely to communicate with older adults or those with ‘mental disabilities’ (ID P9) using DHTs. Several HCPs

said they were less likely to engage in discussions about or supply DHTs to discuss with older patients:

...the older generation are a little bit ‘oh no, I don’t want to do that’, or ‘it confuses me’. So yeah, I judge who I would discuss apps with and technology with age wise... (ID P32)

A participant stated that their team were targeting ‘the younger ones’ in their roll out of an app to support people with bowel cancer (ID P25). However, she acknowledged that the majority of their ‘patients are 70–89’ and were ‘not going to be able to use the app’ (ID P25).

Some HCPs described how the perception that someone was lacking digital skills resulted in them being prioritised for face-to-face consultations, when ‘clinically, they didn’t need that priority’ (ID P5). A participant reflected that ‘the less digitally enabled person might get more of my attention than the more digitally enabled’ (ID P11).

COVID-19 survey

Changes in access to and use of DHTs during the pandemic

HCPs who completed the survey about their use of DHTs during the pandemic described a dramatic shift in ‘practice to almost completely remote working’ in response to government-implemented COVID-19 restrictions (survey ID 10). They described how: they adapted to this shift, the barriers and facilitators to providing care almost exclusively through DHTs, and their perceptions of the barriers and facilitators for patients accessing care through DHTs during the pandemic.

How HCPs adapted to a remote-led model of care during the pandemic

Some of the HCPs reflected positively on the shift to the delivery of care through technology. Participants described how being ‘forced to engage better with digital technology’ (survey ID 25) made them realise ‘the potential of just what you can do by phone (and sometimes video)’ (survey ID 9). An HCP concluded that ‘It has changed the way we work for the long term, I think in a good way’ (survey ID 25). However, several of the HCPs cited similar concerns to pre-pandemic about practising through remote appointments. They found it: ‘more difficult to understand a patient’s problem and support them when you are unable to see them in person and perform certain tests’ (survey ID 15), in addition to hindering the development of an ‘appropriate patient physician relationship’ (survey ID 17).

Barriers and facilitators to providing care through DHTs during the COVID-19 pandemic

The barriers to providing care through DHTs during the pandemic described by the HCPs were similar to pre-pandemic. These included ‘internet problems’ (survey ID 13), issues with DHTs being properly approved and integrated through healthcare services, ‘issues around consent and data sharing’ (survey ID 25), and staff being willing or able to engage with DHTs. For example, a

participant described how ‘some older staff didn’t want to work digitally and struggled to accept change’ (survey ID 10).

However, HCPs described having more resources available to overcome these issues during the pandemic compared with prior to the pandemic. An HCP described how their organisation ‘facilitated’ the use of DHTs ‘more and removed any existing barriers’ (survey ID 28):

...initially [there was] lots of confusion over how we were going to be able to offer patient appointments and what apps etc were NHS approved etc. The local Primary care network were fantastic in supporting local surgeries in implementing change. Barriers also were financial, but when funding was granted for extra equipment etc, there was a boom in embracing new ways of working(...) there was so much change happening at once, that it was sometimes difficult to keep up with the latest information and what was available to use. An online network called Teamnet became the ‘go to’ site for updated information and technology and government updates. (survey ID 10)

Barriers and facilitators for patients accessing care through DHTs during the COVID-19 pandemic

The HCPs felt that some patients faced challenges when they were ‘forced to adapt and resort to digital tools’ in the pandemic (survey ID 25). However, they felt most patients were able to engage with the new way of accessing health support and were more ‘accepting of the technologies as there isn’t an alternative’ during lockdown periods (survey ID 6).

For those patients who did face barriers in accessing and using DHTs, the issues described by the HCPs were similar to pre-pandemic. HCPs felt that ‘there is still a group of patients and conditions for which face to face consulting is preferable’ (survey ID 9). A participant spoke about ‘poorer patients not having internet or not [being] aware of how to use [the internet]’ (survey ID 30). An HCP described how: ‘...elderly patients with no mobile phones or laptops have felt isolated and victimized, age discrimination really. Some cannot or will not embrace technology and want to be seen face to face or can’t get phone to connect to video call...’ (survey ID 6).

