DEMOS
CONSULTING

FAIR ACCESS TO HEALTHCARE IN A DIGITAL WORLD

LONDONERS' VIEWS ON DIGITAL EXCLUSION AND HEALTH INEQUALITIES, AND THE SOLUTIONS THEY WANT TO SEE

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Nicola Stokes, Tyreese Calnan and Miriam Levin

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ABOUT DEMOS

Demos's mission is to upgrade democracy with a new deal to repair the relationship between citizen and state. We see Britain as being in a democratic emergency. The fabric that holds a functioning democracy together is fraying: there is a massive loss of trust between citizen and state, between people and the institutions meant to serve them, and between communities. These broken relationships eat away at goodwill and inhibit the government's ability to deliver effective services, which in turn further damages trust. There are few better examples of this than healthcare.

This paper presents Demos's research into how Londoners who are most at risk of digital exclusion and health inequalities experience the health system, and how this could be improved as the shift to digital ramps up. It lays bare why people's trust and satisfaction in the health system is waning, and works towards realising two core Demos pillars: **Everyday Democracy** and **Public Service Reform**.

Demos's Everyday Democracy aims to upgrade democracy through greater participation of the public in decisions that affect their lives, forging a society where people can have an impact on democracy on a regular basis, not just at elections. It's about investing in the relationships that fuel democracy and giving people a voice in policy decisions. Demos's Public Service Reform starts from the premise that services can only win back public trust if they are rebuilt around and alongside the people who use them, not designed centrally and imposed upon them.

In the context of this report, these two pillars are realised through drawing on the lived experiences of Londoners to tailor healthcare services around local and individual needs, while reducing the distance between policy and delivery through upstream public participation with frontline community organisations. As a result, instead of treating digital exclusion and healthcare access barriers as a checklist of technical fixes, Demos focuses on the human needs as told by Londoners who face some of the starkest health inequalities, and listens to what they think should be done about it. This is the practice of using **Everyday Democracy** to achieve **Public Service Reform**, and in doing so, brokering a new deal between citizen and state.

FOREWORD
FROM THE LONDON HEALTH MISSION BOARD

The **London Health Mission** was established in September 2024 with the aim of ensuring that digital transformation in health and care services has a positive impact on London's health inequalities, and with the ambition of helping make London the healthiest global city.

Bringing together partners from across London's health and care system, including the NHS, the Greater London Authority (GLA), London Councils, the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID), the Mission recognises that no single organisation can tackle health inequalities alone. By working collaboratively across sectors we aim to reduce inequalities in healthy life expectancy whilst ensuring all Londoners can benefit from the opportunities created by digital transformation and health innovation.

The Mission's approach is to get to the heart of the challenge. With our ambition to see digital transformation in healthcare designed with and for the communities who experience the biggest barriers to access, our work must start with understanding that not everyone in London has the same level of digital access, skills, confidence or trust. Whilst new and evolving digital approaches create huge and exciting opportunities, including improving patient choice and access, there is also potential for exclusion. The Mission will focus on those Londoners who continue to experience avoidable barriers, particularly those who face digital exclusion, low health literacy, poverty, disability, language barriers and other forms of disadvantage. London is one of the world's most diverse and dynamic cities, and this is a timely opportunity to utilise our assets to significantly narrow the inequalities in health outcomes that exist.

This report has been commissioned by the London Health Mission and Impact on Urban Health at a pivotal moment for health and care reform. It supports the broader ambitions of the NHS 10 Year Plan to reduce inequalities, strengthen prevention, improve access to services, empower patients and communities, and harness the benefits of digital innovation. To meet these goals Demos was commissioned to work directly with Londoners and to hear their voices first hand and specifically to speak with individuals and communities who are more likely to experience exclusion from healthcare and digital services. Achieving these ambitions requires a deeper understanding of how people experience healthcare in practice, particularly those communities that face the greatest barriers to access. The Mission approach we are taking as part of the discovery phase of this work will ensure that communities will remain at the heart of any solutions that are adopted in the future.

The insights, recommendations and ideas contained within this report will be instrumental in informing the next phase of the London Health Mission work, providing an important evidence base for the Mission and its partners to design, develop and prioritise solutions that address health inequalities, improve access to care and ensure that digital transformation works for all Londoners. Most importantly, as the Health Mission Board we seek to ensure that the voices and experiences of Londoners are at the heart of shaping future policy, service design and delivery across the capital.

London already has so many of the assets needed to achieve a digitally enabled health service that is inclusive by design, not least: our world-leading health and care system, strong partnerships, thriving and diverse communities, and a growing capability for health innovation. We look forward to working with partners and Londoners towards our ambition of making London the healthiest global city.

London Health Mission Board

LONDON HEALTH MISSION BOARD

*Established in 2025, the London Health Mission Board is co-chaired by **Dr Tom Coffey** - the Mayor of London's Health Advisor - and **Councillor Paul Swaddle** - Executive Member for Adult Social Care, Health and Prevention, London Councils, and Leader, Westminster City Council.*

The Board is made up of members from the Greater London Authority (GLA), London Councils, voluntary sector organisations, NHS England / London, London's Integrated Care Boards / Systems, London boroughs, Office for Health Improvement and Disparities and Chief Executive's London Committee. The overall goal of the London Health Mission is to make London the healthiest global city, through tackling health inequalities and using London's unique assets. Its aim is by 2035 to significantly close the gap in health inequalities in our city, utilising London's innovation and digital transformation opportunities.



EXECUTIVE SUMMARY

Over the next decade, through the 10 Year Health Plan for England and the NHS Modernisation Bill, the NHS is set to move healthcare services firmly into the digital realm. A key part of this will be a shift towards online and mobile tools, like the NHS App, becoming the primary means through which patients access services and communicate with their healthcare providers. However, for the 270,000 Londoners who do not have access to the internet, and the two million who have very limited digital engagement, this digital-by-default model risks excluding them from healthcare altogether.[1] It is vital, therefore, that public bodies listen to the concerns of those who are digitally excluded and at greater risk of poor health outcomes. Doing so will ensure that their voices are heard as services are designed.

This paper forms part of the community insights work of the London Health Mission, through which it aims to understand how to best support those who are set to be most impacted by a digital-by-default health model.

Community organisations were selected from across London that represent people from the following population groups who are most at risk from both digital exclusion and poor personal and organisational health literacy:[2]

- People aged 65 or over
- Blind and partially sighted people
- Migrant communities
- People with learning disabilities
- People with experience of homelessness
- People on low incomes

During the course of two workshops, participants described the barriers they commonly face when interacting with health services in the capital and, crucially, what they think should be done to address these problems. They described the obstacles faced when attempting to access services digitally, but also those encountered when accessing healthcare in-person and via phone call; many people described being unable, or not wanting, to use digital services at all.

1 Greater London Authority. (2025, 18 February). Mayor Urges More Businesses to Donate Old IT Equipment and Help Digitally Excluded Londoners Get Online. London City Hall. Available at https://www.london.gov.uk/Mayor%20urges%20more%20businesses%20to%20donate%20old%20IT%20equipment%20and%20help%20digitally%20excluded%20Londoners%20get%20online

2 The London Health Mission's definitions of organisational and personal health literacy informed this report. Organisational health literacy is defined as 'the way health and care organisations make it easier for people to find, understand, trust and use information and services to make informed decisions about their health'. Meanwhile, personal health literacy is defined as 'having the appropriate skills (language, literacy and numeracy), knowledge, understanding, trust and confidence to obtain, communicate, understand, appraise, apply, use and navigate health and social care information and services'.

Speaking directly to Londoners highlights a significant gap between the kind of treatment patients expect, and what they actually experience. Where participants expect smooth transitions between different health bodies and departments, they describe finding themselves in a highly fragmented system, being sent contradictory information and having to repeat their issues again and again to each staff member they meet. Where participants expect to be able to book appointments and receive information in a way that works for them, they often find themselves trying to navigate a confusing array of healthcare apps with the option of speaking to someone in person closed off to them. Where they expect needs around their disabilities, language or financial barriers to be respected, they find that these are frequently unmet.

The key insight that emerged from this research is how critical it is to involve end-users in the design of health services, especially those from more marginalised groups - when services are co-designed to support patients' needs from the start, these services are far more likely to provide healthcare that works for everyone. In light of this, this report calls for a new deal between patients and the health system - a new relationship in which patients are treated not as passive recipients of care, but as active partners in shaping the services they rely on. London, with its unrivalled diversity, its stark inequalities in health and digital access, and a growing network of partnership bodies, is uniquely placed to lead the way in making this new deal a reality.

WHAT LONDONERS SAID: 'SOLUTIONS'

The summary below details the changes participants suggested would make the biggest improvements to their ability to access healthcare (referred to throughout this report as 'solutions'). The London Health Mission focuses on tackling health inequalities that result from digital exclusion. However, digital health barriers are very closely intertwined with other barriers to accessing healthcare that are not digital in nature. This would have made it very difficult to talk about digital barriers in isolation, so this research also explored some of the barriers people face when interacting with healthcare systems in non-digital formats (such as in person, via letter or over the phone) as an important part of the inclusion picture. This summary focuses first on the non-digital solutions, then on the digital ones.[3]

Some of these suggestions have already been put in place by the NHS, although the fact that the research participants were not aware of this shows that these initiatives are not working for many of those who should benefit from them, and much more work needs to be done to ensure that they work effectively and are communicated widely. Other suggestions are currently being considered through the 10 Year Health Plan. This report therefore comes at a time when there is already momentum at the highest levels of healthcare to embed change in how people experience their health services. This has opened a window of opportunity when it comes to implementing some of the solutions that participants said they would like to see.

Since this project was focused on hearing what it is that participants want to see from the health and care system, practical concerns such as cost and feasibility of these interventions have not been considered. Further research is recommended to gauge if and how these suggested solutions can be implemented.

3 Digital barriers and solutions are those that involve a patient using a digital platform to interact with a healthcare body (such as through a website or an app). Non-digital barriers and solutions, on the other hand, refer to instances where the patient's interaction with a healthcare provider does not involve a digital platform. Some barriers and solutions that are described as 'non-digital' may have a digital component for the healthcare provider, but are still categorised as 'non-digital' as the direct experience of the patient does not involve any digital interface.



NON-DIGITAL SOLUTIONS

Patient-centred appointments

- All patients having one allocated GP for continuity across appointments
- Always offering patients a choice between face-to-face and phone consultations
- Longer appointments as standard for patients with additional needs
- Prioritising appointments in services closer to patient's home

Patient record sharing

- Making patient records accessible across all NHS services
- Allowing patient records to be shareable with those outside the NHS (e.g. welfare support) using a patient-verified referral code

Tailored, patient-centred communication

- Communication with patients to use simple language alongside medical jargon (e.g. 'Cardiology (heart)')
- Patient's preferred contact method to be recorded and followed consistently (e.g. phone calls, Easy Read, large print)
- Correspondence provided in the patient's preferred language

Ensure patients' access needs are immediately visible to healthcare staff

- High-visibility flag or banner to appear on patient records showing additional needs

More flexible appointment booking options

- Opportunities to book after the 8am rush
- Allow patients to find appointments at neighbouring surgeries when their local one is full
- Keep more slots open during the day for children and vulnerable people who may deteriorate quickly

Proactive follow-up care

- Mandatory follow-up appointments after tests and operations
- Dedicated worker to follow up with each patient and bridge the gap between medical and social care

Improved patient transport

- Automatic patient transport eligibility for people with a registered disability

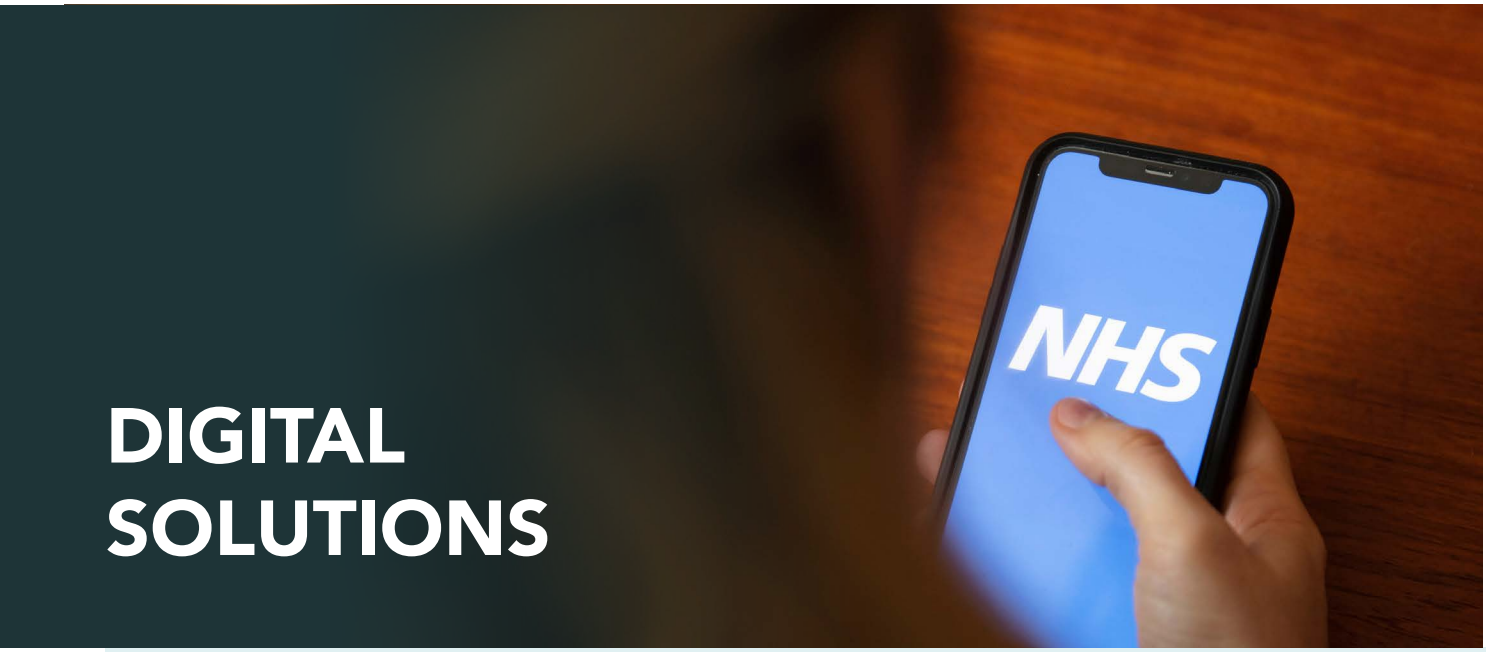
Ensuring accessibility in healthcare spaces

- Volunteers or staff available to help patients navigate unfamiliar buildings and facilities
- Quiet rooms or spaces for patients with sensory sensitivities
- Improved staff training around accessibility needs and best-practice code for in-person interactions

Better transparency and communication of available NHS services

- Actively publicise urgent care centres and expanded pharmacist roles
- Ensure all patients are aware of how to register as carers
- Require dentists to display all fees before treatment
- Provide clear, visible information on how to make a complaint

DIGITAL SOLUTIONS



NHS App as the only app needed to navigate all NHS healthcare services

- Ensure that all NHS bodies are able to contact patients and share information via the NHS App
- Ensure the NHS App does not redirect patients to other healthcare apps, such as Patient Knows Best or DrDoctor.

NHS App to be more inclusive and accessible

- Co-design and test the app with marginalised communities
- Ensure accessibility features are built in (e.g. screen-reader support, high-contrast, large print)
- App to be available in different languages
- Short (30 to 60 second) instructional videos embedded in the app, available in different languages

Ensure a non-digital route for booking appointments and receiving information is always available

- Make sure that patients are always able to communicate with any NHS healthcare service via letters, phone calls, text messages or in person, and are not forced to use digital services

Use the NHS App to proactively communicate with patients

- Patients to receive immediate acknowledgement when an appointment request is received
- Ability for patients to check their position when on waiting lists

More functions to be included in the NHS App

- Clear 'Urgent' button to bypass lengthy forms during emergencies
- Button allowing you to skip or pause repeat prescriptions without cancelling them

Opportunities for training in how to use the NHS App

- Community-based digital skills workshops in trusted, familiar settings
- Drop-in digital support sessions at local pharmacies
- One-to-one or home-based tech tuition, including use of assistive technology
- Mobile skills hubs visiting community centres

More support for people using digital routes

- Free-to-use, staffed digital access points in community spaces for booking appointments for those without their own digital access
- Technical assistants on-site in surgeries to help set up and manage NHS accounts
- Dedicated phone line where staff complete digital tasks on the patient's behalf

RECOMMENDATIONS

While the solutions listed above were all suggested by project participants to be considered by whichever national or regional health bodies are best placed to tackle them, this report also puts forward five overarching recommendations. These were developed by Demos in response to the research findings for consideration by the London Health Mission as they take their work forward:

1. Assess the feasibility of each proposed solution in this report and determine which ones would have the greatest impact relative to effort if implemented.
2. Lead the way on convening partnerships of stakeholders who are able to deliver the solutions.
3. Advocate for public participation, in particular of people from marginalised groups who face barriers engaging with healthcare, when designing health services.
4. Continue to create opportunities for active, continuous dialogue with those most impacted by these issues so that policy, strategy and service development are grounded in lived experience.
5. Maintain open communication with the people involved in this study so they are aware of the outcomes of the project.

In the spirit of the new deal called for between patients and the healthcare system, this report puts the voices of marginalised Londoners at its centre. The NHS was established with the aim to provide for all; therefore it is crucial that its services serve everyone - including the Londoners whose voices form part of this report.

INTRODUCTION

LONDON'S HEALTH LANDSCAPE

Imagine needing to book a GP appointment, but the only way to do so is through an app that you can't use because it isn't designed for someone with your disability. Or being told to check your medical test results online, but you can't because you don't have regular internet access. Or being sent important medical information in a language you don't fully understand, with no one to ask for help. For thousands of Londoners, this is a daily reality.

People across the capital who sit at the intersection of poor health literacy and digital exclusion, such as those on low incomes or people with disabilities or experience of homelessness, find themselves locked out of healthcare services time and time again. Many of these Londoners are at higher risk of, or already living with, chronic health conditions, and barriers that complicate their access to healthcare risk prolonging or worsening illness.[4] Instead of being able to access timely treatment to improve their quality of life, those from marginalised groups face increasing frustration, confusion and anxiety when they have to interact with a healthcare system that does not meet their needs.

This report highlights the voices of those who are being left behind by an increasingly complex healthcare system that takes digital access for granted. People from communities who are most vulnerable to experiencing health inequalities, because they face digital exclusion as well as the impacts of poor personal and organisational health literacy, describe the barriers they come across that hinder their access to healthcare services. And, more importantly, they also explain what they think should be done to overcome these barriers and ensure that they are able to receive the high-quality healthcare that they need and deserve. With the research taking place over the spring and summer of 2026, this report reflects a snapshot of the issues these communities were facing at this time. We anticipate that experiences are likely to evolve over the coming years as the 10 Year Health Plan for England, described below, is embedded across London's healthcare system.

Reform of the NHS must address the long-standing issues faced by patients

The government's 10 Year Health Plan for England, published in July 2025, has set out an ambition to move care from analogue to digital, alongside shifts from hospital to community and from sickness to prevention.[5] The NHS Modernisation Bill is the primary legislative vehicle through which the government intends to deliver the 10 Year Health Plan, and, taken together, the proposals in the Bill and the 10 Year Health Plan represent a fundamental shift in the way that the NHS is governed, both centrally and at a local level.

