access to primary care services in scotland
About the Scottish Consumer Council

The Scottish Consumer Council (SCC) was set up by government in 1975. Our purpose is to promote the interests of Scottish consumers, with particular regard to those people who experience disadvantage in society. While producers of goods and services are usually well-organised and articulate when protecting their own interests, individual consumers very often are not. The people whose interest we represent are consumers of all kinds: they may be patients, tenants, parents, solicitors’ clients, public transport users, or simply shoppers in a supermarket.

Consumers benefit from efficient and effective services in the public and private sector. Service-providers benefit from discriminating consumers. A balanced partnership between the two is essential and the SCC seeks to develop this partnership by:

- carrying out research into consumer issues and concerns;
- informing key policy and decision-makers about consumer concerns and issues;
- influencing key policy and decision-making processes;
- informing and raising awareness among consumers.

The SCC is part of the National Consumer Council (NCC) and is sponsored by the Department of Trade and Industry. The SCC’s Chairman and Council members are appointed by the Secretary of State for Trade and Industry in consultation with the Secretary of State for Scotland. Future appointments will be in consultation with the First Minister. Martyn Evans, the SCC’s Director, leads the staff team.

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The SCC assesses the consumer perspective in any situation by analysing the position of consumers against a set of consumer principles.

These are:

ACCESS
Can consumers actually get the goods or services they need or want?

CHOICE
Can consumers affect the way the goods and services are provided through their own choice?

INFORMATION
Do consumers have the information they need, presented in the way they want, to make informed choices?

REDRESS
If something goes wrong, can it be put right?

SAFETY
Are standards as high as they can reasonably be?

FAIRNESS
Are consumers subject to arbitrary discrimination for reasons unconnected with their characteristics as consumers?

REPRESENTATION
If consumers cannot affect what is provided through their own choices, are there other effective means for their views to be represented?

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Chairman’s preface

Primary care is at the heart of our health service. It is patients’ first port of call when they need information, advice or treatment. This report looks at the experience of the Scottish population. How easy is it to get the help people need when they become ill, or when they are worried about their own health, or the health of those they care for? What are the things that make it difficult to find a dentist, or to get advice from a GP? Are people happy to receive advice from nurses and pharmacists rather than from GPs? These are the kind of questions which this research tries to answer. They are important questions because if it is hard to access this service there may be serious consequences for people’s health and wellbeing.

Access is a key consumer principle: it does not matter how good a service is if those who need it are unable to access it. This report shows that there are many factors which affect how easy or difficult people find it to get the services they need: they may be related to where services are provided, how they are provided or when they are provided. The research on which this summary report is based explored the experience of over 250 people across Scotland: people of all ages and from all walks of life; people with disabilities; members of ethnic minority groups; travelling people; carers; gay people and lesbians; and homeless people. It also draws on the views of service providers in the primary healthcare field, and on the published literature.

The report shows that while particular groups have specific needs and experiences, there are nonetheless many shared experiences and views about how access could be improved.

The SCC is delighted to have been able to undertake this research on behalf of the Scottish Executive Department of Health. We look forward to seeing how this important issue is tackled in the coming months and years, and believe that this research will provide a useful evidence base on which to develop public policy.

Graeme Millar
CHAIRMAN
Acknowledgements

The extensive research on which this summary report is based was carried out for the Scottish Consumer Council by various researchers and organisations. The majority of focus groups with members of the public were facilitated and analysed by Carole Millar, Carole Millar Research; Yvonne Bostock, Bostock Consulting; Clare Wade, Clare Wade Research; and Aine Kennedy, Celtic Health Connections. In addition a team of people assisted with the facilitation of focus groups with particular needs, mostly in relation to language needs (ethnic minority languages and British Sign Language), and the SCC is particularly grateful for the advice and assistance provided by Dr Rafik Gardee, Glasgow Primary Care Trust, the Meridian Centre for Black and Ethnic Minority Women in Glasgow, and the staff at the Napiershall Street Centre. The Mental Health Foundation provided advice on exploring the experiences of people with mental health problems, and the Nuffield Centre for Community Care at the University of Glasgow shared the findings of focus groups with people with learning disabilities. Several voluntary sector organisations assisted with the recruitment of groups. These included Glasgow Gay Lesbian Bisexual and Transgender Centre; Glasgow Women’s Library; Save the Children (Edinburgh); Glasgow and West Society for the Blind; St Ninians Centre, Glasgow; Arthritis Care; Deaf Connections; The Princess Royal Trust for Carers (Anniesland); and CSV Health Action Project.