HCPs highlighted ways in which their services adapted to improve access to health services for those who faced challenges using remote consultations during the pandemic. Most of the HCPs described offering phone consultations or face-to-face consultations with ‘PPE equipment’ (survey ID 30) ‘where safety can be maintained’ (survey ID 28). Some HCPs spoke about how their services made further adjustments to the delivery of their digital support, by establishing alternative people to contact if the patient did not have good digital skills, or by providing equipment to access services: ‘Patients who do not have access to any digital tool (mostly elderly) we usually contacted their children etc who would be able to assist them’ (survey ID 15). A participant spoke about how

they had ‘obtained consent for patients who don’t have smartphones, to allow them to use a neighbours phone (...) to make a video call’ (survey ID 10). A participant described how their service provided ‘mobile phones for homeless clients’ (survey ID 14).

DISCUSSION

Principal findings

In our pre-COVID-19 pandemic interviews, HCPs across different healthcare settings in England generally acknowledged the potential benefit of DHTs in enhancing patient access to healthcare services. However, they expressed concerns regarding the appropriateness of DHTs for specific patient populations, viewing face-to-face appointments as superior in certain situations. The HCPs described three levels where decisions were made which determined who would have access to what DHTs. These were: the health organisation, HCP and patient levels. At the organisation level, HCPs described a lack of cohesive strategy across healthcare services and traditional incentive structures targeting digital health, which resulted in disparities in DHT adoption. At the HCP level, a wide variation in digital skills and knowledge of DHTs created barriers to HCPs using these tools in their practice and recommending them to patients. HCPs described a lack of high-quality centralised information and formal training, and inconsistencies in provision of support across practices or organisations. At the patient level, HCPs held beliefs about groups of patients they felt would benefit from DHTs (eg, young and fit). These preconceptions influenced HCPs’ decisions on whether to introduce DHTs to patients and whether to use these tools for patient communication.

In the survey conducted during the pandemic, the HCPs described an almost complete shift to remote delivery of care. While many barriers to DHT use persisted, HCPs reported receiving significant support to overcome these challenges during the pandemic. This included support from the local primary care networks to implement the shift to digital services, funding for extra equipment and an online network (eg, Teamnet) that provided the most up-to-date information about what DHTs were available.

HCPs felt that the majority of their patients were able to adapt to the change in the delivery of services, mostly due to the lack of alternatives during the pandemic. However, similar concerns regarding digital exclusion persisted. To address these issues, HCPs implemented strategies to enhance access to healthcare services for patients facing difficulties with DHTs. This often included offering face-to-face appointments with the HCP wearing full personal protective equipment or providing additional support for accessing digital services.

Strengths and limitations

To the authors’ knowledge, this is the first study to explore the impact of decision-making around the use of DHTs by HCPs on access to DHTs for patients, before and during

the COVID-19 pandemic in England. In addition to our planned qualitative study, we developed and disseminated a questionnaire that explored whether COVID-19 had changed the way that healthcare professionals used DHTs. By doing this, we were able to ensure that our earlier 'pre-COVID-19' work was still relevant to inform future research and policymaking.

Complete audio data were recorded for all interviews, and there were no issues with lost data. Double-coding of a subset of interviews by five members of the team and ongoing discussion about coding structure ensured the coding scheme was robust. Multiple views of the data promoted confidence in the credibility of the findings.²⁸ A diverse range of experiences and opposing sides of arguments were identified and presented.

There were challenges recruiting the sample of healthcare professionals, meaning both survey and interviews had (relatively) small samples. However, considering both datasets used principles of information power²⁷ suggests that the findings are still relevant and valuable, although some experiences related to DHT access and use may not have captured. As patients were not included in this study, reflections about the barriers patients experience accessing DHTs are from the HCPs' perspective. Consequently, this may not accurately reflect the barriers and facilitators patients experienced accessing DHTs prior to and during the pandemic.