4 Good Things Foundation. (2024). Health Inequalities and Mitigating Risks of Digital Exclusion (2nd ed.). Available at https://www.goodthingsfoundation.org/policy-and-research/research-and-evidence/research-2024/health-inequalities-digital-exclusion

5 Department of Health and Social Care. (2025, 3 July). Fit for the Future: The 10 Year Health Plan for England. GOV.UK. Available at https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

The Bill introduces the possibility for positive change that will be felt by patients on the ground, such as the promise of a single patient record which will centralise data on patient needs and diagnoses rather than this information being scattered across various NHS services. However, in general the Bill is primarily focused on structural reorganisation of NHS bodies. As has happened with previous NHS reorganisations, there is a risk therefore that this high-level, structural change diverts leadership attention away from the things that really matter to patients, like the speed and quality of the care they receive.[6]

Research has been consistently calling attention to some of these patient-centred issues for years. In particular, poor communication has been identified as a serious and recurring issue that makes it difficult for people to navigate the health system as they don't know who to contact when they need support.[7] This is a fundamental problem, with only 32% of the public thinking that the NHS is good at keeping people informed about their care and treatment.[8]

These issues often fall hardest on those facing higher levels of disadvantage, with 81% of those who are struggling financially saying they have experienced problems related to NHS administration, compared with 63% of those who are not.[9] Research has also shown that those who speak English as an additional language do not receive consistent and reliable translation support, substantially impacting their quality of care as well as their trust in the health system.[10]

Without a concerted effort to address these long-standing, well-documented issues, trust in the health system is likely to erode further - particularly among those already facing the greatest barriers to accessing care.

Digital-by-default healthcare risks leaving behind those who are digitally excluded

Within the 10 Year Health Plan's proposals to shift away from analogue and towards digital healthcare, one key aim for significantly impacting patients' everyday experiences centres around the NHS App. The Plan includes the intention to turn the NHS App into a 'world-leading tool' with a variety of different functions that will allow patients to manage some elements of their own healthcare. For example, the Health Plan envisions that, by 2028, patients will be able to use the NHS App to choose their preferred healthcare provider, book their own tests and vaccines where appropriate, and coordinate additional care support for themselves or a loved one.

London's Integrated Care Boards (ICBs) - statutory NHS organisations that are responsible for planning, funding and coordinating health services in a local area - have responded positively to the 10 Year Health Plan. NHS England - London is already reporting that the analogue to digital shift is transforming the care that patients receive (such as through moving away from letters and towards the NHS App for patient communication). There have also been recent London-specific updates to the NHS App so that, as of July 2026, any patient registered with a London GP is now able to use the app to create their own Universal Care Plan, which allows for more patient-centred, personalised care.[11]

However, the 10 Year Health Plan does not address in detail how the NHS will ensure equitable access to healthcare for people who cannot afford their own device or internet connection, or for those who do not have basic digital skills. It is estimated that around 270,000 Londoners

6 Anandaciva, S. (2026, 11 May). Why Do Politicians Restructure the NHS? The King's Fund. Available at https://www.kingsfund.org.uk/insight-and-analysis/blogs/why-do-politicians-restructure-nhs-

7 Brunton-Douglas, T. and others. "I Love the NHS, But…": Preventing Needless Harms Caused by Poor Communications in the NHS. Demos, 2023. Available at https://demos.co.uk/wp-content/uploads/2023/11/Preventing-needless-harms-caused-by-poor-comms-in-the-NHS-1.pdf

8 Wenzel, L. and others. (2026, 16 April). Still Lost in the System: The Urgent Need for Better NHS Admin. The King's Fund. Available at https://www.kingsfund.org.uk/insight-and-analysis/long-reads/still-lost-system-urgent-need-better-nhs-admin

9 Wenzel and others. Still Lost in the System. 2026.

10 https://www.patients-association.org.uk/Handlers/Download.ashx?IDMF=d39a18c6-cc7a-4040-bc17-6a5ce3bd4129

11 Peart, L. (2026, 22 July). Digital Care Plan for NHS Patients Reaches London Milestone. Healthcare Management. Available at https://www.healthcare-management.uk/digital-care-plan-nhs-patients-reaches-london-milestone

have no internet access at all, and that two million have very limited digital engagement.[12] As the digital exclusion charity Good Things Foundation points out, the shift towards digital healthcare risks widening health inequalities for those from the most disadvantaged communities.[13]

It is precisely these concerns that London's health and care leaders are seeking to gain greater understanding of through initiatives such as this research project. While it is the responsibility of wider health bodies, rather than the London Health Mission, to ensure that the analogue to digital shift is inclusive, the Mission's role is to support and advise healthcare bodies on how they can best go about this. It is critical that health providers listen to the voices of those who are most likely to be overlooked by the shift towards digital-by-default healthcare. It is only by understanding their experiences and hearing their concerns that London will be able to build a healthcare system that addresses the needs of everyone. It is heartening therefore to see the London Health Mission take these issues seriously and commit to listening to community insights on healthcare through projects such as this one.

Forging a new deal between patients and the NHS

Listening to the views of NHS patients and actively working with them to find ways to improve their access to healthcare is particularly important given the current social and political climate. DCMS' Community Life Survey reflects the fact that, while 59% of people in England say that influencing decisions affecting their local area is important to them, only 26% feel they can actually do so.[14] This points to a strained relationship between citizen and state and reinforces a feeling of disconnect between public services and how we actually live.

This is especially true when it comes to healthcare, given the public's low satisfaction with the NHS. In 2025, 26% of those asked stated they were satisfied with the way the NHS is run - an increase from the 21% recorded in 2024, but still far below the 60% seen in 2019.[15] This report suggests that, at least in part, this lack of trust is caused by basic expectations about the support that patients will receive going unmet.

This is why this report concludes from the research that healthcare bodies need to prioritise listening to patients, particularly those whose views are not often heard, and actively using their views to shape services. Only by embedding this kind of partnership working into the system can trust between citizens and the NHS, one of the UK's most iconic institutions, begin to be rebuilt. London, with its high density of healthcare services and high numbers of patients, many of whom are from marginalised communities, is the ideal setting in which some of these ideas can start to be put into practice.

12 Greater London Authority. Mayor Urges More Businesses to Donate Old IT Equipment. 2025.
13 Good Things Foundation. (2025). From Analogue to Digital: Tackling Inequality and Digital Exclusion in the Future NHS. Available at https://www.goodthingsfoundation.org/discover/digital-inclusion-insights/digital-inclusion-insights-2025/tackling-digital-exclusion-in-the-future-nhs
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15 Jefferies, D. and others. Public Satisfaction with the NHS and Social Care in 2025: Results from the British Social Attitudes Survey. Nuffield Trust, 2026. Available at https://www.nuffieldtrust.org.uk/research/public-satisfaction-with-the-nhs-and-social-care-in-2025-results-from-the-british-social-attitudes-survey

REPORT SUMMARY

The first part of this paper, the *Methodology*, covers briefly how Demos carried out the research, including how the marginalised communities and London boroughs that the report focuses on were selected.

The second section, *Barriers*, looks in depth at the obstacles that research participants described experiencing when trying to access healthcare. This section looks at digital barriers, but also at non-digital barriers (those which apply when healthcare is accessed face-to-face or via phone calls), in order to better understand some of the core communications and access obstacles for people who are digitally excluded.

Solutions presents the suggestions that research participants put forward describing how the healthcare system could change to better support their needs. Finally, *Recommendations* outlines how the London Health Mission could take some of these solutions forward, and how they can continue to engage the public meaningfully in their future work.

Primarily, this report serves to highlight the immediate needs of people in London who have found themselves unable to access the healthcare they need, and suggests how these issues can be addressed. But beyond this, it demonstrates the importance of listening to the public, especially more marginalised groups, in order to design public services that meet the needs of everybody. It is this need that the London Health Mission has identified in commissioning this work and, in turn, the report findings can help to support the Mission's ultimate aim of reducing London's health inequalities, thereby turning it into the healthiest global city.



METHODOLOGY

The first phase of the project involved in-depth desk research to identify which communities in London experience the most acute combination of poor health outcomes, looking into both personal health literacy (PHL) and organisational health literacy (OHL). As defined by the London Health Mission, PHL is understood as someone having the appropriate language and numeracy skills, knowledge, understanding, trust and confidence to use and navigate health services well; OHL, meanwhile, is how care organisations make it easier for people to find, understand, trust and use information to make informed choices about their health.

We also searched for proof of digital exclusion, which can be understood as inability to fully use digital technologies to partake in modern society. It is not only about connection, but about overlapping barriers. This was determined using the UK government's Essential Digital Skills Framework and Ofcom's Digital Exclusion Framework, which looks at digital exclusion through the lenses of ability, access and affordability.

Through this scoping research, six groups were identified:

- People aged 65 or over
- Blind and partially sighted people
- Migrant communities
- People with learning disabilities
- People with experience of homelessness (including those in temporary accommodation)
- People on low incomes

Narrowing the research down to these six groups does not imply that other marginalised communities do not face barriers when accessing healthcare. Rather, the scoping research suggested that, of all the people in London who face healthcare barriers, those who fall into at least one of these six groups are among the most severely impacted. It is also important to recognise that, while it was necessary for research purposes to identify six separate demographic groups, everybody has intersecting identities and many people fall into more than one of the demographic categories mentioned above (people who are both above 65 and who are blind or partially sighted, for example, or who are on low income and have experience of homelessness).

More details on the scoping methodology, as well as information on how people from these groups are impacted by digital exclusion, PHL and OHL, can be found in Appendix 1.

IDENTIFYING THE MOST AT-RISK BOROUGHS

Once the research identified these six community groups, the next step was to determine which parts of London contain the highest proportions of populations who are at risk of both digital exclusion and poor health outcomes.

To do this, the findings from the desk research were used to assess the key risk factors that lead to health inequalities and digital exclusion. While the need to be selective when deciding on the six community groups had meant that some of these risk factors had been prioritised over others, this was not a constraint for this part of the research. It was therefore possible to include in the calculations additional variables aside from those covered by the six groups, namely, being from an ethnic minority background and having no formal qualifications. It was also possible to consider people who have any disability or long-term health condition, rather than just focusing on those who experience some of the most acute barriers to healthcare.

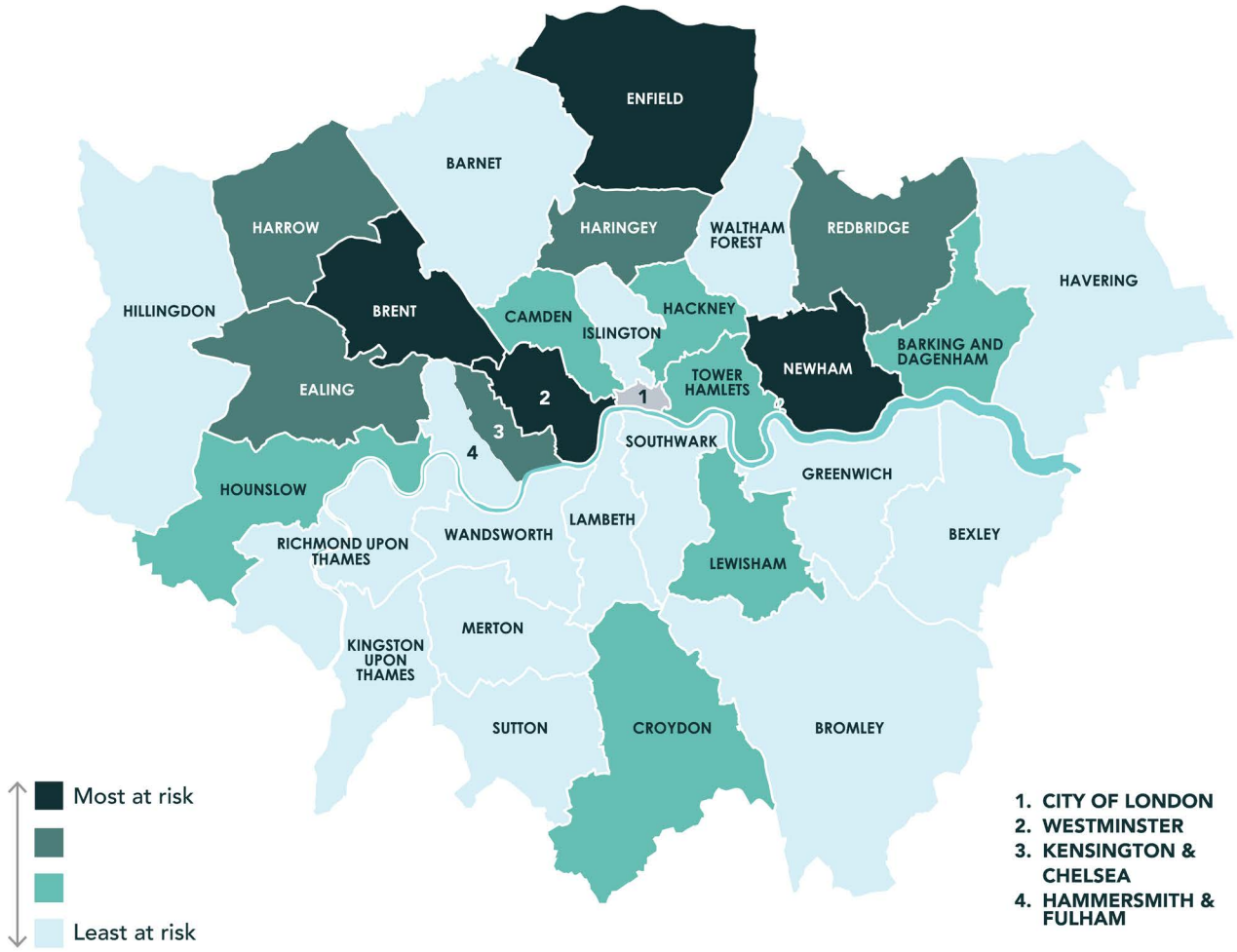
The variables that were used for the borough-level population estimates were the following:

- Being aged 65+
- Experiencing homelessness
- Living in a low-income household (60% or less of median income)
- Being an immigrant (born outside the UK)
- Having a disability or long-term health condition
- Being from an ethnic minority group (Asian, Black, Mixed, White Roma, Gypsy or Irish Traveller, other)
- Having no formal qualifications

For each London borough, Demos found the proportion of its population that fell into each of the above groups, then averaged out these proportions to get a 'final score' for each borough. The results show which boroughs contain the highest percentages of people from across all of these at-risk groups. Further details of the methods and values used can be found in Appendix 2.

This data was used to build a heatmap, shown below, which identifies the boroughs with the highest and lowest levels of at-risk populations. The boroughs that were deemed very high risk (Brent, Enfield, Newham and Westminster) are shown in dark green.

BOROUGHS AT THE INTERSECTION OF DIGITAL EXCLUSION AND POOR HEALTH LITERACY



Next, population data was used to identify which of the highest-risk boroughs contained the largest proportions of the specific population groups that were of interest to this study. In order to focus efforts on the four boroughs labelled as very high risk, these were set apart as 'priority boroughs'. Other at-risk boroughs that contained high proportions of the research population groups were designated 'secondary boroughs'. The boroughs identified for each group are set out in the table below.

GROUP	PRIORITY BOROUGHS	SECONDARY BOROUGHS
65+	Enfield, Westminster	Croydon, Harrow, Kensington and Chelsea
Homelessness	Newham, Westminster	Hackney, Haringey, Kensington and Chelsea
Migrant	Brent, Newham, Westminster	Harrow, Kensington and Chelsea
Low income	Brent, Newham, Westminster	Camden, Redbridge, Tower Hamlets
Blind and partially sighted	Enfield	Croydon, Ealing, Harrow, Kensington and Chelsea
Learning disability	Enfield	Camden, Haringey, Lewisham, Redbridge

By first identifying the most at-risk boroughs overall and then prioritising boroughs for each demographic within that shortlist, this approach ensured that the focus was on areas where need is most concentrated. This method also meant that the findings would be more representative of the lived reality of intersectional disadvantage, rather than treating each demographic as isolated and discrete.

PARTNERING WITH COMMUNITY GROUPS

Once the most at-risk communities and the most-affected London boroughs were identified, there was a joint effort with the London Health Mission to seek out local community organisations that fit the criteria and would be able to partner on this project. In order to get views from people across different parts of the city, each community group was based in a different borough. Efforts were focused on getting representation from each of the four very-high risk boroughs, and then identifying organisations in each of these areas. Where an appropriate organisation could not be found in the priority borough, Demos looked into the secondary boroughs to identify groups to work with.

The community organisations who agreed to partner throughout the duration of the project were the following:

First Love Foundation

First Love Foundation (FLF) provides wrap-around support for Londoners in Tower Hamlets who are living in poverty. This includes providing advice and advocacy and supporting those in need to reduce their reliance on foodbanks.

Middlesex Association for the Blind

Middlesex Association for the Blind (MAB) supports blind and partially sighted people across the Middlesex region. For this project, participants were drawn from their members who live in Ealing and Harrow. They provide various services to reduce isolation and increase independence among their members, including social clubs, employment support and digital inclusion training.

One-to-One Enfield

One-to-One Enfield provides support and runs activities for autistic adults and those with learning difficulties living in Enfield. While participants for this project were drawn from their members who have learning disabilities, One-to-One would like to highlight that autistic adults can also experience significant barriers when it comes to accessing health services.

Open Age

Open Age works to support people aged 50 years and older across west London. For this project, participants were drawn from their members who were 65 or older and living in Westminster.[16] Open Age organises activities and outings to enrich the lives of their members, and also provides several learning courses including some focused on digital skills.

16 Due to the need to quickly replace a last-minute participant drop out, one participant in the final Open Age group was only 62 years old.

Romanian and Eastern European Hub

The Romanian and Eastern European Hub (Ro-EE Hub) provides advice, support, training and advocacy for migrants based across London from Romania, Ukraine and other Eastern European countries. Participants for this project were all from Romania and lived in the borough of Brent.

Your Place

Your Place supports people facing homelessness in East London. It does this by providing supported accommodation as well as offering one-to-one support to help individuals with their specific needs. For this project, participants were drawn from members who were living in Newham.

Once these six partner organisations had agreed to support the project and begin collaboration, staff at each organisation identified around eight members who were interested in taking part in the research. A multi-stage data collection approach ensued to find out about different aspects of the participants' experiences around access to healthcare and digital inclusion.

Stage 1: Each participant completed a health diary over the course of two weeks. In this, they provided information about how they generally access healthcare (for example, which services they use most and whether they usually need any support). They also recorded all interactions they had with health services during this time, including what they felt had gone well and what hadn't gone so well in these interactions. This information provided key insights into the extent to which participants already use digital health services as well as into some of the obstacles they face when accessing healthcare. This data guided some of the discussions that occurred in the following stage of data collection. A blank copy of the diary can be found in Appendix 3.

Stage 2: Demos ran one two-hour workshop with the eight participants from each community organisation in which participants were asked what barriers they have faced when accessing NHS healthcare in London. The workshops were split into two halves: the first focusing on non-digital barriers and the second on digital barriers. The insights gained from the participant diaries steered the initial conversations, but room was allowed for participants to discuss other concerns that had not surfaced in the diary stage. Details around the different barriers that were discussed at this stage can be found in the *Barriers* section of this report.

Stage 3: Demos ran a second two-hour workshop with each community organisation, after conducting a rapid thematic analysis on the conversations from the first workshop to identify the key issues that had been raised. Participants were invited to suggest solutions that they thought would tackle these problems, and the groups were encouraged to discuss what impact these solutions would have on their ability to access healthcare. Half the time was dedicated to solutions that were not related to digital access, and half focused on solutions to digital barriers.

Stage 4: After hearing from each group individually, their conversations were collated into comprehensive lists for digital and non-digital solutions, combining similar solutions into overarching themes. Then a final cross-community consensus-building workshop took place where two representatives from each group discussed these solutions. Following discussions, all group members who were present voted on which solutions they thought were most important, not just to them and people like them, but also to other communities across London who face barriers to digital and health access. The prioritised list of solutions is presented in the *Solutions* section of this report, along with detail around why these were important to the participants.

In addition to hearing directly from community organisation members about their personal experiences when accessing healthcare, staff members from each of the community organisations were interviewed. This helped build a better picture of the system-level barriers that underpin some of their members' experiences, and the solutions that could help to alleviate these. The barriers and solutions discussed with staff are presented in the relevant sections of this report.

BARRIERS



SHARED BARRIERS

Members in each group discussed the barriers - both digital and non-digital - that they face when attempting to access NHS healthcare. While groups did bring up some experiences that were specific to them, there was a large amount of overlap among the various issues that participants highlighted across the study. Equally, when interviewing staff members from each of these groups about system-level barriers, there were some issues that were raised by staff from several community groups. This section discusses the issues that were raised by at least two of the groups.