The focus groups with service providers were facilitated and analysed by Yvonne Bostock. The Scottish Development Centre for Mental Health carried out a short literature review to identify the key areas of concern for those with mental health problems. The literature review, and the surveys of opening hours and examples of practice were carried out by the SCC, principally Liz Macdonald, Policy Manager, and Susan Browne, Researcher.

The work was overseen by a large advisory group, which is listed in Appendix 2. The SCC is grateful for the many constructive suggestions and comments made by members of the group.
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Appendix 1
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1 Introduction

The Scottish Consumer Council was commissioned by the Department of Health at the Scottish Executive to carry out research into access to primary care services in Scotland. The Department of Health sought evidence of the experiences of patients and potential patients in Scotland in getting the services they needed, and the ways in which different groups of people would like to see access to services improved. The research also explored the existing pattern of access to primary care services in Scotland, and has looked for evidence of the ways in which primary care providers are attempting to extend and improve access.

Primary care services are defined as services provided by doctors, nurses, dentists, pharmacists and opticians to which people can refer themselves. Other services such as family planning and genito-urinary medicine (GUM) clinics to which people can self-refer were also included, as was the role of accident and emergency services and out-of-hours services. Some services, such as physiotherapy and chiropody, which have traditionally only been accessible through a GP, were also included, so as to find out to what extent patients in Scotland are now able to refer themselves to such services.

The aim of the research was to provide a strong evidence base for a more coherent strategy on flexible access to primary care, both in relation to existing practice, and in relation to the needs and preferences of service users and potential service users in Scotland.

1.1 Methods

A phased approach was used, commencing with a literature review to identify some of the key themes, and the areas in which there was already evidence about access to services. The literature review helped to focus the research, in terms not only of who to hold groups with, but also what the key questions were. The literature review was, of necessity, not comprehensive, or in depth, but rather a preliminary stage in the research. Many of the groups and areas covered warrant substantial research in their own right. A review of the literature on access to primary care services for those with mental health problems was commissioned from the Scottish Development Centre for Mental Health, and this is available as a separate report.

The second, and major, phase examined the experiences of members of the public in accessing primary care services and the barriers to access. This phase also examined views about how access could be improved. Focus groups were held, with the general population grouped according to age, gender, location and social class, and with groups which were perceived to have special needs, including travelling people, people from ethnic minorities, disabled people and carers. Details of the focus groups are provided in Appendix 1. The work with focus groups covered the entire spectrum of primary care, and participants had an opportunity to express their views on all
aspects of primary care provision. However, the bulk of the discussion centred on doctors, and this is reflected in this report.

The third phase aimed to get a picture of the existing position in relation to access. Some basic information about existing patterns of access in different primary care trusts was obtained through the use of a short questionnaire. A more substantial task was to identify examples of existing practice in improving or extending access. This was done by contacting all primary care trusts, Local Health Care Co-operatives (LHCCs) and health boards to ask them for examples of initiatives or practices which they knew of. The examples sent in are unlikely to be a comprehensive picture of what is going on, and should be treated as examples of practice.

The final phase was to explore with service providers their views about improving access, and the barriers to more flexible or better access. Three focus groups with primary care providers were held in three LHCC areas. One LHCC was in a rural area, one in a relatively deprived post-industrial area, and the third in a city LHCC with pockets of deprivation.

This final summary report draws together the various strands in the research to reach some general conclusions and to make recommendations about how access to primary care services might be improved. The sources for this report are

- the literature review
- the findings of focus groups held with members of the public
- the discussions with service providers
- the information about existing patterns of access and examples of good practice throughout Scotland.

The reports of all these different elements in the research are available as separate reports on the SCC website (www.scotconsumer.org.uk).