Interpretations in the context of existing literature

Our study agrees with previous qualitative research conducted in the USA that emphasised the influence of organisational context on DHT access.^{2 29} Puckett *et al* found that inequality in access to diabetes pumps was related to whether the clinic distributed resources equally as standard policy, or whether they provided patients with access dependent on their predetermined policy/eligibility (eg, interaction with the health service).²⁹

Concerns about the quality and reliability of DHTs cited by the HCPs in the interviews in this study reflect previous review findings that the majority of commercially available health apps are not evidence based or do not reflect public health guidelines.³⁰ The same review reported that surveys from Germany³¹ and the USA^{32 33} agreed with the HCP views in this study that those who used health apps were more likely to be younger, in good health, have higher income, education and health literacy.³⁰ However, some HCPs in our interviews described how their presumptions about age-related technology uptake were challenged when older patients were highly engaged with DHTs, and younger patients were disinterested in technology.

Our study found that during and prior to the pandemic, HCPs had concerns about accessibility of online consultations and made adaptations to support patients who were less digitally literate or did not have internet access. These findings are similar to those of recent qualitative studies conducted before²¹ and during the pandemic,³⁴ where HCPs reported that remote consultations could improve

access for some groups (eg, those with caring responsibilities, not able to leave their homes).^{21 34} However, they also had concerns about digital exclusion and accessibility for some patients,^{21 34} and described providing face-to-face appointments for those who they perceived to be less able to use the digital services (eg, older adults).²¹ A multinational survey found that ophthalmologists felt clinical artificial intelligence would improve accessibility of eye care services, but were less convinced about whether it would result in improvements in quality or affordability.² They were unsure about whether the COVID-19 pandemic would increase adoption of digital technology in the health system, or result in the increased in implementation of the technology through investment, training healthcare workers or educating the public.²

Two YouGov surveys of NHS staff and patients found that while the majority of patients and NHS staff responded positively to the increased use of technology in healthcare during the pandemic, certain groups, including those over 55 years, individuals with caregivers or those unemployed, reported negative experiences with DHTs more frequently than the general population.⁶ This corresponds with the perceptions of the HCPs in our study, that the majority of patients adapted well to delivery of care through technology. But those who were older and had lower incomes faced greater barriers accessing DHTs before and during the pandemic.

In our study, some HCPs described having limited knowledge of what DHTs were available and what to recommend to their patients. This corresponds with the findings from a qualitative study exploring digital access for patients with type 2 diabetes, where participants felt HCPs were not knowledgeable about self-care DHTs.²⁰

Implications for research, practice and policy

Improving digital infrastructure and training of HCPs

The centralised response to the pandemic and the way in which barriers to accessing DHTs were universally addressed in healthcare services across the UK described by HCPs in our survey can be seen as an illustration of good practice in tackling inequalities in access to DHTs at the organisational and HCP level. A recent White Paper the Department of Health and Social Care laid out the aim to make the innovations that the COVID-19 pandemic accelerated permanent.³⁵ However, it is unclear what support will remain to reduce barriers to accessing and using DHTs, and whether this will be universally provided. Future support could consist of government funding and incentives, ensuring HCPs have access to and are aware of central repositories that provide up-to-date information about evidence-based DHTs that they could recommend to their patients (eg, ORCHA) and support for health services to adopt innovations (eg, Adopting Innovation Programme⁶).