NON-DIGITAL BARRIERS IDENTIFIED BY GROUP MEMBERS

The barriers that group members identified that were not directly related to digital systems and platforms are summarised in the table below, along with the names of the groups that identified them.

BARRIER	FIRST LOVE FOUNDATION	MIDDLESEX ASSOCIATION FOR THE BLIND	ONE-TO-ONE ENFIELD	OPEN AGE	RO-EE HUB	YOUR PLACE
NON-DIGITAL BARRIERS						
Identified by group members						
People face difficulties accessing primary and emergency care	✓	✓	✓	✓		✓
The health system is highly fragmented and difficult to navigate	✓	✓		✓	✓	
Patients often feel left in the dark about their own health information	✓	✓		✓	✓	✓
Communication is provided in inaccessible formats		✓	✓	✓	✓	
Staff lack the necessary accessibility training to support all patients	✓	✓				✓

In general, almost all participants expressed some level of frustration around their inability to access primary care services. Restrictive booking practices, long wait times for appointments and last-minute cancellations all meant that many people felt like their health needs were not seen as a priority. This was exacerbated by a highly fragmented health system which can be very difficult for people to navigate and sees many fall through the cracks. These issues are compounded for those with additional needs, with many participants describing how their accessibility needs in relation to communication, transport or staff-patient interactions were overlooked.

The section below discusses these barriers in more detail, highlighting, where relevant, instances where they make access to healthcare particularly difficult for certain groups.

People face difficulties accessing primary and emergency care

Many participants talked about how they found it hard to even get to see healthcare professionals in the first place. This was the case for many different healthcare services, from GPs to dentists to A&E departments.

One significant barrier to accessing GP appointments was the 8am window for booking same-day appointments by phone. Participants discussed how the rush can be incompatible with working adults and parents, noting that this high-pressure booking window effectively excludes those with caring responsibilities or work obligations. This combines with the lack of transparency and inconsistency around how appointments are allocated, with people sometimes getting different responses from one week to the next, to create a highly frustrating experience.

For those with learning disabilities, having a very narrow window in which they can book a GP appointment can be extremely stressful, especially when this leads to them having to wait in a queue for a long time with jarring background music that they may find difficult to tolerate. Participants in this group talked about going through this experience for two or three days in a row before being able to get an appointment.

> *"I always end up like twentieth in the queue. By the time I get through, there are no appointments left."*
>
> **Participant from One-to-One Enfield**

Outside of GP appointments, participants talked about having to wait for very long periods of time before being able to get dental care, or before being seen at A&E. This frustration was magnified when, after such a long wait, they were only offered what they perceived to be a minimal level of care.

> *"I'm still waiting nine and a half hours, just to get some inhalers, because my doctor couldn't [prescribe] me my inhalers."*
>
> **Participant from Your Place**

The health system is highly fragmented and difficult to navigate

Participants in most groups related stories of how their healthcare had been impeded by the fact that the overall healthcare system is highly fragmented, which leaves the patient having to navigate multiple complicated systems that each have different priorities and ways of working.

Participants often found that there was very poor communication between different healthcare settings, which meant the burden was on them to join the dots and ensure each professional they visited had all the relevant information. In one case, a participant had needed to print almost 150 pages of their own medical records since the two hospitals they were visiting could not share medical records between them. All of the participants already face significant barriers to healthcare; being forced to take on the additional responsibility of managing the competing requirements of different services added unnecessary strain to this experience.

> *"It's like spinning plates ... Honestly, in your mind it's so overwhelming, and it really breaks you."*
>
> **Participant from First Love Foundation**

Another related issue that participants described was a lack of continuity of care. For some, this occurred after they had received a significant medical intervention, like surgery, and they did not feel they received adequate follow-up care. Many others complained that they rarely, if ever, see the same GP. This means they have to spend several minutes at the beginning of each appointment updating the GP on their relevant medical history before talking about their immediate health needs. This is particularly difficult for those with additional communication needs, such as participants with learning disabilities or those who do not have English as a first language.

Patients often feel left in the dark about their own health information

Perhaps partially as a result of this fragmented system, participants related how they often don't receive important information from health services in a timely manner, and in some cases they don't hear from them at all.

One particular grievance for several participants is last-minute appointment cancellations. Some people were not informed that their appointment had been cancelled until they had arrived at the relevant department. The costs to patients of attending appointments - time off work, childcare and transport costs, for example - are already more burdensome for many of the participants, such as those on low income, and this adds unnecessary financial strain. This is exacerbated further for those who might need the support of friends, family, or professional carers to attend appointments, such as blind and partially sighted people, those with learning disabilities, or migrants who do not speak English as a first language.

> *"[The receptionist said] 'Oh, I'm very sorry, your appointment's been cancelled … and it's in another centre,' which is four buses away. I said, 'I'm sorry, I cannot get there. I don't have transport, I can't drive anymore.' [The receptionist responded] 'I'm sorry, … you have to go there.'"*
>
> **Participant from Middlesex Association for the Blind**

More generally, it was also noted by several participants that the NHS does not communicate effectively about the services it provides, and what those services entail. People expressed their frustration that queues at local A&E departments were filled with people who were not aware that they would be better served at pharmacies or urgent care centres. Others talked about how they had felt pressured to pay for expensive dental treatment because they were not aware that they were entitled to the same treatment as part of their standard NHS dental check up. While much of this information is easily available online, participants who were not able or not comfortable searching for information on the internet often remained in the dark.

> *"I didn't always know that I could ring 111."*
>
> **Participant from Open Age**

Communication is provided in inaccessible formats

Even where health services are communicating with patients, this communication can often be inaccessible or unintelligible, which leaves patients unclear as to what their diagnosis or treatment plan is and leads to increased fear and anxiety.

Many people in the groups discussed having specific communication needs, whether that be the need for Braille or large print for blind and partially sighted people, Easy Read for people with learning disabilities, or interpreters and text in their preferred language for migrants who are less confident speaking English. However, participants reported that their communication needs often go unmet.

> *"When you ask them to put it in large print, they still send it to you in small print."*
>
> **Participant from Middlesex Association for the Blind**

One barrier that came up among several participants was the use of clinical and technical language ('medical jargon') in texts, emails, letters and other forms of communication. This type of language assumes a baseline of health literacy that not all patients have, and often results in people sharing their private and confidential health information with friends and family to 'translate' the medical jargon into plain English. For those with other communication needs, such as the groups mentioned above, it places their vital health information even further out of reach.

> *"When someone like me struggles to understand even longer emails, medical jargon makes it even worse."*
>
> **Participant from One-to-One Enfield**

Staff lack the necessary accessibility training to support all patients

Participants discussed encounters with NHS staff who lack the training, patience, awareness and knowledge to provide the support that patients need. Participants agreed that this barrier usually arises from a failure to equip staff with the skills and capacity to effectively administer care for a diverse range of patients.

> *"They're not fully trained. They don't know, she might have anxiety, she might have autism. You can't just tell someone to be nice, you have to train for that."*
>
> **Participant from Your Place**

Blind and partially sighted Londoners feel the need for staff training sharply. Participants described routine failures from staff who were not trained on sight awareness: being handed forms that they cannot read, being directed somewhere without aid or being guided in a way that removed their sense of control. In some situations this led to patients feeling disempowered.

> *"They hook their hand under your elbow, and they're pushing you forward, and you feel that you're being pushed into goodness knows what."*
>
> **Participant from Middlesex Association for the Blind**

NON-DIGITAL BARRIERS IDENTIFIED BY COMMUNITY GROUP STAFF

Interviews were conducted with staff from each of the groups to discuss what system-level barriers they see as being behind some of the concerns most frequently raised by their members. Below is a table summarising these non-digital barriers, along with descriptions of what they mean in practice for people seeking access to healthcare.

BARRIER	FIRST LOVE FOUNDATION	MIDDLESEX ASSOCIATION FOR THE BLIND	ONE-TO-ONE ENFIELD	OPEN AGE	RO-EE HUB	YOUR PLACE
NON-DIGITAL BARRIERS						
System-level barriers identified by staff						
Throughput-driven systems erode public trust		✓		✓		
System rigidity creates a barrier to care		✓	✓			✓
An opaque system means patients are unaware of their rights	✓				✓	
Geographically-restricted funding					✓	

For staff members, their primary concern was that patients tend to be treated as numbers to be processed rather than as individuals to be supported. This is particularly concerning for them because many of the people they work with have additional needs and therefore would benefit from more rather than less support to access health services. Furthermore, they pointed out that the health system does not make it easy for people with communication barriers to advocate for themselves, which presents further obstacles to their receiving the healthcare they need. Finally, they pointed out that their own ability to support people across the capital is limited when a lot of health funding is restricted to specific geographic areas.

Throughput-driven systems erode public trust

Some of the staff members shared how, at a structural level, the health system has become a system focused on processing a large volume of patients as quickly as possible, rather than focusing on individual patient journeys and personalised care.

Staff from Middlesex Association for the Blind talked about how some of their members had been discharged from medical settings without a proper care package in place, while Open Age staff pointed out how the health system does not build continuity into patient journeys, prioritising getting patients out the door as quickly as possible. Staff from both organisations highlighted that this behaviour results in low levels of trust from the public that the NHS will provide them with the support that they need when they have health concerns.

> *"The incentives favour throughput rather than relationship building."*
>
> **Staff member from Open Age**

System rigidity creates a barrier to care

Many staff members support service users who, for various reasons, can struggle to always attend their appointments on time, and they found there is a lack of tolerance and flexibility within the system to accommodate these patients.

It is well-documented that people with experience of homelessness are more likely to have poor mental health, and that, in turn, poor mental health can lead to reduced executive functioning which can include poor timekeeping.[17] However, staff members from Your Place spoke about how referrals to community mental health teams can be closed if a resident misses their narrow appointment window, regardless of how acutely unwell they are. This effectively punishes the people who are least able to navigate a rigid system. Similarly, a staff member from One-to-One Enfield talked about how patients with learning disabilities often need additional support to make or attend an appointment. If that support is unavailable, then they are likely to miss their chance at receiving the healthcare they need.

> *"We're all running a race, but they've actually started like five steps behind. There's no way that they're able to make that appointment."*
>
> **Staff member from One-to-One Enfield**

17 Homeless Link. (2024, 8 May). Mental Health and Homelessness: An Inextricable Link? Available at https://homeless.org.uk/news/mental-health-and-homelessness-an-inextricable-link

An opaque system means patients are unaware of their rights

Staff members from several of the groups talked about how, even if their members have experienced poor-quality service from the NHS, they are often reluctant to advocate for their rights, or lack the knowledge of how to do so.

In particular, Ro-EE Hub staff members raised that patients who continue to receive communication in English, a language they struggle to fully comprehend, feel that they would be 'bothering' clinicians if they asked for correspondence in their own language. Staff talked about a particular service user who was repeatedly denied an interpreter and told to speak English, but who refused to complain because she worried about what the consequences might be. More generally, staff from First Love Foundation flagged that issues such as low literacy levels, neurodiversity, mental ill health and lack of transparency within the health system means that individuals may not be able to, or know that they can, advocate for themselves when the healthcare they're offered doesn't work for them. This means that issues affecting the most vulnerable people aren't acknowledged or addressed.

> *"Of course, you can advocate for yourself ... but if people don't know they can do that, they just resign to what's been written."*
>
> **Staff member from First Love Foundation**

Geographically-restricted funding

Staff from Ro-EE Hub explained how NHS funding is often tied to specific Integrated Care Board areas, which can exclude a large proportion of the service users of city-wide community groups like this one. It means that members living just across a borough boundary can't be supported, even for national campaigns like cancer screenings. While this issue was only raised by staff from one community group, it is likely to be relevant to all organisations supporting marginalised individuals across the city.

> *"It is a barrier for us when it comes to engaging with service users and raising awareness of the support available."*
>
> **Staff member from Ro-EE Hub**

DIGITAL BARRIERS IDENTIFIED BY GROUP MEMBERS

Considerable time was spent discussing the barriers that participants face when expected to access services using digital platforms like websites, emails, and apps, focusing particularly on the NHS App. The digital barriers that were common among more than one group are laid out in the table, and then explained in greater detail below.

BARRIER	FIRST LOVE FOUNDATION	MIDDLESEX ASSOCIATION FOR THE BLIND	ONE-TO-ONE ENFIELD	OPEN AGE	RO-EE HUB	YOUR PLACE
DIGITAL BARRIERS						
Identified by group members						
People feel forced to use digital services when they cannot do so or do not want to	✓	✓	✓	✓	✓	✓
Many people do not have the necessary devices or data for digital services	✓		✓	✓		✓
Too many healthcare apps create a fragmented and confusing system	✓	✓	✓	✓		
The NHS App can be confusing and unreliable	✓	✓	✓	✓	✓	✓
Accessibility needs are not built into digital healthcare platforms	✓	✓		✓	✓	

The most common concern for participants across all the groups was the expectation by healthcare staff that they would be both able to and comfortable with accessing services digitally, which was often not the case. This left many people feeling frustrated and anxious that they would end up being locked out of receiving the healthcare they needed. Even those who wanted to use digital platforms found it very confusing to do so when different services use different apps, and the NHS App itself can be difficult to navigate. This is especially true for those with additional needs, since features supporting people with access needs or those who are more comfortable speaking a language other than English are not built into the platform.

People feel forced to use digital services when they cannot do so or do not want to

This was one of the most pressing concerns for all of the groups. The assumption by many services that everyone is able, and wants, to access healthcare via digital routes does not reflect the lived reality of many Londoners. Lots of participants shared stories of how they had felt frustrated when digital services had been the only means through which they could book an appointment or receive important information. This frustration was exacerbated when healthcare staff did not seem to understand or accept that this is something people might struggle with. For the participants, who represent some of the most digitally-excluded people in the city, the fact that using a digital system often felt like their only route to receiving healthcare meant that they sometimes chose to forego that healthcare altogether.

> *"When I'm at the hospital, they can't sort it out for me when I'm there. I say, 'I've got this letter,' [and they say] 'You've got to do it on [the app].' I can't do it. So, what's the point?"*
>
> **Participant from Open Age**

Many people do not have the necessary devices or data for digital services

Many of the participants do not have the necessary data and devices to access digital platforms and so have no way to access digital health services.

Several participants said that they did not have a smart phone or internet access in their homes. The scoping research highlights that for many Londoners, it is the cost of these technologies that is most prohibitive. However, of the people who took part, the most common reasons for not using more advanced technology were: a lack of confidence in their ability to use it; a belief that digital devices would not support their access needs; and the fact that it was simply not necessary for their lives. Many of these individuals use public computers (such as those in libraries) or enlist the help of friends or relatives if they ever need to access the internet to communicate with the NHS, which means they can be forced to consider sensitive health information in public, or to discuss it with other people.

> *"I'm not over keen on using [apps] anyway. Because it means you've got to go somewhere that deals with it, [like a] library."*
>
> **Participant from Open Age**

The situation was different for those with experience of homelessness. While many of the people in this group wanted to be able to use digital technologies, they found that it was 'a lot harder' to access health information, especially when they were rough sleeping, as they did not always have access to a phone, electricity, credit or data.

> *"I had to use the bus [charge points] to charge my phone sometimes."*
>
> **Participant from Your Place**

Too many healthcare apps create a fragmented and confusing system

For those who were able to access digital services, participants from across the groups discussed how navigating the digital health landscape is confusing and difficult because of the proliferation of healthcare apps.

Different health providers operate different apps, with DrDoctor, Patient Knows Best, Patient Access and the NHS App being a few of those that are most widely used. This leaves users with the mental burden of having to remember which app they need to use to communicate with each of their health providers. With each app looking different and requiring different login credentials, this fragmentation only leads to increased confusion.

> *"So which am I supposed to use, and what is the difference? What is Patient Knows Best? … How's that different from the NHS [app]?"*
>
> **Participant from First Love Foundation**

The NHS App can be confusing and unreliable

Many of the conversations focused around people's experiences of the NHS App specifically. While people appreciated the fact that the app made things like ordering a repeat prescription very easy, at the same time participants often struggled to engage with it.

A common complaint about the NHS App was that people find it too complicated to navigate. There are multiple possible pathways that people can follow within the app, and it is unclear how users are supposed to obtain the information that they need since there is no obvious guidance to support new users or those with low digital confidence. For some participants, the frustration came when trying to book an appointment online - unlike booking via a phone call, where you get immediate confirmation of your appointment time, participants found they have to wait days and sometimes weeks to hear if their appointment has indeed been made, leaving them feeling left in the dark.

Additionally, some people struggle to log into the app in the first place because of the need to input a password. This is a particular barrier for those with poor memory and people who do not have the digital confidence or skills to be able to reset their previous password easily. This leads to frustration which stops people from even trying to access the app.

> *"Every time I try to open the app and put the password in, it doesn't recognise my password ... In the end, I've just decided that I'm not using any apps for the NHS."*
>
> **Participant from One-to-One Enfield**

Even for those who are able to access and navigate the NHS App, there were several reports of there being discrepancies between the personal medical information provided on the app and that which was recorded by in-person healthcare services. One person went to attend an appointment the app had advised them of, only to find when they arrived that the appointment had been cancelled without the app having been updated. Other people shared that the test results they had been shown on the app differed from the results that their GPs shared with them directly. This has caused frustration as well as confusion, with participants unsure which sources to trust for reliable information on their own health conditions.

> *"I was given my results on the NHS App, but I don't understand them. There's a red flag on the account, I can't figure out what that means."*
>
> **Participant from Open Age**

It should be noted that, while most of the conversations around digital access revolved around the NHS App, participants across groups also highlighted other digital platforms as being too complicated and long-winded for them to be able to use comfortably. This included Patchs online consultation service as well as other online forms that patients need to fill in when requesting medical support.

Accessibility needs are not built into digital healthcare platforms

Many of the participants have specific access needs that the NHS App does not meet, which makes it extremely difficult, and sometimes impossible, for them to use the app without significant support. The blind and partially sighted group shared that the accessibility features needed for them to be able to access the app, such as increasing the font size or changing the text and background colours to enhance contrast, are not available, which means that many of them cannot use the app independently. Furthermore, since the app is only available in English, this left most participants who do not have English as a first language needing to enlist the support of a friend, family member or support worker every time they want to use the app.

> *"It's quite embarrassing to have to go to her son, and feels like she's bothering him with these questions and requests for support."*
>
> **Participant from Ro-EE Hub**

DIGITAL BARRIERS IDENTIFIED BY COMMUNITY GROUP STAFF

Staff members also talked about the systemic barriers that are driving some of the issues their service users are facing when they are expected to access healthcare digitally, which are expanded upon below.

BARRIER	FIRST LOVE FOUNDATION	MIDDLESEX ASSOCIATION FOR THE BLIND	ONE-TO-ONE ENFIELD	OPEN AGE	RO-EE HUB	YOUR PLACE
DIGITAL BARRIERS						
System-level barriers identified by staff						
The NHS App relies on people having functional literacy levels	✓					✓
Low levels of trust	✓		✓			
Some Londoners will never be interested in engaging with digital services		✓		✓		✓

Many of the concerns raised by community group staff echoed what was said by the group members, in particular the fact that assumptions around people's ability to access digital platforms will lock many out of healthcare. Along with lower literacy levels and a disinterest in digital technologies, staff also pointed out that low levels of trust in both digital platforms and healthcare services more broadly are barriers when it comes to patients accessing healthcare services digitally.

The NHS App relies on people having functional literacy levels

Staff members shared how the health service's reliance on the NHS App for communication with patients assumes a functional level of literacy, but this is not always the case for their service users.

Participants for this project were targeted in part because they sit in demographics that are more likely to have low levels of personal health literacy. Given that there is a high correlation between an individual's literacy level and their personal health literacy, it is unsurprising that staff members said that literacy was a barrier preventing some of their members from accessing the NHS App. It was discussed that low literacy could be caused by a number of factors, from not having been supported fully at school to undiagnosed neurodivergence or learning disabilities, and that this meant some members were fully reliant on other people to read their messages and notifications.