1.2 Advisory group

The research was overseen by an advisory group which brought together professional representatives of those working in primary care with representatives from patient and carer organisations. Membership of the group is listed in Appendix 2. The research has benefited greatly from the input of members of this group, but membership of the advisory group should not be taken as endorsement of all the recommendations made in the report.
2 Background

2.1 Policy context

The provision of primary healthcare is going through a period of change, with new structures, and in relation to its position within the health service. It is important that primary care is seen in the wider context of the NHS in Scotland, and the changing policy environment.

**Designed to Care (1997)**

The government spelled out its commitment to a “seamless health service centred on primary care” in the White Paper *Designed to Care*. The introduction of primary care trusts was intended to create a “robust organisational structure” to support primary care and to enable it to realise its potential. One of the roles of the primary care trusts is described as

‘To address inequalities in health provision and support the development of local initiatives which address local health needs.’

The creation of local healthcare co-operatives (LHCCs) represents a move towards more integrated care services within distinct communities. They hold the potential to encourage more intersectoral working between health and other services, as well as between health professionals.

**Achieving better services for patients (1999)**

In April 1999, the NHS Management Executive issued a letter to health boards and trusts outlining the various policy components which formed part of the thrust towards making the health service more patient-focused, with greater levels of patient and public involvement. One of the issues highlighted in the letter is the importance of ensuring that local NHS services are meeting the needs of ethnic minority groups, including

‘Improving the access and experience of minority ethnic people in relation to primary care.’

**Priorities and Planning Guidance for 1999/2002**

For the NHS in Scotland, the *Priorities and Planning Guidance for 1999/2002*, issued in September 1998, gave fresh focus to its work. The Guidance re-emphasises that the prime aim of the NHS is to improve health, underlines the strategic imperative of tackling inequalities, and stresses the vital importance of securing the health of our children and young people.

**Towards a Healthier Scotland (1999)**

The White Paper on public health *Towards a Healthier Scotland* emphasised the importance of inclusive approaches to health promotion recognising that different
settings of daily life – schools, workplaces, GP surgeries, leisure centres – are important sources of information and motivation. In communities where health is generally poor, health agencies must work alongside local community organisations.

All parts of the NHS are expected to contribute to this agenda.

‘Primary care services have a key role in health improvement, the potential of which will be enhanced by the advent of Primary Care Trusts (PCTs) on 1 April, 1999. This change, coupled with the new working arrangements that are flowing from the White Paper, Designed to Care, will foster an environment in which staff from different disciplines can work together in the community to improve health and reduce health inequalities. With their combined local knowledge, skills and resources, PCTs with their local healthcare co-operatives and individual practices will be powerful agents for change in areas such as service delivery, screening, immunisation and health promotion.’

A Lottery-financed network of healthy living centres with the aim of improving health and wellbeing, with particular reference to those with the worst health living in deprived communities, are in the process of being set up. The projects will address wider social, economic and environmental influences on health.

The government also recognises that the concept of the health-promoting school can help to ensure not only that health education is integral to the curriculum but also that school ethos, policies, services and extra-curricular activities foster mental, physical and social wellbeing and healthy development. The concept is central to the New Community Schools initiative.

**Acute Services Review (1998)**

This review of acute service provision in Scotland saw a major continuing role for GP community hospitals in providing local access to services, particularly (although not exclusively) in remote and rural areas. It encouraged the removal of barriers at the interface between primary and secondary care and saw managed clinical networks as promoting new and effective ways of working, with extension of traditional staff roles, multiskilling and multidisciplinary working. It saw the extension of integration as a highly desirable long-term objective and looked to the constructive use of joint investment funds as a means of developing further intersector collaboration. It promoted the concept of intermediate specialists as a means of increasing consultant involvement in primary care and/or the development of special skills and expertise on the part of general practitioners.

**Social inclusion**

The Social Inclusion Strategy has been developed through the Scottish Social Inclusion Network, a wide-ranging group including government officials, representatives of key organisations including CoSLA, Scottish Homes, the Scottish Council for Voluntary Organisations and the Poverty Alliance, and individuals with direct, personal experience of tackling exclusion, including community representatives. The report *Social Inclusion:*
Opening the door to a better Scotland sets out the government’s programme to promote social inclusion in Scotland, and the principles behind that programme. It is intended to inform both practitioners currently engaged in promoting social inclusion at a local level, and policy makers at national level.