Reducing inequalities in access to DHTs for patients

The HCPs in this study did not describe any centralised provision of support to ensure less digitally engaged

patients had access to DHTs during the pandemic. Instead, individual HCPs and health organisations made decisions about who could benefit from DHTs, and what support would be offered to reduce barriers to accessing DHTs. By making judgements about who can benefit from DHTs, HCPs are potentially preventing some patients from being able to benefit from these services, which has implications for inequalities in access to healthcare. This is particularly poignant as we move towards the ‘digital first’ service as laid out in the NHS Long Term Plan.¹ To avoid digital exclusion, through the lack of provision of information about DHTs, it could become standard policy that all patients should be signposted to evidence-based DHTs. This could be sent to patients using existing systems (eg, accuRx) so as not to add additional burden on to HCP, and to circumvent HCPs acting as gatekeepers to DHTs. HCPs could also be provided with information about where to signpost patients for support to access or use DHTs. Digital participation schemes piloted by NHS Digital have been successful in reducing inequalities in access to DHTs, by providing people with low digital literacy with support from digital champions.^{36,37} Although there are plans to roll these out more widely following the success of the pilots,³⁶ current unequal provision of these services across the UK risks widening digital inequities in areas not served by these schemes. Speeding up the availability of this support could involve the development and rollout of engaging accessible training for digital health champions and access to up-to-date resources these digital champions could refer to. Such an approach is in line with recent recommendations to recognise variation in user needs to improve technology adoption and acceptance.³⁸

CONCLUSIONS

This research has highlighted how decision-making at the health organisation, HCP and patient levels influences inequalities in access to DHTs for HCPs and patients. The pandemic prompted the centralised mobilisation of resources for health organisation and HCPs to access and implement DHTs. However, the patients still faced uneven access to DHTs, determined by decisions made by individual health services and HCPs. Attention must be paid to ensuring all patients have access to information about what DHTs could support them. There is also a need to increase access to support for less digitally engaged patients so they can benefit from the ‘digital first’ health service.

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Patient consent for publication Not required.

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REFERENCES

- 1 NHS. *NHS long-term plan*. 2019.
- 2 Gunasekeran DV, Zheng F, Lim GYS, *et al*. Acceptance and perception of artificial intelligence usability in eye care (appraise) for ophthalmologists: a multinational perspective. *Front Med (Lausanne)* 2022;9:875242.
- 3 NICE. Evidence standards framework for digital health technologies, Available: <https://www.nice.org.uk/corporate/ecd7>
- 4 Sauchelli S. Digitalising diabetes support groups in response to the coronavirus COVID -19 outbreak: a collaborative initiative. *Practical Diabetes* 2020;37:208.