> *"There is no one way, and we probably need to accept the fact that we need to be diverse in terms of how we communicate with people."*
>
> **Staff member from First Love Foundation**

Low levels of trust

Staff raised that the level of engagement patients have with digital NHS platforms depends not only on how far they trust digital technologies, but also the extent to which they trust the NHS as a whole.

Staff explained that many people struggle to engage with the NHS App because they are suspicious of AI and 'big data', which they have come to associate with most online platforms. For some people, this is because they don't know what AI is and this makes them wary when they hear it is being used. Others have experienced identity theft or have been the victim of a scam which has led to money being taken from their bank accounts, and the fear of this happening again leads to a fear of digital platforms more broadly.

> *"It's a fear of technology, with what happened in those days, with people's identities being stolen … So why the NHS, why my personal details?"*
>
> **Staff member from First Love Foundation**

However, a member of staff from One-to-One Enfield pointed out that it is not just trust in digital systems that can be a barrier to people engaging with digital systems, but trust in the NHS as a whole. Since people tend to view the NHS as one connected system rather than as separate parts, their trust in the NHS App is shaped by how positive, or how negative, their prior in-person experience with the NHS has been.

> *"One negative experience could jeopardise your whole view of the NHS, but one positive could change it."*
>
> **Staff member from One-to-One Enfield**

Some Londoners will never be interested in engaging with digital services

Similar to what the participants shared, one of the most common concerns raised by community group staff members was the fact that there is a cohort of their service users who they don't think will ever be interested in using technology, regardless of the support that is provided to them.

Staff were clear that even with a perfect, fully accessible NHS App, there would always be some residents who would not want to engage with it. This is not something they thought any level of up-skilling or improved training would be able to address. One staff member gave the example of a member who was offered a subsidised digital device and training on how to use it, but they still chose to refuse this offer.

> *"They just have no interest in using technology at all."*
>
> **Staff member from Your Place**

SPECIFIC BARRIERS FACED BY INDIVIDUAL GROUPS

While there were many points of similarity across the groups, with participants having experienced similar barriers at both a personal and system-wide level, nonetheless each group also experienced their own specific obstacles to accessing healthcare, both digitally and otherwise. The section below takes each group in turn and highlights the needs that were particular to their own demographic.

Blind and partially sighted people

Participants shared that, as blind and partially sighted people, they often felt like 'second-class citizens'. Their needs go unrecognised or ignored at many different stages of their healthcare journeys.

Non-digital barriers

It was noted by participants that healthcare staff were often not aware of their disability, or if they were, they had not had training to teach them how to provide adequate support. Particularly difficult issues included: feeling uneasy because they were not told who was in the room with them; staff not adequately supporting participants to physically access spaces that they cannot see; and repeatedly receiving inaccessible communication even when they

have already specified their access needs. In spite of these issues being caused by a lack of awareness training for staff, these experiences often caused embarrassment and discomfort for participants, leading them to frequently feel the need to apologise because they felt like a burden.

> *"I think we always apologise … [you] feel as if you're in the way, and then sometimes you think, I'm bothering people because of my disability."*
>
> **Participant from Middlesex Association for the Blind**

One problem that came up more in this group than in others was the unreliability of patient transport. Since many of these participants are unable to drive or take public transport unassisted, or to navigate new spaces independently, they tend to rely on patient transport to get to their appointments on time. However, some participants had found it very difficult to secure patient transport in the first place as they had been told they did not qualify for it, even though this was the only way for them to get to their appointment. One participant was rejected when they first applied, only to be guided through the qualifying questions by another member of staff and instructed on how to provide answers that would allow them access to patient transport. The fact that it can take a service professional manipulating the system to ensure that a blind person is able to get to their appointment is indicative of how significant the barriers can be for this group of people when they need to access healthcare. Even when participants have been able to secure patient transport, it could not always be relied upon to get them to their appointments on time, with one person sharing that they had missed three appointments because their transport was late.

> *"Transport is a nightmare. They tell you to ring your doctor, you ring your doctor, your doctor tells you to ring the hospital … Nobody wants to do it. You really have to fight to get it."*
>
> **Participant from Middlesex Association for the Blind**

Digital barriers

The participants in this group faced particularly high barriers when it came to accessing healthcare via digital platforms, and it was clear that many of these systems had been designed with very little thought given to the needs of blind and partially sighted people.

On top of the issues mentioned above, including inability to change the size and colour of text, participants stated that many features included in healthcare apps make them very difficult to access. These include verification processes like CAPTCHAs and One-Time Passwords (OTPs), links embedded in text messages connecting them to inaccessible webpages, and automated telephone systems that ask users to press buttons to navigate their menus. Participants shared that even completing an online form that is supposed to take 15 minutes can take them up to an hour. These features are fairly ubiquitous throughout the digital world and so are often included in the design of digital healthcare services, making it almost impossible sometimes for blind and partially sighted people to access the care that they need.

"You have to click on the images. I can't see the images. The audio version, if you try to listen, you can hardly understand anything. So I missed the meeting."

Participant from Middlesex Association for the Blind

People on low incomes

For people living in London on low incomes, the costs involved in accessing healthcare both in-person and digitally can be significant barriers to receiving the support they need, as can the difficulty of navigating other services like welfare alongside healthcare.

Non-digital barriers

As mentioned above, the additional costs incurred by last-minute appointment cancellations can be particularly burdensome for this group. In addition, another issue that came up more in this group than in other groups was the fact that the health system is not well-linked with the Department for Work and Pensions (DWP), and this can result in financial and mental strain. Participants in this group talked about the fact that they often need to share their medical records with the DWP in order to be eligible for payment of certain benefits, with the onus being on the benefits claimants to obtain and present these records to the DWP. As the participants noted, this burden can be very difficult, if not impossible, when they are already sick. On top of that, participants said that they had been asked to pay £25 by their GP surgeries for copies of their medical histories - a sum that can be a significant barrier for people already on low incomes.

"I can't be running around looking for a sick note every two months, because you're actually sick, you are genuinely [sick]."

Participant from First Love Foundation

Digital barriers

Both community group members and staff highlighted how a digital-first approach to healthcare assumes a level of infrastructure that is not always affordable for those on low incomes. Staff did acknowledge that there may be initiatives aimed at addressing these issues, such as free Wi-Fi in public spaces, but pointed out that promotion of these initiatives is poor which means that local people are not aware of them. They added that the NHS is not currently putting enough effort into its engagement and onboarding strategies for services like the NHS App, which means that people who are already digitally excluded are either not aware of these services, or are reluctant to use them as they do not understand how they work or why they are necessary.

"Has anyone ever sat down, Mr. Joe Smith, and said this is what [the app] is, this is how you can best use it?"

Staff member from First Love Foundation

People with learning disabilities

People with learning disabilities face specific challenges accessing healthcare services, most of which are directly tied to their accessibility needs.

Non-digital barriers

Participants from this group described how healthcare environments rarely account for how overwhelming these high-stress situations can be for people with learning disabilities. Getting lost in hospitals or GP surgeries was a common source of stress, exacerbated by the noise, crowds and unfamiliar settings that participants can find hard to tolerate. Lack of staff awareness of their accessibility needs made receiving help arduous, leaving some to have to either explain their circumstances from scratch or bear through an environment built without them in mind.

> *"I'm not very good with places that I've not been to, I could get lost quite easily. I get a bit nervous and agitated if I've not been somewhere before."*
>
> **Participant from One-to-One Enfield**

Appointment length added another layer of complexity. The standard appointment length was consistently described as too short for participants to process information and communicate their needs. As a result, participants felt under pressure and unable to convey what was wrong.

> *"The doctors give you about 10 minutes, and that's it, you know, they want the next patient. Well, I'm sorry, that shouldn't happen. If you're slow at explaining something, then the doctor has got to listen to you."*
>
> **Participant from One-to-One Enfield**

This is compounded by support networks for patients, such as carers or care workers, often facing trouble accessing patient information or being blocked from advocating on their behalf. Some discussed how carers are not recorded on their care records, leading to staff refusing to speak with them - as per confidentiality rules - despite the patient consenting. In some scenarios this can lead to treatments not being discussed with the person who would be administering them. Therefore, while patient confidentiality is important, there needs to be a better way to balance confidentiality with ensuring treatment is understood by all parties who depend upon it.

> *"They haven't registered me as a carer ... sometimes when you speak to a new receptionist, they refuse to give you any information."*
>
> **Participant's carer from One-to-One Enfield**

Digital barriers

Both participants and staff corroborated that digital barriers are largely tied to unfamiliarity with digital systems and an overwhelm of information. Staff discussed how it is important to differentiate between a lack of digital skills and hesitation using new technology. Someone may be fully capable of working out and using a new piece of technology, but it is the unfamiliarity and change of routine itself that is a barrier, not technical ability.

People who have experienced homelessness

During the conversations with people who have experienced homelessness, they talked about how the barriers they face leave them feeling 'abandoned' and 'sent into the dark' by the NHS.

Non-digital barriers

Participants shared that they had been removed from waiting lists without being informed, which they said was damaging to their mental health. Others shared how they had waited between nine months and four years for treatment, only to find that they had never been on a waiting list in the first place.

> *"I waited for CBT for about four years. Then … a counsellor called me and said, 'You're not even on the waiting list'. No one told me. It was a complete waste of time. And then the depression takes over everything."*
>
> **Participant from Your Place**

Staff also shared how mental health services stipulate that patients address substance use before being considered for mental health support, despite the two frequently being intertwined. This leaves patients stuck between two services that redirect responsibility to each other.

> *"Their mental health issue is set aside because they have ongoing substance use, which both go hand in hand. People self-medicate because they have underlying mental health issues."*
>
> **Participant from Your Place**

Digital barriers

Along with the difficulties accessing devices and a reliable internet connection described above, staff raised how digital connection isn't always the solution, especially for some of their residents who are in chaotic or addiction scenarios. They noted, for example, that some would sell their smartphones for money.

> *"There are also people who are in a very chaotic state of life at the moment, and they haven't got the time. If you give them a smartphone, they will sell it in two days."*
>
> **Staff from Your Place**

People aged 65 and over

Participants discussed how complicated the healthcare system had become and how much it had changed during their lifetimes. Technology has transformed society, and the NHS has been transformed with it, yet they feel little has been done to help them adapt.

Non-digital barriers

People aged 65 and over face a unique set of challenges. They described a healthcare system that has reduced the number of face-to-face appointments on offer - a shift many found difficult as it removed the format they were most confident communicating in - and replaced it with e-consultations, apps and forms they found harder to follow. Discontent with the digital-first approach led to some participants explicitly calling for change.

> *"I'd like to go back to the old ways, where doctors really just sat in the waiting room ... that would be better."*
>
> **Participant from Open Age**

The shift in how healthcare is administered was also raised as a barrier. In the past, healthcare was provider-led, with patients waiting on correspondence from their GPs. Now, healthcare is sought and self-managed by the patient, who has to be more proactive in seeking help. This has meant that some older Londoners have not accessed the healthcare they needed.

> *"The NHS is moving towards patients taking ownership of their care, making their appointments, doing whatever, but actually the population hasn't been guided or supported in doing that."*
>
> **Staff from Open Age**

Digital barriers

Often ageing comes with declining memory and cognition; participants shared how this can erode their ability to use digital tools. Some discussed how they doubt training would help them to use digital platforms as they may forget what they had learnt. Similar problems arise when memorable information is needed to get online, like passwords or verification codes.

> *"It's always the password that seems to be a great source of irritability ... because I've got a very short-lived memory."*
>
> **Participant from Open Age**

Repeat prescriptions were also a point of frustration. Participants shared that it is impossible to pause medication if you no longer need it, leading to some stockpiling medication without wanting to.

> *"If you don't keep on ordering the [medication], next time you need it, they don't give it to you … I just accumulate a lot of it"*
>
> **Participant from Open Age**

Migrant communities

Our conversations with members of Ro-EE Hub revealed that the bulk of the barriers to healthcare they experience stem from a lack of language accessibility in the NHS to accommodate Londoners with English as a second language.

Non-digital barriers

Language barriers are the leading obstacle in this group preventing access to healthcare, and shape all aspects of the healthcare experience. Interpretation and translation were repeatedly described as inconsistent, sometimes entirely absent, during GP visits. Patients frequently relied on family or friends to translate.

> *"I had an interpreter, but I had to remind him to actually start interpreting for me, because he wasn't communicating, wasn't relaying back what I was saying."*
>
> **Participant from Ro-EE Hub**

Digital barriers

Digital exclusion in this group was also closely tied to language exclusion. Automated systems - like Patchs - failed to recognise Romanian names and the NHS App is only available in English, meaning that even participants with digital confidence are excluded.

> *"AI might not understand your name and would ask for additional information, when you have a little child maybe vomiting next to you … it can be quite frustrating."*
>
> **Participant from Ro-EE Hub**

Staff also shared how some of their service users are vulnerable to health misinformation on social media, highlighting vaccine misinformation as an example. Staff saw this as a live risk that is specific to their group. It illustrates the need for credible and accessible information for all to ensure that these information vacuums are not filled with misleading claims.

SOLUTIONS

After discussing the various barriers that participants face, members of each group were asked what solutions they think should be put in place to help alleviate those obstacles. The solutions presented in this section all come from these discussions and therefore specifically reflect what the research participants - representatives of marginalised groups in London - want to see changed to improve their experiences of the health service.

The lists of digital and non-digital solutions proposed by group members in order of votes received, starting with the most popular, are set out below. However, it should be noted that even those solutions that received fewest votes are still solutions that participants advocated for and want to see implemented, and should not be considered unimportant. The voting exercise merely provided a mechanism for the participants to voice which of the solutions they consider to be the highest priority.

Additionally, during interviews with staff members from each group, they also suggested solutions that they thought would address some of the barriers they identified. Where these align with the solutions suggested by participants, their comments are included in the relevant sections.



As this project was designed to capture what Londoners want to see from the healthcare system, the solutions presented here do not take into account practical considerations such as cost or feasibility. Furthermore, many of the solutions suggested would require input from multiple actors within the healthcare space, in some cases with support from other public and civil society bodies, often at a national level. The *Recommendations* section of this report presents suggestions as to which local, regional and national-level actors could take responsibility for implementing each of the solutions presented below.

NON-DIGITAL SOLUTIONS IDENTIFIED BY GROUP MEMBERS AND STAFF

Below is a table that summarises the non-digital solutions put forward by group members, some of which were also suggested by staff, starting with the ones that received the highest number of votes in the cross-community consensus-building workshop. Following that, there is more detail regarding what concrete actions the participants and staff expect to be covered by each solution, and the impact that they felt this would have on their ability to access healthcare.

✓ = raised by group members, ✓ = raised by staff

NON-DIGITAL SOLUTIONS	FIRST LOVE FOUNDATION	MIDDLESEX ASSOCIATION FOR THE BLIND	ONE-TO-ONE ENFIELD	OPEN AGE	RO-EE HUB	YOUR PLACE
Patient-centred appointments	✓ ✓	✓	✓	✓ ✓	✓	✓
Patient record sharing	✓	✓	✓	✓		
Tailored, patient-centred communication	✓	✓	✓	✓	✓	
Ensure patients' access needs are immediately visible to healthcare staff		✓	✓			
More flexible appointment booking options	✓	✓ ✓	✓	✓		
Proactive follow-up care	✓			✓	✓	
Improved patient transport		✓	✓			
Ensuring accessibility in healthcare spaces	✓ ✓	✓ ✓	✓ ✓			✓
Better transparency and communication of available NHS services			✓ ✓	✓	✓	✓

Broadly, the solutions suggested by community group members and staff revolved around creating a more joined-up, flexible system that adequately supports people's individual access needs. Continuity of care was clearly a priority, with many people advocating for patients to have one allocated GP and for more comprehensive follow-up care after any health procedures. Ensuring that patients have more choice in the time and location of their appointments, as well as whether they take place in person or remotely, was also important.

Many of the solutions centred around making sure that healthcare staff are able to support patients' access needs. This ranged from making any patient needs immediately visible to staff when they open their records, to improved staff training, ensuring that all communication is accessible, and putting more measures in place to guarantee that patients can always physically get to their appointments and are supported within healthcare settings.

Patient-centred appointments

The solutions people suggested were:

- All patients having one allocated GP for continuity across appointments
- Always offering patients a choice between face-to-face and phone consultations
- Longer appointments as standard for patients with additional needs
- Prioritising appointments in services closer to patient's home

One of the most important things for the participants was that the health service as a whole prioritises the needs of the patient when it comes to the logistics of appointments: where and how they take place, with whom, and for how long. Suggestions as to how this could be achieved often centred around giving the patient more freedom to choose: whether to have a phone or in-person appointment, for example, or which hospital they'd like to attend. Having this personal freedom meant a lot to the people who participated; they wanted to be treated as individuals rather than as an issue that needed to be solved.

> *"Caring for a problem is not just going to the problem, it's going to the person as well, isn't it?"*
>
> **Participant from First Love Foundation**

Similarly, organisation staff were also keen for patients to be seen as a 'whole person', suggesting that more joined-up services would be a key enabler for this. For example, they were keen to have more wellbeing support embedded in frontline services, and better links between addiction teams and homeless pathway teams in hospitals, with further connections with local charities to improve patient support. This would help to ensure that individual departments could understand how the specific issue they were addressing impacted, and was impacted by, other health and lifestyle issues the patient was currently experiencing.

> *"Have a more holistic, person-centred service … it's expensive to do, but I think if you invest the time up front, it reaps dividends."*
>
> **Staff from First Love Foundation**

This drive to be seen as a whole person was also evident in the changes that participants wanted to see in GP appointments. One of the most common solutions that came from multiple groups was that patients want to be allocated a single GP, so that when they book appointments, they are more likely to be seen by the same person. The benefits that participants thought they would gain from this were twofold: firstly, for ongoing health issues, every time people see a new GP they have to repeat their medical history from scratch, which takes up precious time in what is already a short appointment window; and secondly, participants saw themselves as holistic beings with physical and emotional health needs that intersect and change with time, and that might have an impact on future health concerns. If an individual has been seen by one GP for the past several years, participants thought that it would be much more likely that these needs would be understood.

> *"It's very important to get to see the same medical professional GP every time, because they know your track medical record, and then you don't need to repeat yourself every time you see someone else."*
>
> **Participant from Ro-EE Hub**

There was some acknowledgement that, given long waiting lists, individuals having one allocated GP could lengthen the time it takes to get an appointment. One participant suggested that, to remedy this, each person should be assigned one or two reserve GPs, who are also familiar with the patient's history.

Patient record sharing

The solutions people suggested were:

- Making patient records accessible across all NHS services
- Allowing patient records to be shareable with those outside the NHS (e.g. welfare support) using a patient-verified referral code

Many participants were frustrated that their healthcare records are often not shared between healthcare providers, and said that ensuring that their records are accessible across all NHS services was a priority for them. The rationale for this was similar to that described above around individuals being assigned a specific GP: if all medical practitioners have access to a patient's entire medical history, it both saves the patient time and effort in explaining something they've previously discussed with other professionals, and it also increases the chance that they will receive the most appropriate treatment.

> *"I think record keeping should be shared between everybody, and whoever you're seeing sees the holistic person, not just the one eye problem or stomach problem."*
>
> **Participant from Middlesex Association for the Blind**

Some participants also suggested that records should be available to services outside of the NHS as well. In order to maintain patient confidentiality and ensure that the individual had the power over when and with whom their records were shared, this could be managed by giving each individual their own unique referral code. They would then be able to share this code with

officials who requested access to their medical records, such as DWP staff who need proof of ill health to process benefits payments.

> *"I reckon you should have a one stop shop that is actually linked to the benefits system, so that when you want to get PIP or whatever, you just give them something and they can collect all the evidence they want."*
>
> **Participant from First Love Foundation**

Tailored, patient-centred communication

The solutions people suggested were:

- Communication with patients to use simple language alongside medical jargon (e.g. 'Cardiology (heart)')
- Patient's preferred contact method to be recorded and followed consistently (e.g. phone calls, Easy Read, large print)
- Correspondence provided in the patient's preferred language

Using straightforward language as well as, or instead of, technical medical terms when communicating with patients was seen as vital to ensuring that they are able to follow treatment plans and attend upcoming appointments. Participants commented that this, in turn, would help them to feel more confident and less anxious around their medical care. An example of what this might look like could be: 'John Smith will be referred to the cardiology (heart) department for further investigation into their tachycardia (fast heart rate).'

