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Multidisciplinary teams must work together to co-develop inclusive digital primary care for older people

The COVID-19 pandemic has abruptly changed healthcare service delivery.[1] In a few weeks, clinicians and patients were asked to transition from face-to-face contacts to 'digital-first' solutions (that is, telephone, video, online) wherever possible.

However, there is a real risk that innovation entrenches inequalities in care access, delivery, and patient safety.[2] The adoption of digital technologies is known to happen unevenly across different groups, therefore contributing to the so-called 'digital divide'.[3] Older people seem to be particularly underserved: evidence shows that increased age is associated with less access to technology and lower digital literacy,[3,4] which may contribute to lower adoption, less sustained use, and less access to care and treatment. Paradoxically, this same group was identified as high risk and is more likely to have comorbidities, physical disabilities, and be shielding,[5] and, therefore, they have most to gain from the regular and remote care that digital technologies can offer.

For these reasons, it is critical to work with a diverse group of older people, particularly from seldom heard groups. GPs and other healthcare providers, researchers, designers, and relevant voluntary and community organisations must come together to explore the main barriers and enhancers to access remote and digital care, and find innovative ways to translate these findings into high-quality solutions to improve the experience both for providers and patients — in order to deliver high-quality, patient-centred care that leaves no one behind.

Ana Luisa Neves,

Research Fellow in Clinical Analytics and Patient Safety, Institute of Global Health Innovation, Imperial College London, London. Email: ana.luisa.neves14@imperial.ac.uk

Anna Lawrence-Jones,

Patient and Public Involvement and Engagement Lead, Institute of Global Health Innovation, Imperial College London, London.

Lenny Naar,

Head of Design Strategy, Helix Centre, Institute of Global Health Innovation, Imperial College London, London.

Geva Greenfield,

Research Fellow in Public Health, Department of Primary Care and Public Health, School of Public Health, Imperial College London, London.

Frances Sanderson,

Consultant in Infectious Disease, Imperial College Healthcare NHS Trust, London.

Toby Hyde,

Deputy Director of Transformation, Imperial College Healthcare NHS Trust, London.

David Wingfield,

GP and Honorary Senior Lecturer, Hammersmith and Fulham Partnership, London.

Iain Cassidy,

CEO, Open Age, London.

Erik Mayer,

Institute of Global Health Innovation, Imperial College London, London.

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Competing interests

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Herd thinking

Thank you for your remarks on COVID vaccination in your October editorial 'Herd thinking'.[1] You are absolutely right that the positivist philosophical approach that some doctors might use to persuade patients of the benefits of vaccination is often not shared by the patients.

However, all is not lost. As I described in an article in your journal,[2] the way forward is to identify the patient's explanatory perspective and, having identified it, to respond within that perspective. This is a technique that every successful salesman has learnt and which I make no claim to have invented. In the case of immunisation, many of the papers quoted in that article come from the World Health Organization 'Sociology and Immunisation Project', which has sponsored relevant research all over the world.

Much has been written and well written about immunisation since,[3] but I do not think that this basic point has been superseded.

Gervase Vernon,

Retired GP, John Tasker House Surgery, Dunmow, Essex. Email: gvernon@nhs.net

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GP trainers should learn how to provide primary care in community settings

I agree with Zou and colleagues[1] that challenges concerning the quality of training remain, mainly because most GP trainers in China are practising in hospitals and lack expertise in managing patients in community settings. But, for the same reason, the development and implementation of community-based training programmes for GP trainers, as Zou *et al* suggest, may be difficult to realise on a large scale.

Under the hierarchical medical system initiated in 2015, China's GPs and specialists in hospitals are encouraged to practise in community health centres, aiming to establish a stable cooperative relationship of technical assistance.[2] It could be an opportunity for GP trainers to learn how to provide primary care in community settings. However, they seldom interact with primary care practitioners because of the limited duration of practice and the unawareness of improving their teaching competence regarding primary care in community settings.

Measures should be taken to promote interactions between GP trainers and primary care practitioners. Some recommendations may be worth considering. First, GP trainers should be treated as equals when they practise in the community. It is essential for managers and GP trainers to recognise the importance of learning from primary care practitioners. Second, the duration of GP trainers practising in community settings could be extended to increase continuity. For example, for a GP trainer who practises in the community for a half-day per week, it could be arranged for them to practise for 1 month per year. Third, opportunities for collaborative work could be created to help GP trainers be more familiar with managing community-dwelling patients in daily practice. They could become a member of the team led by GPs in the community to provide primary care, such as vaccinations and home visits. Finally, GP trainers could be encouraged to train GP residents in cooperation with GPs in the community. The effectiveness and limitations of their teaching method can appear more obviously in this approach, which may improve the quality of training in the long term.

Zhijie Xu,

GP, Department of General Practice, Sir Run Run Shaw Hospital, Zhejiang University School of Medicine, Hangzhou. Email: zhijiexu@zju.edu.cn

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