**Modernising government**
The Modernising Government White Paper, published in March 1999, included a commitment that public services would be made available to suit the needs and convenience of the citizen rather than the service provider.

**Disability Discrimination Act 1995**
The Act makes it unlawful for service providers to treat disabled people less favourably than they would treat other people, for a reason related to their disability, when offering or providing goods, facilities, or services. This clearly applies to health service providers, and extends not only to the physical accessibility of premises, but also to how information is produced and how communication is used.

**Race Relations (Amendment) Act 2000**
This legislation strengthens the Race Relations Act 1976, and makes it unlawful for any public body to discriminate in the service it provides. It also places a statutory duty on all public bodies to promote race equality.

Section 4, *Improving the patient’s journey*, is particularly relevant to access to health services, with its core aims of achieving better, fairer access to services; increasing flexibility; reducing waiting and improving the patient’s journey of care; improving communications and breaking down barriers; and making best use of all skills and resources. The plan was published after this research started, but many of its themes chime with what is covered in the research. The plan says

‘Extending access, reducing waiting and improving the way the NHS responds to the needs of patients must be a key priority for every part of the NHS.’

**2.2 What do we mean by access?**

This report follows the definition of access suggested by Hulka, which splits it into three elements: accessibility, availability and acceptability. Each of these three elements has a section in this report (sections 3–5). Each section is then subdivided into various aspects, based on the experiences of members of the public reported in the focus groups, and each is addressed. Under each heading the findings of the various parts of the research, particularly the literature review and the focus group findings, are included, as well as a brief consideration of the potential impact of policy proposals and illustrative examples of the ways in which the problems are being addressed throughout Scotland. The views of service providers are also reported.
Supply and demand
The various factors which affect access can be divided into those which are characteristic of supply, and those which are characteristic of demand. The supply factors include the geographical distribution; the availability of primary care staff; the range and quality of primary care facilities; levels of training, education and recruitment of primary care staff; cultural sensitivity; timing and organisation of services; and the availability of affordable and safe transport. Demand factors include people’s attitudes to being ill, knowing what services are available, financial insecurity, and lack of informal carer support.

Part of the solution to problems of access involves analysing the range of factors relating to both demand and supply, which can be affected by policy or practice, and which will result in meeting demand at an appropriate level and in an appropriate way which reduces the current blockages to satisfying demand. An attempt to conceptualise this is made in section 6 of the report, which draws together the specific recommendations made in the earlier sections.

Equity of access
Underlying the discussion of access is the question of whether there is equity of access for different groups in society. Equity was one of the founding principles of the NHS, and the Acheson Report in 1998 inquired into the state of inequalities in health in the UK. The principle of equity includes ensuring that

- healthcare services serving disadvantaged populations are not of poorer quality or less acceptable;
- the allocations and application of resources are in relation to need; and
- positive efforts are made to achieve greater uptake and use of effective services by making extra efforts to reach those whose health is worst.

This principle is still at the heart of the NHS in Scotland, and the research aims to show how far that is a reality.

Access and quality
Research has shown that the top priorities for patients in their dealings with general practice were having enough time in a consultation, being able to get an appointment easily, getting a quick service in an emergency and having a GP who listens. This presents an immediate tension, as longer consultation times are likely to reduce the number of consultations available, although it may reduce the need for follow-up appointments, which can be an important determinant of workload. In other countries, market forces and patient preference have led to longer consultation times.

It also raises the question of the relationship between access to services and the quality of services. While these may appear to be distinct issues, they are difficult to keep separate. Simple access to a service which completely fails to meet the needs of the service user is of no value.
2.3 Context of this research

Service provider representatives on the steering group were keen that we should present this research in the context of high satisfaction levels with GP services, reported in different surveys. For example, a survey undertaken using the People’s Panel set up by the Service First Unit (the replacement for the Citizen’s Charter Unit) in September 2000 found a 90% satisfaction level with GPs, higher than any other public service.