> *"Sometimes they put in these medical jargons … I think to myself, what's this? So, if they put next to it something in brackets, what it actually means … you can understand."*
>
> **Participant from One-to-One Enfield**

In addition, evidently having communication provided in a language and/or format that is accessible to the patient will greatly improve their ability to comprehend that information. Those in Ro-EE Hub, who were all native Romanian speakers and had varying levels of English, acknowledged that, in an English-speaking country, there is a need for their medical information to be communicated in English. But they were unanimous in their agreement that their lives would be made much easier if this information were shared with them in Romanian as well. In addition, participants from Middlesex Association for the Blind pointed out that different blind and partially sighted people will prefer contact in different ways (ranging from large print letters to emails to Braille), and that it's important that each individual is asked what their preference is, rather than people with the same disability being automatically assumed to have the same needs.

> *"If they've got a patient's record, there should be an option. How do you like information?"*
>
> **Participant from Middlesex Association for the Blind**

Ensure patients' access needs are immediately visible to healthcare staff

The solutions people suggested were:

- High-visibility flag or banner to appear on patient records showing additional needs

Groups identified that one way to ensure patient accessibility needs are met in healthcare settings could be to have a digital flag or banner that is immediately visible to staff when they open a patient's records. This would appear alongside a patient's name and date of birth, and would just need to be one or two words (for example, 'blind' or 'learning disability') so that the staff member knows straightaway that this patient may need additional support. Further details as to the exact nature of the patient's support needs can be provided in another part of the patient's records if necessary, but this system would at least ensure that staff are aware immediately that a patient might need extra time or help. While this would be an opt-in system to ensure patient control over their information, for those who participate it would remove the burden on them to have to advocate for their needs during every single interaction with a different member of staff.

> *"Because of my visual impairment, I think it's quite important that that is recorded, so that if you're on your own, the people at reception … know that you might need help."*
>
> **Participant from Middlesex Association for the Blind**

More flexible appointment booking options

The solutions people suggested were:

- Opportunities to book after the 8am rush
- Allow patients to find appointments at neighbouring surgeries when their local one is full
- Keep more slots open during the day for children and vulnerable people who may deteriorate quickly

Participants suggested several methods to alleviate the problems of inflexible booking systems. Firstly, they would appreciate a wider window in which to book appointments so they are not forced to sit in a phone queue when they are already busy getting ready for work or getting their children ready for school.

Secondly, they thought there should be more flexibility as to which surgery they were sent to, with the option to be given an appointment at a neighbouring GP surgery if their usual one had no appointments left. And finally, it was noted that children and other vulnerable people may deteriorate very rapidly during the day, but the 8am booking window precludes the opportunity

for them to see a GP at that point. Participants therefore called for more appointment slots to be kept open for last-minute appointments for these patients. This suggestion was also made by staff from Open Age.

> *"I want that system where there's like an open appointment for children, basically."*
>
> **Participant from First Love Foundation**

Another suggestion put forward by staff was to have a dedicated phone line for vulnerable patients, whereby a 'middle person' can complete a booking for somebody who does not have the independence or familiarity with the system to do this themselves.

> *"The telephone helpline is a very popular thing … they would prefer to talk to someone than to go via a digital tool."*
>
> **Staff from Middlesex Association for the Blind**

Proactive follow-up care

The solutions people suggested were:

- Mandatory follow-up appointments after tests and operations
- Dedicated worker to follow up with each patient and bridge the gap between medical and social care

Illnesses are both physically and mentally draining, and so it can be difficult for a patient to coordinate their own care pathways. Participants therefore advocated for patients who have recently been through medical procedures to be connected with a key worker who could help them to navigate both future health needs related to their intervention, but also any associated social care support to ensure that they received all necessary aftercare.

Similarly, several participants had undertaken medical tests or investigations but had never heard about the outcome, leaving them feeling like they'd been left in limbo. They believed that all patients should be proactively contacted about their test results once they have come in, even if they show there is nothing to be concerned about, to alleviate any patient worries. While the NHS App does often provide patients with the chance to see test results, since many of the participants could not access or confidently navigate the app, this does not suffice for many and more direct contact, such as through a text, phone call or letter, would be needed.

> *"It would be very nice to get a telephone call from your GP when you've had a test of some sort, you know, just to put your mind at rest."*
>
> **Participant from Open Age**

Improved patient transport

The solutions people suggested were:

- Automatic patient transport eligibility for people with a registered disability

As discussed above, trying to access patient transport can be a very stressful experience. To resolve this, participants from the groups that have most experience with patient transport, Middlesex Association for the Blind and One-to-One Enfield, suggested that all patients who are recorded as having a disability of any kind should automatically be eligible for patient transport. This would end the anxiety-inducing phone calls where patients feel like they are being tested, and in providing guaranteed transport is likely to lead to more patients being able to attend their appointments.

> *"I think visually impaired people should have almost automatic access. People that have mobility problems should have access, and people that are concerned [about] travelling on public transport … because that would put them off wanting to go to an appointment in the first place."*
>
> **Participant from Middlesex Association for the Blind**

Ensuring accessibility in healthcare spaces

The solutions people suggested were:

- Volunteers or staff available to help patients navigate unfamiliar buildings and facilities
- Quiet rooms or spaces for patients with sensory sensitivities
- Improved staff training around accessibility needs and best-practice code for in-person interactions

Participants came up with several ideas around how their accessibility needs could be met when they were in healthcare spaces like hospitals and GP surgeries. Particularly popular among participants with disabilities was the idea of having volunteers (or potentially paid staff members) in healthcare spaces who could support patients with various needs. This included helping them to navigate around the building, or even supporting them to go and take a walk or get a cup of tea if they know they will be waiting a long time to be seen. One staff member who was present for these conversations said she thought this might alleviate people's nerves around being able to find the right location, which could lead to more people turning up to their appointments in the first place.

> *"People won't feel frustrated … because they don't know where the place is, and I think there should be people walking around to guide them to the right departments."*
>
> **Participant from One-to-One Enfield**

One point that was raised repeatedly by several groups - by both members and staff - was the need for improved staff training around accessibility needs. This included how to support people with physical, sensory and learning disabilities, as well as how to support people with varying levels of mental ill health, how to manage and resolve conflict, and a better

understanding of how having a low income can impact all aspects of people's lives. Participants recognised that staff are 'not robots' and have a very mentally-taxing and stressful job, and that in spite of this, 'they're doing their best'. They felt that additional training would ensure that staff were more equipped to support patients, which would lead to fewer altercations and make the working environment better for staff as well as improve the patient experience.

> *"I think if management makes sure that the staff are well trained … then I think 99% of the problem should be solved."*
>
> **Participant from Your Place**

Better transparency and communication of available NHS services

The solutions people suggested were:

- Actively publicise urgent care centres and expanded pharmacist roles
- Ensure all patients are aware of how to register as carers
- Require dentists to display all fees before treatment
- Provide clear, visible information on how to make a complaint

Participants felt that sometimes there was a lack of transparency around certain NHS services, and thought there should be clearer communication to ensure that patients are fully informed. This ranged from making sure that patients are aware of all dental fees before they commit to a particular treatment, to there being a clear, straightforward and secure mechanism to allow patients to register a complaint about a service if they so wish. When one Your Place participant explained how PALS (the Patient Advice and Liaison Service) had helped them to resolve an issue with their healthcare provider, all other participants in that group were surprised to find that such a service existed since they had never heard of it before. They were very interested to learn more, and indicated that they believed clearer feedback mechanisms within healthcare settings would help to improve relationships between staff and patients.

Other participants - both group members and staff - talked about how several services provided by the NHS are not well-publicised, and are therefore underutilised by the public. In particular, it was pointed out that there are alternative routes to having a health complaint seen to - such as going to a pharmacist instead of a GP, or an urgent care centre rather than A&E - that many people are just not aware of. They noted that if more people in London knew that these options existed, it would likely improve outcomes for patients as they could be treated more quickly. It would also help to ease capacity pressures on some of the most strained sectors of the NHS, which would further improve how the NHS is viewed by the public.

> *"Urgent care centres should be publicised more, pharmacists' help should be specified and publicised more, and get people to see the positive side of the NHS."*
>
> **Participant from Open Age**

Staff pointed out that the NHS is capable of running very successful awareness campaigns - such as promoting the flu vaccine - and suggested that they make better use of connections with local community organisations as well as other public spaces like schools and libraries to disseminate information about their various services.

DIGITAL SOLUTIONS IDENTIFIED BY GROUP MEMBERS AND STAFF

This section focuses on the solutions put forward by group members and staff to the digital barriers that they had identified. Again, these are presented in the order in which they were voted on in the cross-community consensus-building workshop, starting with the most popular solution.

✓ = raised by group members, ✓ = raised by staff

NON-DIGITAL SOLUTIONS	FIRST LOVE FOUNDATION	MIDDLESEX ASSOCIATION FOR THE BLIND	ONE-TO-ONE ENFIELD	OPEN AGE	RO-EE HUB	YOUR PLACE
NHS App as the only app needed to navigate all NHS healthcare services	✓	✓	✓	✓		✓
NHS App to be more inclusive and accessible	✓	✓	✓ ✓	✓	✓	✓ ✓
Ensure a non-digital route for booking appointments and receiving information is always available	✓	✓	✓	✓	✓	✓
Use the NHS App to proactively communicate with patients	✓					✓
More functions to be included in the NHS App	✓	✓		✓	✓	
Opportunities for training in how to use the NHS App	✓ ✓	✓	✓	✓		✓
More support for people using digital routes	✓ ✓	✓ ✓		✓	✓	✓

The majority of solutions that were put forward by community group members and staff revolved around streamlining people's experiences so that they only need to interact with one healthcare app (specifically, the NHS App), and improving the NHS App's functionality and usability. It was also seen as highly important by the majority of participants that there are always non-digital routes for patients to use so that those who cannot or do not want to use digital platforms are not locked out of healthcare, and that more support (in the form of training or subsidised equipment) is offered to those who want to use digital platforms but currently face barriers to doing so.

NHS App as the only app needed to navigate all NHS healthcare services

Given how many participants had experienced frustration at the fragmentation of digital healthcare platforms, it is unsurprising that the most popular digital solution was to integrate all these services into one app. The key benefit to this would be preventing the confusion and exasperation that participants currently feel when being told to navigate between multiple apps for different services, as well as the anxiety that they might miss an important piece of information if they do not check the right app.

> *"If the NHS App could just be a much more user-friendly, comprehensive go-to, one place, not five places … you had one password guarded - you could use it, everybody could use it."*
>
> **Participant from First Love Foundation**

Participants also identified additional benefits that they would experience from having the NHS App as the 'one source of truth'. For example, it would mean that patients would be able to find all their medical records in one place, so they could easily access their own medical history and show this to others when necessary. Similarly, the app could be the primary source that people use to record their access needs, with medical professionals able to use this information to understand how to best support these patients when they access healthcare.

> *"On the NHS App, you've got the platform, and you should be able to go into my profile and say these are my accessibility needs … and then when you speak to a GP, they would say, okay, this person is visually impaired, these are their needs."*
>
> **Participant from Middlesex Association for the Blind**

NHS App to be more inclusive and accessible

The solutions people suggested were:

- Co-design and test the app with marginalised communities
- Ensure accessibility features are built in (e.g. screen-reader support, high-contrast, large print)
- App to be available in different languages
- Short (30 to 60 second) instructional videos embedded in the app, available in different languages

However, having the NHS App as the single digital platform used for all medical needs will only be effective if people find the app easy to navigate. Participants suggested many ways that this could be made possible. Firstly, the app needs to be accessible for all those who will be using it. This means ensuring that accessibility features and options for multiple languages are built into the app as part of its core functionality. In order to ensure that all needs are taken into account and are fully supported, the app must be co-designed and tested with people from communities with a range of access needs, since they have the knowledge and experience that is required to build an app that is fully accessible.

> *"When they actually design the website, they should involve service users, so they can then watch what kind of issues come [up]."*
>
> **Participant from Middlesex Association for the Blind**

To further enhance the navigability of the app, participants suggested that additional features could be added to make it clearer to patients the different ways in which the app can be used. This could be done, for example, via short videos which clearly show the functions of different parts of the app and explain how patients can access and navigate these.

> *"Maybe they could do a little video explaining what to do … I think that would help, yeah, it really would. It'd make a big difference."*
>
> **Participant from Your Place**

Staff from One-to-One Enfield suggested that those who continue to struggle with accessing the app should be able to nominate a digital proxy - a carer or family member - who can login and navigate the app on their behalf. This would ensure that they are still able to access all the app's functions, but they would have a trusted person doing this for them with whom they are comfortable sharing their private health information.

Ensure a non-digital route for booking appointments and receiving information is always available

It is important to note that, while a lot of time was spent during the workshops talking to participants about how best to optimise digital services to make them more accessible and appealing to patients, the third-highest voted 'digital' solution in the final workshop was to ensure that all patients always have access to non-digital routes when seeking and receiving medical information. There remained participants throughout the process who stated that they would not be interested in using digital platforms regardless of how well-built they were, and while many participants acknowledged that 'the future is digital', several were also concerned that this means they would be left behind. It is crucial to ensure the move towards digital-by-default services in the NHS does not lead to a two-tier system whereby those who do use digital services receive information and treatment faster and with fewer obstacles than those who do not.

In practice, this means ensuring that patients' communication preferences are clearly recorded and that those who wish their correspondence to be via texts, letters or phone calls have their wishes respected. It also means making sure that staff are available both in person and over the phone to support patients who prefer to 'talk to a human being' over using text-based services.

> *"GP surgeries should keep phone and in-person appointments. Some older people aren't confident around digitisation … as the population lives longer and people become housebound, what will happen if they don't have the internet?"*
>
> **Participant from Open Age**

Use the NHS App to proactively communicate with patients

The solutions people suggested were:

- Patients to receive immediate acknowledgement when an appointment request is received
- Ability for patients to check their position when on waiting lists

Poor communication was a key theme that participants brought up again and again, but they did believe that the NHS App could be used to help mitigate some of these concerns. Participants did understand and accept that it is usually inevitable that they would have to wait before hearing confirmations about appointments and referrals. However, they felt that more proactive messaging using the app could help to alleviate some of the anxieties that this can lead to. For example, when they use the app to request a GP appointment, they would appreciate notifications to let them know that their request is being processed rather than not hearing anything until the appointment has been confirmed several days later.

Similarly, participants said that when a referral has been made, being able to use the NHS App to see where they were in the referral 'queue' would put their mind at rest during the months they were waiting to be seen. They also thought this would help to create more accountability towards the healthcare services as it would be easier to see if a patient has been waiting an inordinate amount of time for their referral to be processed.

> *"Even if you're 1,000 [in the queue] … at least if you get a number, you're like, okay, and in two or three months' time, you see the list is moving on, and you don't feel so left in the dark."*
>
> **Participant from Your Place**

More functions to be included in the NHS App

The solutions people suggested were:

- Clear 'Urgent' button to bypass lengthy forms during emergencies
- Button allowing you to skip or pause repeat prescriptions without cancelling them

With a fully accessible NHS App that patients know is the only digital platform they require to manage their health needs, there is increased opportunity to add additional functions to the app to give patients more control of their healthcare. Participants suggested several examples of how the app could be improved in this way, based on the needs that they had experienced in the past. For example, one person noted that sometimes medication is wasted through repeat prescriptions when patients don't always need the full dose provided each time, and thought

the app could help resolve this with a button that would allow patients to pause or skip their repeat prescription without cancelling it altogether.

Another suggestion that came up several times was an option for a quick referral in emergencies that would allow patients to bypass the lengthy form-filling process they usually need to undergo when booking a GP appointment. It was also noted that a simpler form would make the process much more accessible, particularly for people with disabilities and those who do not speak English as a first language.

> *"[It would be] useful if there was a section for booking on-the-day urgent appointments, rather than having to fill in a lot of information … When you have a little child maybe vomiting next to you, and you need to go through that, it can be quite frustrating."*
>
> **Participant from Ro-EE Hub**

Opportunities for training in how to use the NHS App

The solutions people suggested were:

- Community-based digital skills workshops in trusted, familiar settings
- Drop-in digital support sessions at local pharmacies
- One-to-one or home-based tech tuition, including the use of assistive technology
- Mobile skills hubs visiting community centres

Participants at almost all of the workshops pointed out that, even if the NHS App is well-designed, there will still be individuals who are less digitally literate and who will be unable to use it properly without receiving training. They suggested multiple different routes through which this training could be carried out - one-to-one or in a group setting, online, at home, in community centres, or in local pharmacies - but several groups reflected that the training would have to be delivered in a way that understood their needs in order to be effective. For example, participants at Your Place suggested that mobile skills hubs would be beneficial to support people experiencing homelessness in London and who therefore have no fixed address. Meanwhile, participants in Middlesex Association for the Blind highlighted that any training provided to them would need to include the use of assistive technology. Ultimately, as with the design of the app itself, training for people to use the app would need to be co-designed with different communities to ensure it was delivered in a way that understands the needs of all those who will be using it, as training en masse often does not provide adequate support.

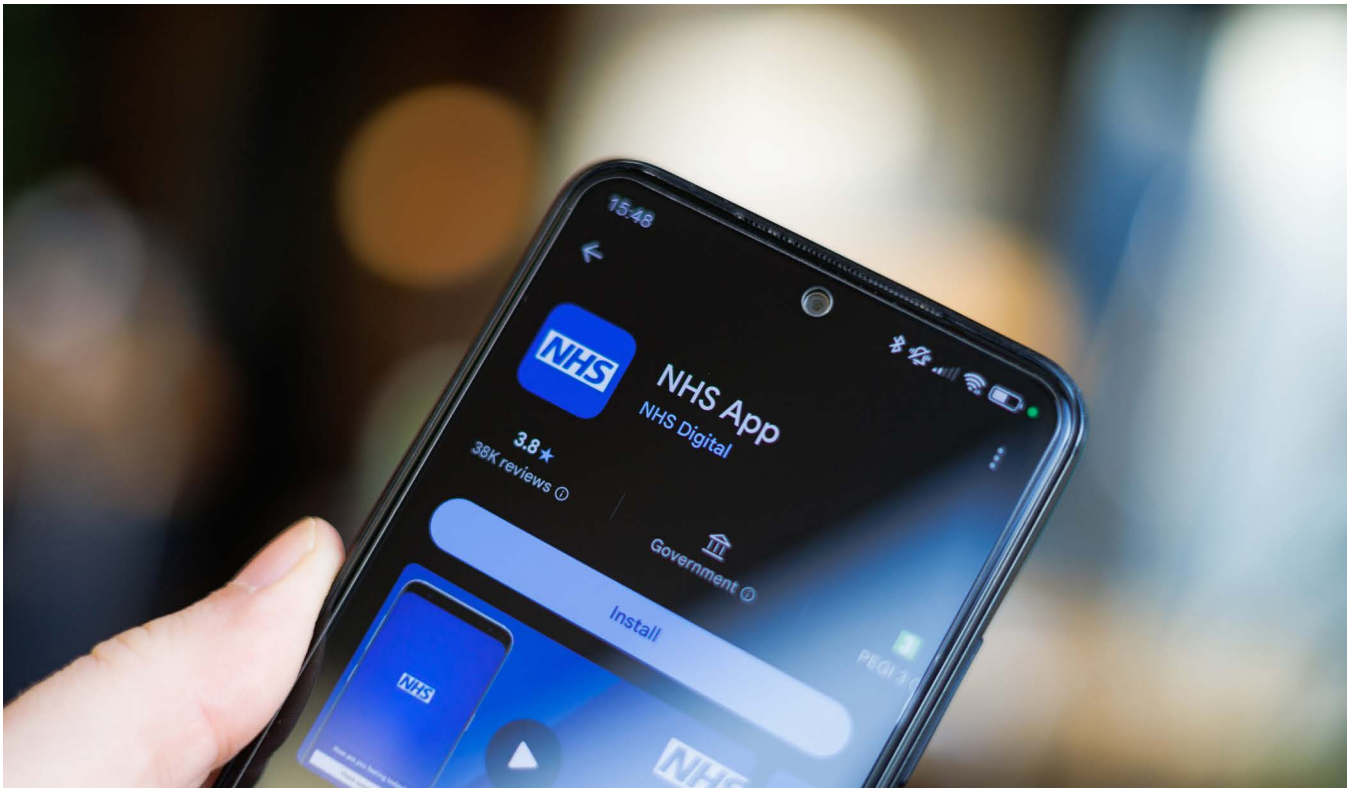
> *"[I used to go to] a special class for visually impaired people … unfortunately people decided to put [blind participants] in mainstream classes, where they give you a support person, but it's not quite the same as your special class."*
>
> **Participant from Middlesex Association for the Blind**

Finally, many participants talked about how the community groups that they were part of would be invaluable in helping to deliver this training. Indeed, several of the groups that engaged already provide extensive digital training and support to their members, with one (Open Age) having been funded in the past to provide training specifically on using the NHS App. Staff from many community groups were keen for the NHS to cooperate more with frontline organisations like theirs to run classes in digital skills or the NHS App. Not only are these settings that people are familiar with and so are likely to feel comfortable in, but frontline staff have an excellent understanding of their members' needs and so are ideally-placed to deliver bespoke training.