- 5 Sauchelli S, Bradley J, England C, *et al*. Exploring support needs of people living with diabetes during the coronavirus COVID-19 pandemic: insights from a UK survey. *BMJ Open Diabetes Res Care* 2021;9:e002162.
- 6 Horton T, Hardie T, Mahadeva S, *et al*. *Securing a positive health care technology legacy from COVID-19*. London: Health Foundation, 2021.
- 7 Castle-Clarke S. *What will new technology mean for the NHS and its patients: Four big technological trends*. London: King's Fund, 2018.
- 8 Murray E, Burns J, See TS, *et al*. Interactive health communication applications for people with chronic disease. *Cochrane Database Syst Rev* 2004;2005:CD004274.
- 9 Muñoz RF. Using evidence-based internet interventions to reduce health disparities worldwide. *J Med Internet Res* 2010;12:e60.
- 10 Kilvert A, Wilmot EG, Davies M, *et al*. Virtual consultations: are we missing anything? *Practical Diabetes* 2020;37:143–6.
- 11 Fleming GA, Petrie JR, Bergenstal RM, *et al*. Diabetes Digital App Technology: Benefits, Challenges, and Recommendations. A Consensus Report by the European Association for the Study of Diabetes (EASD) and the American Diabetes Association (ADA) Diabetes Technology Working Group. *Diabetes Care* 2020;43:250–60.
- 12 van Kessel R, Hrzic R, O'Nuallain E, *et al*. Digital health paradox: international policy perspectives to address increased health inequalities for people living with disabilities. *J Med Internet Res* 2022;24:e33819.
- 13 Hutchesson MJ, Rollo ME, Krukowski R, *et al*. eHealth interventions for the prevention and treatment of overweight and obesity in adults: a systematic review with meta-analysis. *Obes Rev* 2015;16:376–92.
- 14 Yoshida Y, Boren SA, Soares J, *et al*. Effect of health information technologies on glycemic control among patients with type 2 diabetes. *Curr Diab Rep* 2018;18:130.
- 15 Turnbull S, Cabral C, Hay A, *et al*. Health equity in the effectiveness of web-based health interventions for the self-care of people with chronic health conditions: systematic review. *J Med Internet Res* 2020;22:e17849.
- 16 Turnbull S, Lucas PJ, Hay AD, *et al*. Digital health interventions for people with type 2 diabetes to develop self-care expertise, adapt to identity changes, and influence other's perception: qualitative study. *J Med Internet Res* 2020;22:e21328.
- 17 Gustafson DH, Hawkins RP, Boberg EW, *et al*. CHESS: 10 years of research and development in consumer health informatics for broad populations, including the underserved. *Int J Med Inform* 2002;65:169–77.
- 18 Turnbull S. *The influence of digital self-care interventions on health inequality in high burden chronic health conditions*. University of Bristol, 2019.
- 19 Western MJ, Armstrong MEG, Islam I, *et al*. The effectiveness of digital interventions for increasing physical activity in individuals of low socioeconomic status: a systematic review and meta-analysis. *Int J Behav Nutr Phys Act* 2021;18:148.
- 20 Turnbull S, Lucas PJ, Hay AD, *et al*. The role of economic, educational and social resources in supporting the use of digital health technologies by people with T2D: a qualitative study. *BMC Public Health* 2021;21:293.
- 21 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:e128–37.
- 22 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:e166–77.
- 23 Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19:349–57.
- 24 Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006;3:77–101.
- 25 Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods* 2006;5:80–92.
- 26 Gov.uk. English indices of deprivation 2019 [Ministry of Housing Clg, editor]. n.d. Available: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-20192019>
- 27 Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qual Health Res* 2016;26:1753–60.
- 28 Sandelowski M. Sample size in qualitative research. *Research in Nursing & Health* 1995;18:179–83. 10.1002/nur.4770180211 Available: <https://onlinelibrary.wiley.com/doi/10.1002/nur.4770180211>
- 29 Puckett C, Wong JC, Daley TC, *et al*. How organizations shape medical technology allocation: Insulin pumps and pediatric patients with type 1 diabetes. *Social Science & Medicine* 2020;249:112825.
- 30 Grundy Q. A review of the quality and impact of mobile health apps. *Annu Rev Public Health* 2022;43:117–34.
- 31 Ernsting C, Dombrowski SU, Oedekoven M, *et al*. Using smartphones and health apps to change and manage health behaviors: a population-based survey. *J Med Internet Res* 2017;19:e101.
- 32 Carroll JK, Moorhead A, Bond R, *et al*. Who uses mobile phone health apps and does use matter? A secondary data analytics approach. *J Med Internet Res* 2017;19:e125.
- 33 Krebs P, Duncan DT. Health app use among us mobile phone owners: a national survey. *JMIR Mhealth Uhealth* 2015;3:e101.
- 34 Jones B, Scott J. *Building the evidence base on video consultations*. The Health Foundation, 2020.
- 35 Health Do, Care S. *Integration and innovation: working together to improve health and social care for all*. Department of Health and Social Care London, 2021.
- 36 NHS digital. Digital health Hub rolled out across more areas following pilot success. 2019. Available: <https://digital.nhs.uk/news/2019/digital-health-hub-rolled-out-across-more-areas-following-pilot-success>
- 37 digital N. Widening Digital participation programme helps patients improve their health. 2018. Available: <https://digital.nhs.uk/news/2018/widening-digital-participation>
- 38 Shachak A, Kuziemy C, Petersen C. Beyond TAM and UTAUT: future directions for HIT implementation research. *J Biomed Inform* 2019;100:103315.