Looking more specifically at access, a survey carried out by MORI in 1991 suggested that the public perceived general practice in the UK to be accessible. In contrast, the national survey of NHS patients in 1998, which focused on general practice, showed that a fifth of people in work had been put off going to their GP at least once in the last twelve months because of inconvenient surgery hours. Research in March 2000, again using the People’s Panel, showed that three in five wanted to be able to see their GP outside normal office hours. Few people, however, thought that services should be available 24 hours a day, seven days a week. Around a third would like extended weekday opening of their GP practice, while 25% would like extended Saturday opening.

The recent MORI poll commissioned in the lead-up to the health plan Our National Health found that 44% of those asked thought it should be easier to get a GP appointment, while 32% of those visiting their GP surgery said they wanted more time with their doctor or nurse.

2.4 General comment on research findings

This report indicates a wide range of experience and attitudes towards the primary care system. Most of the discussion in the focus groups concentrated on GPs. This indicates that it is the GP who is seen as the key provider in this area, and that it is the care provided by the GP which is seen as central to primary care. Much less time was spent discussing other aspects of primary care, and the report reflects this. However, the kind of recommendations which flow from the research apply to primary care generally, and not just to doctors.

Some individuals had a particularly good relationship with their doctor, and did not mind if they had to wait to see them. There were some who felt reasonably happy that they would be able to access appropriate care within an acceptable timescale. There were, however, fairly significant numbers who expressed dissatisfaction with the length of time they had to wait to see a doctor, and who had criticisms of the process of accessing that care. At the extreme, there were people whose experiences appeared significantly to affect their ability to access care at all. The scale of the difficulties in accessing primary care does appear considerably greater amongst the groups which we highlighted in the literature review as being more likely to be excluded from services.
Deaf people, homeless people, those with mental health problems, people with learning disabilities, and some ethnic minority groups experience particular difficulty in accessing services which meet their needs.

Within the general population there was a tendency on the part of older people to refer to changes in the system as becoming more impersonal and centralised, and referring to the “good old days” of the family GP who would come out at any hour of day or night. There was, however, also a degree of realism about the pressures which the present-day primary care services are under, and many people showed either an acceptance of the system, or a fairly astute understanding of how to make the system work.

In addition, respondents suggested that the system was burdened by a general decline in the nation’s health through poor eating and lack of exercise; the dependency culture; an increased awareness of risk, for example of meningitis, and a resulting need for reassurance; social deprivation leading to worse mental and physical health; the increasing elderly population; higher expectations and time-wasters.

Understanding of “primary care”

Finally, it is worth pointing out the very low recognition or understanding of the term “primary care”. While some members of the focus groups had a rough idea of what was meant by this term, the vast majority of those we spoke to had little idea of what was meant by it. The Scottish Executive should be aware of this in any public information or education campaigns which relate to the use of primary care services.

2.5 Format of report

The following three sections of the report deal with different aspects of accessibility: accessibility, availability and acceptability. Under each subheading, the findings of the various parts of the research are summarised: the literature, the focus group findings, service providers’ views, suggestions for ways in which improvements to access could be made, and examples of policy proposals and examples of practice which are relevant. Where a particular subheading is missing, this indicates that there is little or no evidence from this source. Examples of practice, where there is some evidence available, are presented in a shaded box to highlight them, and differentiate them from more generalised comment.

For ease of reading, references to literature have been omitted in this report. References are available in the report of the literature review.
3 Accessibility

Various factors can make services inaccessible. These include:

- Geography and location
- Transport
- Physical barriers
- Absence of respite or childcare
- Not being registered
- Difficulties with phone systems
- Lack of knowledge or awareness of services
- Cost

Each of these factors is discussed below.

3.1 Geography and location

This section deals primarily with situations where there is an absence of services locally, while the following section deals with the closely related situation where there are difficulties in accessing services as a result of lack of transport.

**Literature**

Evidence has shown that the further you are from a general practice surgery the less likely you are to consult. A study in Scotland has shown higher mortality rates from asthma in more rural areas. In addition there may be restricted choice in rural areas, for example when young people are seeking advice about contraception.

Distance from services also affects the cost, both the cost of travel and costs associated with the time spent travelling, for example loss of paid work and childcare costs (see section 3.8). Public transport also tends to be poorer in rural areas (see section 3.2).