> *"You've got an army of well-meaning frontline organisations that are doing really good work ... why not use them to help bring people on that technological journey, but do it safely and do it well"*
>
> **Staff from First Love Foundation**

Participants were unanimous in praising the dedication and reach of community group staff and volunteers in supporting them in this, but acknowledged that the groups are often over-stretched and do not have time to support everyone. They therefore thought the NHS should ensure that training can also be delivered in other settings.

> *"I think [training] should be for everybody, not just for Open Age. I mean, it could be in libraries or something … so if you're struggling to use the app … they'll often be a volunteer there who can help you out accessing that."*
>
> **Participant from Open Age**



More support for people using digital routes

The solutions people suggested were:

- Free-to-use, staffed digital access points in community spaces for booking appointments for those without their own digital access
- Technical assistants on-site in surgeries to help set up and manage NHS accounts
- Dedicated phone line where staff complete digital tasks on the patient's behalf

Even with more training available to the public, participants acknowledged that there would still be many people who would need support to carry out specific digital tasks and manage their accounts on the NHS App. They therefore suggested several settings in which this type of short-term support could be made available as and when it was needed. One participant suggested that staffed digital access points could be installed in GP surgeries as well as in other community spaces like libraries. These would be similar to the screens that are currently in place in some primary and secondary healthcare settings that patients can use to check in to their appointment. However, these types of screens could also be used to allow patients, potentially with the help of staff or volunteers, to book and manage appointments online. Booking via these screens would be quicker and more straightforward than doing the same thing on a public computer, since their interface would be designed with only NHS appointments in mind which would make it much simpler to navigate.

For those who do have their own devices but who may struggle to use them, participants suggested that there could be technical assistants on-site in GP surgeries who were there to help patients manage their NHS accounts before or after their appointments. And for those who found themselves unable to navigate the NHS App while not in a healthcare setting, a dedicated phone line could be set up that would connect patients with workers who could either talk the patient through how to complete their desired task, or else complete the task themselves on the patient's behalf.

> *"What about digital services within … the GP surgery … If you say, 'I have a bit of struggle with this,' they might say, 'Do you want to come half an hour earlier before your appointment? And we can make sure you're prepared for this particular appointment.'"*
>
> **Participant from First Love Foundation**

Staff from community groups were keen to point out that many Londoners do not have their own digital devices and so are almost entirely cut off from using digital routes. They advocated for schemes that provide subsidised or free devices and SIM cards to those without internet access, as well as more free Wi-Fi spots across London boroughs.

RECOMMENDATIONS

This research has spotlighted the voices of those in London who face some of the greatest barriers to healthcare, and sets out what they believe to be the most appropriate solutions to address these problems.

What is clear from this work is that there is a significant gap between the kind of care that patients expect to receive and what they find themselves faced with when they attempt to access that care. This gap between expectation and reality is leading to disappointment, frustration, potentially poorer health outcomes, and in some cases complete disengagement from the NHS.

With this in mind, Demos has developed some recommendations to be considered by the London Health Mission. In contrast to the solutions outlined in the previous section, these recommendations do not focus on how to resolve specific patient access needs. Rather, they take a broader approach to looking at how healthcare services should be designed and developed to ensure that patient needs are considered and accounted for in the first place.

While these specific recommendations were developed with the London Health Mission in mind, other actors are also responsible for improving the delivery of healthcare services to better support all Londoners, including people from marginalised groups. Healthcare bodies, along with other public sector and civil society organisations across the country as well as in London, should take the opportunity presented by the implementation of the 10 Year Health Plan for England to embed meaningful change in the country's healthcare services. It is incumbent upon all of these actors to consider the points made below, particularly those around including people from marginalised groups in conversations around service delivery, to ensure that healthcare services in this country are open and accessible to everyone.

RECOMMENDATION 1

Assess the feasibility of each proposed solution in this report and determine which ones would have the greatest impact relative to effort if implemented

All of the solutions put forward by the community groups were important suggestions that they believe could make a real, tangible difference to their ability to access healthcare. However, some of these will have a more significant impact on Londoners' lives, improve the lives of more individuals, or be more straightforward to carry out than others. The London Health Mission should look at each of these potential solutions to determine whether they can be implemented, and if so where, when, how and by whom, and through doing so formulate a prioritised list based on which could be enacted the soonest and have the largest impact.

The solutions listed in this paper cover a wide range of areas, and their effective implementation will require coordination from a number of actors across the health and care sector, along with support from local government and civil society organisations. To assist with taking these solutions forward, the tables below suggest which health system stakeholders could play a lead or supportive role in exploring next steps in each area, although this is by no means an exhaustive list of players involved.

NON-DIGITAL SOLUTIONS

Patient-centred appointments

Examples of Application:

- All patients having one allocated GP for continuity across appointments
- Always offering patients a choice between face-to-face and phone consultations
- Longer appointments as standard for patients with additional needs
- Prioritising appointments in services closer to patient's home



Potential Delivery Partners: GP practices, Integrated Care Boards (ICBs)

Patient record sharing

Examples of Application:

- Making patient records accessible across all NHS services
- Allowing patient records to be shareable with those outside the NHS (e.g. welfare support) using a patient-verified referral code



Potential Delivery Partners: NHS, ICBs, community health services, Department for Work and Pensions

Tailored, patient-centred communication

Examples of Application:

- Communication with patients to use simple language alongside medical jargon (e.g. 'Cardiology (heart)')
- Patient's preferred contact method to be recorded and followed consistently (e.g. phone calls, Easy Read, large print)
- Correspondence provided in the patient's preferred language



Potential Delivery Partners: NHS, ICBs, GP practices, acute trusts

Ensure patients' access needs are immediately visible to healthcare staff

Examples of Application:

- High-visibility flag or banner to appear on patient records showing additional needs



Potential Delivery Partners: NHS Electronic Patient Record, GP practices

More flexible appointment booking options

Examples of Application:

- Opportunities to book after the 8am rush
- Allow patients to find appointments at neighbouring surgeries when their local one is full
- Keep more slots open during the day for children and vulnerable people who may deteriorate quickly



Potential Delivery Partners: GP practices, ICBs

Proactive follow-up care

Examples of Application:

- Mandatory follow-up appointments after tests and operations
- Dedicated worker to follow up with each patient and bridge the gap between medical and social care



Potential Delivery Partners: Community health services, ICBs

Improved patient transport

Examples of Application:

- Automatic patient transport eligibility for people with a registered disability

Potential Delivery Partners: NHS, ICBs, patient transport providers

Ensuring accessibility in healthcare spaces

Examples of Application:

- Volunteers or staff available to help patients navigate unfamiliar buildings and facilities
- Quiet rooms or spaces for patients with sensory sensitivities
- Improved staff training around accessibility needs and best-practice code for in-person interactions

Potential Delivery Partners: NHS community healthcare providers, estate teams, GP practices

Better transparency and communication of available NHS services

Examples of Application:

- Actively publicise urgent care centres and expanded pharmacist roles
- Ensure all patients are aware of how to register as carers
- Require dentists to display all fees before treatment
- Provide clear, visible information on how to make a complaint

Potential Delivery Partners: NHS communication teams, NHS dentists, ICBs, local authorities, community organisations

DIGITAL SOLUTIONS

NHS App as the only app needed to navigate all NHS healthcare services

Examples of Application:

- Ensure that all NHS bodies are able to contact patients and share information via the NHS App
- Ensure the NHS App does not redirect patients to other healthcare apps, such as Patient Knows Best or DrDoctor

Potential Delivery Partners: NHS digital teams, ICBs

NHS App to be more inclusive and accessible

Examples of Application:

- Co-design and test the app with marginalised communities
- Ensure accessibility features are built in (e.g. screen-reader support, high-contrast, large print)
- App to be available in different languages
- Short (30 to 60 second) instructional videos embedded in the app, available in different languages

Potential Delivery Partners: NHS digital teams, Voluntary and community sector (VCS)

Ensure a non-digital route for booking appointments and receiving information is always available

Examples of Application:

- Make sure that patients are always able to communicate with any NHS healthcare service via letters, phone calls, text messages or in person, and are not forced to use digital services

Potential Delivery Partners: NHS, ICBs, GP practices

Use the NHS App to proactively communicate with patients

Examples of Application:

- Patients to receive immediate acknowledgement when an appointment request is received
- Ability for patients to check their position when on waiting lists

Potential Delivery Partners: NHS digital teams, ICBs

More functions to be included in the NHS App

Examples of Application:

- Clear 'Urgent' button to bypass lengthy forms during emergencies
- Button allowing you to skip or pause repeat prescriptions without cancelling them

Potential Delivery Partners: NHS digital teams, ICBs

Opportunities for training in how to use the NHS App

Examples of Application:

- Community-based digital skills workshops in trusted, familiar settings
- Drop-in digital support sessions at local pharmacies
- One-to-one or home-based tech tuition, including use of assistive technology
- Mobile skills hubs visiting community centres

Potential Delivery Partners: Community organisations, GP practices, pharmacies, ICBs, local authorities

More support for people using digital routes

Examples of Application:

- Free-to-use, staffed digital access points in community spaces for booking appointments for those without their own digital access
- Technical assistants on-site in surgeries to help set up and manage NHS accounts
- Dedicated phone line where staff complete digital tasks on the patient's behalf

Potential Delivery Partners: Local authorities and community organisations, NHS digital teams

RECOMMENDATION 2

Lead the way on convening partnerships of stakeholders who are able to deliver the solutions

With its partnership decision-making Board with senior representatives from a number of London-wide organisations, the London Health Mission is well-placed to convene important actors across London's health services, including local councils and Integrated Care Boards, and advocate for their cooperation in implementing the solutions proposed here. These solutions will only be successful if there is buy-in from all relevant actors who are responsible for providing healthcare to Londoners, whether that be digitally or in person. The London Health Mission can act as the connective tissue between these organisations - convening dialogue, building consensus, and helping to ensure that commitments translate into coordinated action across London.

RECOMMENDATION 3

Advocate for public participation, in particular of people from marginalised groups who face barriers engaging with healthcare, when designing health services

As this research has shown, when health services are designed without the input of people who sit at the intersection of poor health literacy and digital exclusion, those services can become almost completely inaccessible, further distancing individuals and communities from the healthcare they need. The London Health Mission should ensure that it champions the co-design of health services with marginalised groups, such as those identified through this research and those who face barriers engaging in health services, including testing or implementing pilot projects where appropriate, so that their lived experience directly shapes how services are designed and delivered. While the London Health Mission is well-placed to promote this participatory activity, it will need to be implemented by the national, regional and local actors who are responsible for delivering healthcare policy and services to ensure that they are accessible to everyone.

RECOMMENDATION 4

Continue to create opportunities for active, continuous dialogue with those most impacted by these issues so that policy, strategy and service development are grounded in lived experience

The high level of interest that was received from community groups across the capital who expressed a wish to be involved in this project shows that there is a significant appetite for more grassroots involvement in the development of healthcare strategy, policy and services. Beyond this specific project, the London Health Mission should ensure active communication with community organisations across London by establishing regular, ongoing channels for engagement - rather than one-off consultations - so that community voices continue to inform the London Health Mission and its partners' work over time. This model of citizen engagement could then serve as a best-practice example for other healthcare bodies, so that citizens across the country can benefit from being part of a sustained dialogue around what they need from their healthcare providers.

RECOMMENDATION 5

Maintain open communication with the people involved in this study so they are aware of the outcomes of the project

As the workshops and interviews with research participants were underway, both community group staff and members raised several requests that they be kept updated on what actions are taken as a consequence of this research. While the London Health Mission has shown that it is committed to understanding the needs of marginalised groups by commissioning this research, it is important that the individuals involved do not feel like their input has been ignored. The London Health Mission should therefore close the communication loop by remaining in contact with the six community groups who worked closely on this project and update them on any impacts the research has on London's healthcare services.

CONCLUSION

This research provides a powerful insight into how Londoners who experience digital exclusion, poor health literacy and wider inequalities navigate health and care services. People across the capital are facing a multitude of barriers that are preventing them from accessing the healthcare they need in a way that works for them, instead encountering a fragmented system that is insufficiently responsive to their individual needs.

But while people from a wide range of demographics and with varying access needs took part, one thing that stood out was the striking degree of similarity across people's experiences. While the details might look different for each group, there was considerable agreement among all the participants not only on what isn't working but, crucially, what they think should be done to fix it. This is certainly cause for optimism, since it suggests that the changes offered in the *Solutions* section of this report could make a tangible difference to the lives of millions of people across London, building a health and care system that is easier to navigate, more joined-up and better able to respond to people as individuals.

However, that is not to say that health services should embody a one size fits all model. Perhaps the strongest message from this work is that it is crucial that services are designed with a deep understanding of all the support and access needs that more marginalised groups are likely to face when attempting to access healthcare. In order to ensure that all needs are considered, and are addressed with appropriate solutions, services should be designed alongside representatives from the patient groups who are likely to face the most barriers. Only then can healthcare providers and the wider health and care system ensure that patient needs are truly embedded within the services that they will be using day in, day out.

Insofar as this report looks at how to improve digital access to healthcare for marginalised groups, there are some clear steps that can be taken to make digital platforms and services simpler to navigate and more accommodating of users' needs. **If these are addressed alongside more proactive and targeted promotion of these services and funding to support digital skills training, this study suggests that many more patients will feel comfortable and confident using digital services.**

It is crucial that services are designed with a **deep understanding of all the support and access needs that more marginalised groups are likely to face** when attempting to access healthcare.

However, another key finding of this report is that there remains a significant proportion of people who will simply not be able, or want, to access healthcare services digitally, even if all the suggested supportive measures were put in place. **It is critical therefore that alternative healthcare routes are always provided to ensure that digital exclusion does not automatically lead to exclusion from healthcare.**

It is worth noting that some of the potential solutions put forward by the research participants are already available to NHS patients, at least theoretically. For example, the Accessible Information Standard should mean that patients always receive communication via their preferred contact method. However, this research shows that these initiatives are not working for many people who should benefit from them, and much more work needs to be done to ensure that they work effectively and are communicated widely.

Encouragingly, several solutions suggested by the participants reflect commitments that the government has already made in the 10 Year Health Plan for England and the NHS Modernisation Bill. These include creating a single patient record, ensuring that translation and accessibility features are designed into the NHS App 'by default', and partnering with libraries and community organisations to help set people up on the app. This shows that the NHS is already heading in the right direction when it comes to addressing patient needs.

It must ensure, however, that these initiatives are designed and implemented with the public so that they fully address patient needs and concerns. For example, while the 10 Year Health Plan commits to co-creating the re-designed NHS App alongside patient groups, healthcare organisations must ensure they also work with local community groups like the ones involved in this research so the most marginalised patients are actively part of delivering health services that work for them, rather than being shut out of the system.

As this research has shown, **Londoners are keen to get involved in these sorts of processes and make their voices heard.** The London Health Mission has an important opportunity to build on this work. Its role in bringing together partners across London provides a platform for collective action, but meaningful change will depend on ambition and sustained collaboration across health and care services, national health and care policy teams, local government, community and voluntary organisations, and Londoners themselves. **The London Health Mission must seize this moment as active champions of co-design and co-creation with the public, and particularly with those from marginalised groups.**



APPENDIX 1
SCOPING RESEARCH: METHODOLOGY & FINDINGS

METHODOLOGY

The in-depth desk research that led to the identification of the six priority groups that formed the core focus of this project utilised the following frameworks to steer the analysis of experiences of digital exclusion, personal health literacy and organisational health literacy.

Ofcom's Digital Exclusion Framework

Ofcom has tracked digital exclusion since the mid-2000s, measuring three separate digital exclusion indicators: the Technology Tracker measures access and attitudes towards communication services; the Adults' Media Literacy Tracker examines skills and confidence online; and, launched in 2020, the Communications Affordability Tracker monitors cost barriers. It was the 2022 Digital Exclusion Reviews that formalised the three-part model that became the Digital Exclusion Framework, after recognition that connectivity alone is insufficient to guarantee meaningful inclusion in the growing digital world.[18]

The framework assesses exclusion across three dimensions:

- Access refers to whether an individual has a suitable internet connection.
- Affordability captures whether the cost - of devices, data plans, etc. - is prohibitive.
- Ability covers whether individuals have the digital skills and confidence to navigate online spaces effectively, safely and independently.[19]

This has become a reference point for researchers and policymakers and is used widely because it moves past binary measures of being online or offline and acknowledges that access doesn't equate to inclusion. For this research, it provides a lens through which the digital barriers faced by community groups are assessed.

UK Government Essential Digital Skills Framework

Out of the three areas outlined by Ofcom's Digital Exclusion Framework, 'ability' is the most complicated facet to define. The Essential Digital Skills Framework - published in 2018 by the Department for Education - outlines the minimum digital capabilities adults need to participate effectively in modern life and work. It does so across five areas: communicating, handling

18 Ofcom. (2022). Digital Exclusion: A Review of Ofcom's Research on Digital Exclusion Among Adults in the UK. Available at https://www.ofcom.org.uk/siteassets/resources/documentsadults/digital-exclusion-review-2022
19 Ofcom. Digital Exclusion Review. 2022.

information and content, transacting, problem-solving, and being safe and legal online.[20] It also includes a foundation level for those who are not yet using technology or who need to develop basic skills before progressing to the five areas, including learning how to turn on a device and how to navigate a home screen.[21]

This framework was used as a benchmark for assessing skills across community groups.

Health literacy framework

The final framework that was utilised is a two-pronged approach to health literacy, distinguishing between the capacities of individuals and the responsibilities of organisations, aligned with the definitions provided by the London Health Mission.

	DEFINITION	EXAMPLE
Organisational health literacy	Defined as 'the way health and care organisations make it easier for people to find, understand, trust and use information and services to make informed decisions about their health.'	A GP surgery offering appointment information in plain English rather than using medical jargon, having translation support for non-English speakers and maintaining flexible booking options - in person and online - for those who lack digital skills.
Personal health literacy	Defined as 'having the appropriate skills (language, literacy and numeracy), knowledge, understanding, trust and confidence to obtain, communicate, understand, appraise, apply, use and navigate health and social care information and services.'	A patient understands their diagnosis, knows when to seek medical attention, and is able to follow a prescription correctly.

Applying both dimensions together prevents the burden of healthcare access falling solely on individuals. Where low personal health literacy is present, it is viewed alongside the organisational conditions that either mitigate or exacerbate it.

Identifying the research demographic groups

These groups consistently arose as priority groups on the basis that existing evidence links them to higher rates of digital exclusion, lower health literacy and poorer health outcomes relative to the general population. However, each of the six groups encompasses a wide range of experiences. Treating any of these demographics as homogenous risks flattening meaningful differences. To avoid this, the research adopted a sub-grouping approach to find the most affected sub-populations. For example, rather than examining all disabilities as interacting with the healthcare service uniformly, the research determined that people with learning disabilities and blind and partially sighted people are markedly on the sharp end of digital exclusion and poor health outcomes. Other groups remain relatively broad for the sake of pragmatism, so as to make it easier to engage with community groups representing specific communities of Londoners.

20 Department for Education. (2018). Essential Digital Skills Framework. Available at https://assets.publishing.service.gov.uk/media/Essential_digital_skills_framework.pdf
21 Department for Education. Essential Digital Skills Framework. 2018.

Through the scoping research, the following six groups were identified as the focus for the project:

- People aged 65 or over
- Blind and partially sighted people
- Migrant communities
- People with learning disabilities
- People with experience of homelessness
- People on low incomes

FINDINGS

This section describes the impacts of digital exclusion and poor personal and organisational health literacy on the healthcare experiences and outcomes of people who sit within one of the six priority groups identified above. All the statistics in the following sections are at a national level unless otherwise stated.

People aged 65 or over

Digital exclusion

Old age is the single strongest predictor of digital exclusion, with 'limited users' of online technology being eight times more likely to be over 65.[22,23] These individuals did not grow up with the internet, and the youngest person in this demographic - born in 1961 - was 34 when Windows 95 marked the boom of the personal computer. Hence, it is unsurprising that people over 65 lead a less digital life and face greater exclusion:

- **Ability:** Around half (48%) of people over 75 and 29% of people between 65-74 are unable to complete basic digital tasks, such as setting up video calls or turning on hardware, compared to 15% of the general adult population.[24,25]
- **Access:** Almost a quarter (23%) of people aged 65+ don't own a smartphone, the primary device for going online, compared with only 7% of 55-64 year olds.[26]
- **Affordability:** Only 52% of older people living in the 20% most deprived parts of England use the internet daily, compared to 80% living in the 20% least deprived areas.[27]

Personal health literacy and organisational health literacy

Older people face cognitive challenges that impact the skills personal health literacy is rooted in. Memory, processing speed, numeracy and reasoning all decline with age, making it harder to grasp instructions or learn new skills. This leads to poorer management of medication and reduced uptake of preventative care.[28] When healthcare needs increase, the cognitive load of navigating health services grows with them, creating a negative cycle that is hard to break.

22 Hall, A. and others. (2022). Older People's Access to Digitalised Services. Available at https://arc-gm.nihr.ac.uk/media/page-images/ARC/Healthy%20Ageing/DI%20Briefing%20Note
23 Hamblin, K. and Whitfield, G. (2025). Digital Exclusion and Social Care: Evidence Briefing.
24 Age UK. (2025). Facts and Figures About Digital Inclusion and Older People. Available at https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/reports-and-briefings/active-communities/internet-use-statistics-july-2025-1.pdf
25 Good Things Foundation. (2024). What We Know About Digital Inclusion. Available at https://www.goodthingsfoundation.org/policy-and-research/research-and-evidence/research-2024/digital-inclusion-datasets
26 Elagina, D. (2024). Smartphone Usage by Age 2012–2024. Statista. Available at https://www.statista.com/statistics/300402/smartphone-usage-in-the-uk-by-age
27 Age UK. Facts and Figures About Digital Inclusion and Older People. 2025.
28 Kobayashi, L.C. and others. (2015). Cognitive Function and Health Literacy Decline in a Cohort of Aging English Adults. Journal of General Internal Medicine, 30(7), 958–964. Available at https://doi.org/10.1007/s11606-015-3206-9

Additionally, the world has transformed around older people during their lifetimes: online portals, e-consultations and online information have replaced traditional routes to healthcare, meaning that some may struggle to utilise these new digital healthcare routes. These changes materially impact older people's lives: around a third (31%) of people above 60 report that life is harder than it was five years ago due to services going online.[29] In a healthcare setting, this can lead to missed appointments, postponed medical attention, and increased reliance on emergency services.

Blind and partially sighted people

Digital exclusion

Many blind and partially sighted people rely on assistive technology, such as screen readers or Braille displays, to access online spaces. In addition, digital services can be designed to be more accessible, such as through having high contrast options between background and text. However, this demographic faces numerous challenges to going digital:

- **Ability:** The top two most common Web Content Accessibility Guideline (WCAG) errors are low contrast text, found on 83.9% of homepages, and missing alternative text for images, found on 53.1% of home pages. Both directly impact partially sighted and blind people's ability to access online content.[30]
- **Access:** Blind and partially sighted people are less likely to use the internet daily,[31] and only 46% own a smartphone.[32]
- **Affordability:** The employment rate for blind and partially sighted people in the UK is 27%, compared to 83% for non-disabled people.[33] RNIB found that more than a third (37%) of blind or partially sighted people struggle to make ends meet or cannot afford their costs and often go without essentials.[34] When choosing between data or food, the price of digital connection is almost always secondary.

Personal health literacy and organisational health literacy

There is little evidence that being blind or partially sighted impacts literacy rates.[35] Instead, it is inaccessibility that shapes blind and partially sighted people's experiences. For example, some can struggle with reading standard print and often lean on others to read or explain text, which can lead to miscommunication and a loss of privacy.

Accessible Information Standard (AIS) are meant to ensure that the NHS provides information in accessible formats such as Braille, large font or EasyRead. However, in 2021, 90% of blind or partially sighted people didn't receive medical information in their preferred format, and 51% of NHS trusts report having never engaged with disabled people as part of their AIS implementation.[36]

29 Age UK. (2024). One in Three (31%) Over 60s Say Life Is Harder Than Five Years Ago Because More Services Are Now Online. Available at https://www.ageuk.org.uk/latest-press/articles/one-in-three-31-over-60s-say-life-is-harder-than-five-years-ago-because-more-services-are-now-online

30 WebAIM. (2024). The WebAIM Million: An Annual Accessibility Analysis of the Top 1,000,000 Home Pages. Available at https://webaim.org/projects/million

31 RNIB. (2024, 21 October). Sight Loss and Technology. Available at https://www.rnib.org.uk/professionals/research-and-data/reports-and-insight/sight-loss-and-technology

32 Edwards, E. (2021, September). Sight Loss and Technology Briefing. Available at https://www.tavip.org.uk/wp-content/uploads/2022/01/APDF-Sight-Loss-and-Technology-Briefing.pdf

33 Hansard. (2026). Employment Gap for Blind and Sight-Impaired People. Parliament.uk. Available at https://hansard.parliament.uk/lords/2025-12-17/debates/03C34573-E3BF-4587-A4B7-EFFA7D802391/EmploymentGapForBlindAndSight-ImpairedPeople

34 RNIB. (2022). Why the Cost of Living Crisis Has a Bigger Impact on People with Sight Loss. Available at https://media.rnib.org.uk/documents/Cost_of_living_-_Final_-_1_Aug_22.pdf

35 Veispak, A., Boets, B. and Ghesquière, P. (2013). Differential Cognitive and Perceptual Correlates of Print Reading versus Braille Reading. Research in Developmental Disabilities, 34(1), 372–385. Available at https://doi.org/10.1016/j.ridd.2012.08.012

36 Thomas Pocklington Trust. (2025, 17 July). Equity of Access to Health and Social Care Services. Available at https://www.pocklington.org.uk/health/equity-of-access-to-health-and-social-care-

Ultimately, this means blind or partially sighted people are more at risk of potential harm due to safety gaps in communicating health information, and the RNIB found that blind or partially sighted people face fear and anxiety around taking the wrong medication or dose. For example, designs of diabetes-specific devices 'failed to meet accessibility needs', despite the fact that diabetes contributes to sight loss.[37]

Migrant communities

Digital exclusion

Migrant communities, especially those whose first language is not English, can face significant digital exclusion as language barriers seep into almost all aspects of their lives:

- **Ability:** Limited language skills undermine many migrants' digital ability. People with lower levels of English fluency report significant barriers to getting online, including issues with the design of platforms like chatbots being monolingual.[38]
- **Affordability:** Economic hardship disproportionately impacts migrant communities, creating a significant affordability barrier. Almost a third (31%) of people living in the UK who were born outside the country live in poverty, compared with 16% of those who are UK-born.[39] In turn migrants often lack access to digital devices, meaning many rely on schools, libraries or community centres for connection.[40]

Personal health literacy and organisational health literacy

Language proficiency is the leading barrier to personal health literacy; approximately 1 million people in the UK cannot speak English well or at all.[41] Additional barriers include the fact that norms and stigma around illness and healthcare vary greatly: in some cultures, health - both mental and physical - is not spoken about openly, leading to migrants under-reporting or avoiding seeking healthcare.[42] Moreover, a lack of institutional trust - scepticism regarding the government and the desire to stay 'under the radar' out of fear of deportation - has been cited as a leading cause of migrants not seeking healthcare.[43] This sits alongside the fact that some migrant groups are expected to pay upfront charges for access to some healthcare services, which can deter them from seeking healthcare in the first place.[44]

For all the personal barriers migrants must overcome, health providers don't ease this transition. NHS digital services are predominantly English-only. For people whose preferred language is not English, this makes receiving healthcare difficult. The NHS has tried to address this issue through its framework for community language translation and interpretation, introduced in 2025, that provides recommendations to Integrated Care Boards (ICBs) and NHS Trusts as well as individual primary care settings.[45] But reports show that at least 33% of frontline staff use AI

37 Eye News. (2025, 30 April). New Research Shows the Unhealthy State of Access to Medicine and Medical Devices for Blind Patients. Available at https://www.eyenews.uk.com/news/post/new-research-shows-the-unhealthy-state-of-access-to-medicine-and-medical-devices-for-blind-patients

38 Ofcom. (2025). Exploring How People in the UK Are Affected by 'Digital Disadvantage'. Available at https://www.ofcom.org.uk/internet-based-services/technology/exploring-how-people-in-the-uk-are-affected-by-digital-disadvantage

39 Joseph Rowntree Foundation. (2026, 27 January). UK Poverty 2026: The Essential Guide to Understanding Poverty in the UK. Available at https://www.jrf.org.uk/uk-poverty-2026-the-essential-guide-to-understanding-poverty-in-the-uk

40 Stone, E. and Maye, K. (2020). Supporting Digital Inclusion of Adults with Low English Language Skills. Available at https://d1ssu070pg2v9i.cloudfront.net/pex/carnegie_uk_trust/2020/06/11122825/supporting_digital_inclusion_of_adults_with_low_english_language_skills_2020.pdf

41 Office for National Statistics. (2022, 29 November). Language, England and Wales: Census 2021. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/language/bulletins/languageenglandandwales/census2021

42 Bansal, N. and others. (2022). Understanding Ethnic Inequalities in Mental Healthcare in the UK: A Meta-Ethnography. PLOS Medicine, 19(12), 1–36. Available at https://doi.org/10.1371/journal.pmed.1004139

43 Hawthorne, A., Bobek, A. and Sandström, L. (2025). Inequality, Trust and Fear: Migrant Healthcare During the COVID-19 Pandemic and Beyond. Sociology of Health & Illness, 47(7). Available at https://doi.org/10.1111/1467-9566.70077

44 Allen, L. and others. Immigration and the NHS: The Evidence. The Health Foundation, 2026. Available at https://www.health.org.uk/reports-and-analysis/briefings/immigration-and-the-nhs-the-evidence

45 NHS England. (2025, 27 May). Improvement Framework: Community Language Translation and Interpreting Services. England.nhs.uk. Available at https://www.england.nhs.uk/long-read/improvement-framework-community-language-translation-and-interpreting-services

or machine translation in their work, often on personal devices and without oversight, raising concerns about miscommunication in high-stakes medical settings.[46]

This is especially important because people with English as a second language are more likely to experience adverse events while in hospital.[47] In one documented case, a family received in-person interpretation during consultations, but written communication remained in English. This meant that the family brought their child to a cancer scan without understanding the child needed to fast beforehand, so the scan had to be cancelled. Months later, following a lost referral and no change to the language of written communication, the situation repeated - leading to a late diagnosis. Tragically, the child passed away.[48] While this cannot be solely attributed to the lack of translation, this illustrates that patient safety rests on health information being accessible.

People with learning disabilities

Digital exclusion

People with learning disabilities (LD) face barriers to digital inclusion across all domains. Many of these barriers stem from challenges with numeracy and literacy, but are compounded by services not being inclusive in their design. Many struggle to get online:

- **Ability:** Around 7 in 10 (72%) of those with a learning or memory impairment have foundation level digital skills, compared to 91% of those with no impairments.[49]
- **Access:** Among those with learning disabilities, digital access is distributed unevenly. Those with profound and multiple learning disabilities have generally lower levels of internet access (57%) than those who don't have profound or multiple learning disabilities (74%).[50]
- **Affordability:** Low employment rates create a significant affordability barrier for people with LD. Only 6% of adults with LD known to their local authority are in paid employment, making it harder to afford the devices and data needed for digital inclusion.[51]

Personal health literacy and organisational health literacy

Learning disabilities can impact a person's comprehension and general literacy and numeracy - appointment letters, prescription instructions and test results are harder to understand. People with learning disabilities may have difficulty reading and 58% struggle to communicate with others, which can make it difficult to build personal health literacy.[52]

As mentioned above, the NHS has a legal duty - under the AIS - to provide communication in formats that meet patients' individual needs. Despite this, the Care Quality Commission found that only around 1 in 4 of the estimated 1.3 million people with LD are recorded on their GP's LD register.[53] Where needs are not recorded, they cannot be flagged to staff nor can they be

46 Chartered Institute of Linguists. (2024). Uses of AI Translation in UK Public Service Contexts. Available at https://www.ciol.org.uk/ai-translation-uk-public-services
47 Al Shamsi, H. and others. (2020). Implications of Language Barriers for Healthcare: A Systematic Review. Oman Medical Journal, 35(2), 1–7. Available at https://doi.org/10.5001/omj.2020.40
48 Mitchell, H. (2023, 21 September). Clinical Investigation Booking Systems Failures: Written Communications in Community Languages. Health Services Safety Investigations Body. Available at https://www.hssib.org.uk/patient-safety-investigations/clinical-investigation-booking-systems-failures-written-communications-in-community-languages/investigation-report
49 Good Things Foundation. (2024, 9 December). Digital Inclusion and Health Statistics. Available at https://www.goodthingsfoundation.org/discover/digital-inclusion-insights/digital-inclusion-insights-2024/digital-inclusion-and-health
50 Mackey, J. and others. (2022). Digital Lifeline: A Qualitative Evaluation. Available at https://assets.publishing.service.gov.uk/media/623aef4bd3bf7f6ac322fbde/3703_GTF_Digital_Lifeline_A_Qualitative_Evaluation_Report_v3_WA.pdf
51 Department of Health and Social Care. (2025, 23 October). Adult Social Care Activity Report 2024 to 2025: Commentary. GOV.UK. Available at: https://www.gov.uk/government/statistics/adult-social-care-activity-report-england-2024-to-2025/adult-social-care-activity-report-2024-to-2025-commentary
52 Shady, K., Phillips, S. and Newman, S. (2022). Barriers and Facilitators to Healthcare Access in Adults with Intellectual and Developmental Disorders and Communication Difficulties: An Integrative Review. Review Journal of Autism and Developmental Disorders, 11(1).
53 Care Quality Commission. (2025). The State of Health Care and Adult Social Care in England 2024/25 (HC 1367). Available at https://www.cqc.org.uk/sites/default/files/2025-10/20251024_stateofcare2425_print.pdf

met. This leaves people navigating services that have not accounted for their communication needs.

Health inequalities for people with learning disabilities are well documented. A 2024 review found that those with a profound learning disability die around 40 years younger on average than the general population.[54] Flu immunisation and cancer screenings were administered less to people with LD. And 38% of those with mild or moderate LD die an avoidable death.[55] The digital exclusion this demographic faces can lead to online healthcare being inaccessible, which leads to worsening health, then a growing need for medical attention that is increasingly locked behind a digital barrier.

People with experience of homelessness (including those in temporary accommodation)

Digital exclusion

Before discussing the findings for this demographic, it is important to note that Demos defines homelessness as including those in temporary accommodation. However due to the paucity of research for this population, some statistics are focused on those who are rough sleeping.

Homelessness is a leading cause of digital exclusion: 35% of homeless people report never accessing the internet.[56] Across all three elements of Ofcom's framework, homelessness is clearly linked to increased exclusion:

- **Ability:** The majority (82%) of people experiencing homelessness have a mental health diagnosis, compared with 12% of the general population.[57] Poor mental health is linked to lower digital skills - 42% of people with severe mental illness lack basic digital skills.[58]
- **Access:** People experiencing homelessness often rely on smartphones as their primary method of accessing the internet. But without a stable address, reliable Wi-Fi or access to charging points, access and connectivity is hard to maintain.
- **Affordability:** People experiencing homelessness are likely to have little or no income, making the cost of devices and connection a significant barrier. Whether in temporary accommodation, hostels or rough sleeping, the cost of connectivity competes with basic needs, placing digital access out of reach.

Personal health literacy and organisational health literacy

Lower literacy and numeracy rates in childhood are correlated with an increased chance of experiencing homelessness at some point in life.[59] Lower numeracy and literacy is correlated with lower personal health literacy, resulting in issues accessing healthcare. Paired with difficulty accessing digital devices, people experiencing homelessness face major challenges receiving medical care.

The health system exacerbates these challenges: most healthcare pathways assume stable addresses, phone numbers and means to access digital platforms - all of which people experiencing homelessness lack. Furthermore, identity verification is difficult without paperwork,

54 Yu, M.K.L. and others. (2024). Learning from Lives and Deaths: People with a Learning Disability and Autistic People (LeDeR) Report for 2024. LeDeR Autism and Learning Disability Partnership, King's College London. Available at https://www.kcl.ac.uk/research/leder
55 Yu, M.K.L. and others. Learning from Lives and Deaths. 2024.
56 Williams, H. and Whelan, A. (2017). An Investigation into Access to Digital Inclusion for Healthcare for the Homeless Population. Available at https://amhp.org.uk/wp-content/uploads/2018/11/Digital-Inclusion-and-Homeless-People.pdf
57 Hertzberg, D. and Boobis, S. (2022). The Unhealthy State of Homelessness 2022. Available at https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf
58 Beeston, A. (2022, 6 December). Many People with Severe Mental Illness Lack Digital Skills. NIHR Evidence. Available at https://evidence.nihr.ac.uk/alert/many-people-severe-mental-illness-lack-digital-skills
59 Ellingwood, J., Vallis, D. and Sanders, M. (2024). Literacy, Numeracy, and Homelessness: What Do We Know? Available at https://cdn.prod.website-files.com/646dd81ef095aa13072c44e0/674f25a4f70fa36bb750190b_CHI_Literacy_Numeracy_Homelessness_Report_FINAL.pdf

resulting in many people experiencing homelessness falling out of healthcare completely.[60]

Altogether, these issues contribute to people experiencing homelessness having some of the worst health outcomes in the UK: 63% of homeless people report their general health being bad or very bad, compared to 5.3% of the population.[61] Difficulty registering at a GP and utilising standard routes to medical care - such as a GP appointment - contribute to those experiencing homelessness being 60 times more likely to visit A&E.[62] Ultimately, this cements a cycle of needing medical attention, not receiving it, worsening health, and deeper exclusion.

People on low incomes

Digital exclusion

Low income is a leading factor in digital exclusion. People on low incomes frequently face barriers across all three aspects of Ofcom's digital exclusion framework:

- **Ability:** Digital skills gaps are strongly linked to socioeconomic status. Children from low-income households on average do less well in education, leading to lower attainment of formal qualifications.[63] Studies show a correlation between formal qualifications and digital skills - 48% of people with no formal qualifications lack foundational essential digital skills.[64]
- **Access:** One in ten (11%) people in poverty do not have internet access.[65] Among people who use foodbanks, 16% have no access to the internet.[66]
- **Affordability:** For this demographic, affordability is the strongest barrier. Among households on incomes of £25,000 or less, one in five never use the internet.[67] The price of Wi-Fi, devices and unaffordable repairs on top of the existing cost of living pressures all reduce digital inclusion.

Personal health literacy and organisational health literacy

Low income is closely linked to lower general literacy, numeracy and digital confidence, all of which underpin personal health literacy. For example, people with lower wealth are less likely to take part in NHS bowel cancer screenings.[68] Where health literacy is not the primary driver, low income brings practical hurdles that compound this problem. Appointments have real costs - lost work, childcare, transportation and more - that are rarely acknowledged by medical services.

Organisational health literacy often worsens this demographic's outcomes. Where healthcare access is digital first, the cost of data, Wi-Fi and suitable devices add other barriers. A study found that the pandemic-driven shift to digital healthcare had a negative effect on people on low incomes - it favoured patients who were digitally confident and disadvantaged those who lack the skills or money to get online.[69]

60 Healthwatch. (2023, 24 August). What Homeless People Told Us About Their Experience of Health and Care Services. Available at https://www.healthwatch.co.uk/blog/2023-12-19/what-homeless-people-told-us-about-their-experience-health-and-care-services
61 Healthwatch. What Homeless People Told Us About Their Experience of Health and Care Services. 2023.
62 Davis, N. (2019, 2 July). Homeless People Are 60 Times More Likely to Visit A&E, Study Shows. The Guardian. Available at https://www.theguardian.com/society/2019/jul/02/homeless-people-60-times-more-likely-visit-ae-study
63 Child Poverty Action Group. (2024). The Effects of Poverty. Available at https://cpag.org.uk/child-poverty/effects-poverty
64 Good Things Foundation, Lloyds Banking Group, Nominet and University of Liverpool. (2024, September). Digital Inclusion: What the Main UK Datasets Tell Us. Available at https://www.goodthingsfoundation.org/policy-and-research/research-and-evidence/research-2024/digital-inclusion-datasets
65 NCFE. (n.d.). Digital Poverty: 3 Factors and How Society Can Tackle It. Available at https://www.ncfe.org.uk/all-articles/digital-poverty-3-factors-and-how-society-can-tackle-it
66 Bull, R. and others. (2023). Hunger in the UK. Available at https://cms.trussell.org.uk/sites/default/files/wp-assets/2023-The-Trussell-Trust-Hunger-in-the-UK-report-web-updated-10Aug23.pdf
67 Institute of Development Studies. (2022). Digital Poverty in the UK. Available at https://www.ids.ac.uk/publications/digital-poverty-in-the-uk-accessible-version
68 Solmi, F. and others. (2015). Decomposing Socio-Economic Inequality in Colorectal Cancer Screening Uptake in England. Social Science & Medicine, 134, 76–86. Available at https://doi.org/10.1016/j.socscimed.2015.04.010
69 Bidmead, E. and others. (2024). Poverty Proofing Healthcare: A Qualitative Study of Barriers to Accessing Healthcare for Low-Income Families with Children in Northern England. Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC11051590/pdf/pone.0292983.pdf

All of the above lead to worse outcomes for families on low incomes. Repeated failed attempts to reach a GP have led some to give up trying and turn to emergency services because it is the only route that feels accessible.[70] This care arrives later, costs more, and falls hardest on those least able to absorb the fallout. The culmination of all of these barriers is extreme: people in the most deprived areas of England can expect around 20 fewer years of healthy life than those in the least deprived areas, and a life expectancy gap of roughly 10 years.[71]

70 Bidmead, E. and others. Poverty Proofing Healthcare. 2024.
71 Office for National Statistics. (2026, 14 April). Healthy Life Expectancy by National Area Deprivation, England and Wales. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthylifeexpectancybynationalareadeprivationenglandandwales/between2013to2015and2022to2024

APPENDIX 2
IDENTIFYING BOROUGHS WITH AT-RISK POPULATIONS

In order to find out which London boroughs contained the highest proportions of populations at risk of both digital exclusion and poor personal and organisational health literacy, the first step was to identify variables that are key risk factors for this. These risk factors are listed below along with the data sources used to find the number of people in each borough that fall into these categories.

- Being aged 65+ - ONS mid-2024 population estimates[72]
- Having a disability or long-term health condition - ONS 2021 census[73]
- Experiencing homelessness - Shelter, Interactive Map of Homelessness in England (2025)[74]
- Living in a low-income household (60% or less of median income) - Trust for London, Poverty Rates for London Boroughs (2023/24)[75]
- Being an immigrant (born outside the UK) - ONS 2021 census[76]
- Being from an ethnic minority group (Asian, Black, Mixed, White Roma, Gypsy or Irish Traveller, other) - ONS 2021 census[77]
- Having no formal qualifications - ONS 2021 census[78]

The ONS mid-2024 population estimates were used to find the overall population of each borough, which informed the calculation for the proportion of each borough's population that was affected by each of the variables listed above. By converting variables into percentages of borough populations, it ensured that the analysis was not skewed towards the most populous boroughs. (At this point, the City of London was excluded from the analysis due to lack of data.)

The tables below show the percentage of each borough's population that fall into each of these variables.

72 Office for National Statistics. (2021.). Population Estimates for the UK, England, Wales, Scotland and Northern Ireland. Available at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
73 Office for National Statistics. (n.d.). Census. Available at https://www.ons.gov.uk/census
74 Shelter. (n.d.). Homelessness Map [interactive]. Available at https://england.shelter.org.uk/what_we_do/updates_insights_and_impact/interactive_homelessness_map
75 Trust for London. (n.d.). Poverty by Borough. Available at https://trustforlondon.org.uk/data/poverty-borough
76 Office for National Statistics. Census. 2021
77 Office for National Statistics. Census. 2021
78 Office for National Statistics. Census. 2021

LONDON BOROUGHS	65+ %	DISABILITY AND LONG TERM HEALTH %	HOMELESSNESS %	LOW IN-COME %	NON-UK BORN %	ETHNIC MINORITIES %	NO FORMAL QUALS %
Barking and Dagenham	8.60	12.46	1.43	32.00	38.84	52.26	15.81
Barnet	14.98	12.26	1.83	25.00	41.49	41.06	11.79
Bexley	16.55	14.07	0.46	20.00	20.19	27.39	13.88
Brent	12.17	11.66	2.01	33.00	53.99	63.71	16.93
Bromley	17.89	13.69	1.22	13.00	19.96	23.51	10.91
Camden	12.13	14.70	N/A	42.00	44.02	39.72	9.66
Croydon	13.86	13.40	2.13	22.00	33.27	49.61	12.18
Ealing	12.60	11.61	2.38	31.00	48.33	54.49	13.71
Enfield	14.67	13.71	2.78	32.00	40.67	48.74	17.66
Greenwich	10.76	13.88	1.91	26.00	36.22	43.18	12.79
Hackney	8.47	13.88	3.33	26.00	38.59	45.94	13.14
Hammersmith and Fulham	10.86	12.17	1.98	24.00	44.16	36.60	9.72
Haringey	11.28	13.69	3.19	26.00	45.91	43.92	15.13
Harrow	15.73	11.55	1.73	25.00	49.35	61.90	13.47
Havering	17.27	13.92	1.34	19.00	18.42	23.68	15.18
Hillingdon	13.12	11.99	1.19	22.00	35.74	48.51	13.34
Hounslow	12.23	11.79	0.51	34.00	47.63	54.23	14.24
Islington	9.70	15.72	1.77	20.00	38.73	37.17	11.32
Kensington and Chelsea	15.44	12.67	3.50	33.00	53.50	36.75	9.67
Kingston upon Thames	15.01	12.73	1.39	26.00	32.80	31.12	9.34
Lambeth	9.47	13.26	3.82	23.00	38.67	45.61	11.10
Lewisham	10.33	14.36	2.41	28.00	35.54	48.78	11.77
Merton	13.22	11.85	0.96	18.00	40.24	39.62	11.26

Newham	7.53	11.22	5.54	38.00	50.36	65.62	15.26
Redbridge	12.57	11.53	2.64	34.00	42.12	63.37	13.06
Richmond upon Thames	16.97	11.94	0.73	14.00	28.59	19.65	7.20
Southwark	9.11	13.35	2.80	22.00	39.78	48.02	11.28
Sutton	15.33	13.80	1.32	19.00	27.13	31.20	11.71
Tower Hamlets	5.89	12.09	2.76	40.00	43.76	57.36	12.35
Waltham Forest	10.75	13.14	1.70	24.00	38.38	47.54	14.49
Wandsworth	9.94	11.09	2.61	26.00	36.78	31.77	8.06
Westminster	12.63	13.39	4.80	42.00	54.06	44.31	10.90

Each variable was standardised by subtracting each variable's mean from each data point within that variable, and dividing that by that variable's standard deviation, using the formula

$$z = (x - \mu) / \sigma$$

Where **z** = standardised score, **x** = an individual data point, **μ** = the variable mean and **σ** = the variable standard deviation.

Standardising meant that the variables were more comparable with each other since it ensured they all had the same mean and standard deviation, which meant that the analysis was not dominated by variables with a larger numerical value.

The tables below show the standardised variables for each borough.

LONDON BOROUGHS	65+ STAN-DARDISED	DISABILITY STAN-DARDISED	HOMELESSNESS STANDARDISED	LOW IN-COME STAN-DARDISED	NON-UK BORN STAN-DARDISED	ETHNIC MIN STAN-DARDISED	NO FORMAL QUALS STAN-DARDISED
Barking and Dagenham	-1.256	-0.383	-0.660	0.682	-0.048	0.688	1.371
Barnet	0.846	-0.551	-0.315	-0.244	0.236	-0.239	-0.267
Bexley	1.367	1.035	-1.480	-0.906	-2.048	-1.370	0.583
Brent	-0.080	-1.081	-0.158	0.815	1.576	1.635	1.829
Bromley	1.807	0.698	-0.837	-1.832	-2.072	-1.692	-0.627

LONDON BOROUGHS	65+ STANDARDISED	DISABILITY STANDARDISED	HOMELESSNESS STANDARDISED	LOW INCOME STANDARDISED	NON-UK BORN STANDARDISED	ETHNIC MIN STANDARDISED	NO FORMAL QUALS STANDARDISED
Camden	-0.092	1.584	-1.877	2.006	0.507	-0.350	-1.138
Croydon	0.479	0.446	-0.058	-0.641	-0.645	0.468	-0.107
Ealing	0.064	-1.127	0.157	0.550	0.970	0.872	0.516
Enfield	0.746	0.714	0.492	0.682	0.148	0.397	2.124
Greenwich	-0.543	0.868	-0.246	-0.112	-0.329	-0.064	0.141
Hackney	-1.298	0.865	0.961	-0.112	-0.075	0.165	0.281
Hammersmith and Fulham	-0.509	-0.630	-0.186	-0.376	0.523	-0.608	-1.113
Haringey	-0.373	0.698	0.848	-0.112	0.710	-0.002	1.094
Harrow	1.095	-1.183	-0.405	-0.244	1.079	1.485	0.415
Havering	1.602	0.900	-0.737	-1.038	-2.238	-1.677	1.116
Hillingdon	0.236	-0.793	-0.857	-0.641	-0.380	0.377	0.363
Hounslow	-0.058	-0.971	-1.442	0.947	0.895	0.851	0.730
Islington	-0.893	2.485	-0.367	-0.906	-0.059	-0.561	-0.457
Kensington and Chelsea	1.000	-0.195	1.110	0.815	1.524	-0.596	-1.133
Kingston upon Thames	0.859	-0.139	-0.691	-0.112	-0.695	-1.062	-1.267
Lambeth	-0.969	0.321	1.386	-0.509	-0.066	0.138	-0.548
Lewisham	-0.687	1.285	0.183	0.153	-0.402	0.400	-0.277
Merton	0.267	-0.914	-1.059	-1.170	0.102	-0.359	-0.484
Newham	-1.608	-1.466	2.852	1.476	1.187	1.794	1.147
Redbridge	0.052	-1.201	0.375	0.947	0.303	1.607	0.249
Richmond upon Thames	1.506	-0.838	-1.251	-1.700	-1.147	-2.011	-2.138

LONDON BOROUGHS	65+ STAN-DARDISED	DISABILITY STAN-DARDISED	HOMELESSNESS STANDARDISED	LOW IN-COME STAN-DARDISED	NON-UK BORN STAN-DARDISED	ETHNIC MIN STAN-DARDISED	NO FORMAL QUALS STAN-DARDISED
Southwark	-1.087	0.401	0.513	-0.641	0.053	0.337	-0.475
Sutton	0.964	0.801	-0.749	-1.038	-1.304	-1.055	-0.300
Tower Hamlets	-2.148	-0.705	0.476	1.741	0.479	1.110	-0.038
Waltham Forest	-0.547	0.219	-0.423	-0.376	-0.098	0.298	0.833
Wandsworth	-0.815	-1.584	0.351	-0.112	-0.269	-1.008	-1.790
Westminster	0.074	0.439	2.216	2.006	1.584	0.030	-0.632

Finally, the average of the standardised variables for each borough served as the risk indicator. Then the mean and standard deviation of this risk indicator was taken and used to identify the most at-risk boroughs.

- **Very high risk** = risk indicator score one standard deviation or more above the mean
- **High risk** = risk indicator score between 0.5 and one standard deviation above the mean
- **Moderate risk** = risk indicator score between the mean and 0.5 standard deviations above the mean
- **Low risk** = risk indicator score below the mean

The table shows the risk indicator of each borough along with the risk category in which they were placed.

LONDON BOROUGHS	RISK INDICATOR	RISK CATEGORY
Westminster	0.817	Very high risk
Newham	0.769	Very high risk
Enfield	0.758	Very high risk
Brent	0.648	Very high risk
Haringey	0.409	High risk
Kensington and Chelsea	0.361	High risk
Redbridge	0.333	High risk
Harrow	0.320	High risk
Ealing	0.286	High risk
Hounslow	0.136	Moderate risk
Tower Hamlets	0.131	Moderate risk
Hackney	0.113	Moderate risk
Lewisham	0.094	Moderate risk
Camden	0.092	Moderate risk
Barking and Dagenham	0.056	Moderate risk
Croydon	-0.008	Moderate risk
Waltham Forest	-0.014	Low risk
Lambeth	-0.035	Low risk
Greenwich	-0.041	Low risk
Barnet	-0.076	Low risk
Islington	-0.108	Low risk
Southwark	-0.128	Low risk
Hillingdon	-0.242	Low risk
Havering	-0.296	Low risk
Sutton	-0.383	Low risk
Bexley	-0.403	Low risk
Hammersmith and Fulham	-0.414	Low risk
Kingston upon Thames	-0.444	Low risk
Merton	-0.516	Low risk
Bromley	-0.651	Low risk
Wandsworth	-0.747	Low risk
Richmond upon Thames	-1.083	Low risk

This method identified which London boroughs are likely to contain the highest proportions of people at the highest risk of digital exclusion and poor health outcomes, but it did have some limitations. This included the fact that some datasets did not have data for every borough. Averaging out the standardised variables meant these boroughs were not disadvantaged, although their risk indicator may be slightly less accurate. In addition, in the analysis, each variable was given the same weighting to calculate the final risk indicator. It is likely that some variables have a higher impact on digital exclusion and health literacy than others, but resource constraints made it difficult to quantify this as part of this project. Finally, these datasets will not capture every individual, and often the most vulnerable will be those that are missed.

APPENDIX 3
PARTICIPANT HEALTH ACCESS DIARY

Below is the standard template for the health access diary that participants were asked to complete in stage 1 of the data collection work. Demos worked with staff from each community organisation to ensure that the final version of the diary was adapted for each group to ensure the format and wording was accessible for all participants. For example, a Romanian version for participants from Ro-EE Hub was developed alongside a version without pictures or check boxes for MAB so that it would be readable by the screen reader software used by some blind and partially sighted people.

Section 2 was repeated multiple times to give participants the opportunity to write about all the interactions with health services they had during the two-week data collection period.

HEALTH ACCESS DIARY

Demos and *[community organisation]* are working together to understand how people access health services and health information: what makes things easier for you and what makes things harder. We want to understand how using phones, apps, the internet, or any other digital device affects how you get health care.

So we want to hear about your experiences.

Over the next two weeks, please complete this diary. You only need to complete the questions in Section 1 once. Then please fill in the questions in Section 2 every time you use or try to use a health service.

When we say health services we mean things like:

- GP surgeries and health centres
- Hospitals and outpatient clinics
- Pharmacies and chemists
- Online health services (e.g. NHS website, virtual consultations)
- Health apps and digital tools
- NHS 111 and other telephone advice lines

- Community health services (e.g. district nurses, health visitors)
- Mental health services and counselling support
- Sexual health clinics
- Walk-in centres and urgent treatment centres
- Dentists and dental services
- Opticians and eye care services
- Physiotherapy and rehabilitation services
- Social care or support services linked to health needs
- Charity or voluntary sector health support services

You don't need to share any details about your health in your responses, so you don't need to include things like what your medical concern was or what medication you have been prescribed. What you share is confidential and will only be seen by the Demos research team and the staff at *[community organisation]*. We will not tell anybody else what you have said. All information will only be used for research and we will not include your name in our report so you cannot be identified in anything we write.

You will be invited to take part in two workshops where we will be talking about some of the experiences that you and others have had trying to access health services. We will make sure that any reference to people's experiences is anonymised. It is completely up to you how much you would like to share in the workshops.

If you change your mind and don't want us to hold this information about you, you can ask us to delete any information you gave us. Information you do share will be kept in line with Demos's Privacy Policy for a maximum of one year after the project ends and then we will delete it from our system.

Taking part will not affect your healthcare, housing, or immigration status.

If you have any questions please reach out to *[community organisation]* or email nicola.stokes@demos.co.uk.

SECTION 1

You only need to fill in this section once

First name:

_____

Do you use the NHS App? (e.g. to book appointments, access health records, order prescriptions, etc)

☐ Yes
☐ No

You only need to fill in this section once

Do you use any other health service app?
(e.g. Pharmacy2U, Patient Access, etc)

☐ Yes
☐ No

If yes, which ones?

_____

_____

Do you need someone to help you access health information?
(you can select more than one option)

☐ Yes, I need help on the phone
☐ Yes, I need help if using the internet
☐ Yes, I need help using an app
☐ Yes, I need help if accessing health services In person
☐ No, I don't need help
☐ Other (Specify): _____

If you need someone to support you, who would normally help you?
(you can select more than one)

☐ A friend or family member
☐ A paid carer or support worker
☐ A staff member or volunteer from a community group (e.g. Open Age)
☐ Other

If you need someone to help you, what do you need support to do?
(you can select more than one option)

☐ Physically get to the location
☐ Access the internet
☐ Translate to and from my preferred language
☐ Ensuring I have understood medical information
☐ Explaining my medical concerns to staff
☐ Other (Specify): _____

SECTION 2

Tell us about your experience

Please complete this section each time you access a health service, or try to. Do include any time you tried but were unable to get help.

Date: _____

I wanted to… (Select one)

☐ Book an appointment
☐ Get medical advice
☐ Collect or buy medication
☐ Attend an appointment
☐ Get test results
☐ Find health information
☐ Other (Specify): _____

At or on… (Select one)

☐ GP surgery
☐ Hospital
☐ Pharmacy
☐ NHS 111
☐ NHS App
☐ Community/charity service
☐ Online service
☐ Other (Specify): _____

I did this… (Select one)

☐ In person
☐ Via a phone call
☐ On the website
☐ On the NHS app
☐ On another app
☐ Through email
☐ Over text
☐ Other (Specify): _____

Tell us about your experience

Because... (you can select more than one option)

☐ It was the easiest option

☐ I can't access the internet/devices

☐ I prefer speaking to someone

☐ It's a habit

☐ I have accessibility needs

☐ I have cost/data concerns

☐ I was told to use this method

☐ Other (Specify): _____

When you answer the next questions, please write as much or as little as you want.

This is what happened: _____

_____

_____

What I thought went well: _____

_____

_____

What I thought didn't go so well: _____

_____

_____

During the interaction I felt...
(you can select more than one option)

☐ Confident

☐ Supported

☐ Respected

☐ Neutral

☐ Confused

☐ Frustrated

☐ Anxious

☐ Upset

☐ Other (Specify): _____

Tell us about your experience

Because…

_____

_____

_____

_____

Overall, how would you score this interaction? (Select one)

☐ 😞 Very bad

☐ 😕 Bad

☐ 😐 Neither good or bad

☐ 🙂 Good

☐ 😀 Very good

Is there anything else you want to tell us about your experience accessing the health service? You don't have to write anything here if you don't want to.

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