**Focus group findings**

We held four focus groups in rural/small town situations, and one in a remote community. These groups were relatively satisfied with the services available to them, although some of the older people would like to return to a time when they had a closer relationship with their family doctor. In the remote area, travel was accepted as part of rural living and few people saw this as a major disadvantage. Despite the distances involved there were few complaints. Home visits appeared to be more common in the remote area, with follow-up visits a few days later being reported. In the rural areas there were more concerns expressed about the out-of-hours service than in other parts of Scotland.

Most people felt that pharmacists were available in most locations.
Providers’ views
In one area, responding to demand was made more difficult because patients were scattered over a large geographic area. As a result practices tended to zone their calls which meant that for house calls some patients would not get the doctor of their choice. This was also a problem in terms of time and cost for health visitors.

Towards solutions
The kind of solutions to problems of access which have been tried in various parts of the UK include the use of branch surgeries and mobile provision. Such surgeries can improve access, especially for elderly people, women, those on a low income and those without a car. Mobile screening services and baby clinics have also been effective in increasing access.

There was very little discussion about mobile clinics at the focus groups, possibly because people did not have experience of them, but where there was, the reaction was mainly negative, even in rural areas in which they might have been seen to be beneficial. They were seen to be useful for traditional purposes such as breast screening or giving blood, rather than for consultations. Participants said that they would not like having a doctor that they did not know, while the travelling people said that they wouldn’t know where to go to access a mobile clinic. The Cantonese-speaking groups were more in favour of this sort of service.

Examples of policy proposals

• The development of community planning and local health plans by the new NHS boards could play a role in identifying areas in which there is an absence of services, though there will be limited power to relocate services, given the autonomy enjoyed by doctors and dentists.

• The Acute Services Review devoted a chapter of its final report to services for remote communities, covering both acute and primary care services, urging the need for greater integration between the two, and highlighting the particular difficulties of delivering care in remote and rural areas. Falling applications for rural practice vacancies, particularly single-handed practices, poses a serious threat. Telemedicine was proposed as one potential solution to remote access, as was the use of community care and primary care resource centres as a rural form of ambulatory care centre. Video conferencing is being used in Unst and Yell to improve access to services in those remote island settings.

• In October 2000 the Health Minister announced the first allocations from Remote and Rural Areas Resource Initiative (RURARI), worth £1.2 million. The initiative aims to address the training, recruitment and retention of NHS staff, as well as improving access. Over three years £6 million will be put into this initiative.
• The **Personal Medical Services** initiative is relevant in this area, as a means of employing staff in remote locations where there is difficulty in recruiting or retaining staff.

• Similarly, the **Dental Access Initiative** can be used to provide for salaried dentists in areas where there is no access to NHS dentistry, and this has been used in Lochaber, Wick, Thurso and Arisaig.

### 3.2 Transport

Transport is most likely to constitute a barrier to services for older people, women, people on a lower income, and those with young children.

**Literature**

Research with people with learning disabilities has shown that they have problems with transport as well as with accessibility of surgeries. Research into one out-of-hours service in Scotland found that almost one fifth of respondents experienced some difficulty in attending the emergency out-of-hours centre, and of these, almost half had difficulty with transport. The research also showed that those living in more deprived communities were four times more likely to use a taxi than those living in more affluent areas, thereby increasing the cost of accessing care.

**Focus group findings**

The focus groups held with the general population did not on the whole raise concerns about travel to the surgery, although in the more rural groups there was less public transport, and greater difficulty in arranging appointment times to fit in with bus timetables, particularly in places which had lost a local surgery. In general, transport was more of a problem for older people and for the parents of young children who did not have their own car. Those with physical disabilities and their carers were also more likely to have difficulties in getting to the health centre to access the GP and other services. As a consequence health professionals often go out to their homes. One homeless single mother said that it was impossible for her to attend an out-of-hours centre when she had another child to look after and no transport.

**Towards solutions**

Various initiatives aim to tackle the transport problem for primary care service users. These include the use of a telemedicine link between Letham in Angus, and the Forfar practice. In several areas, volunteers are used in transport schemes. Clydebank Health Centre runs a service with funding from Volunteer Development Scotland, and a larger scale project in Highland uses volunteers and a vehicle leased from the primary care trust. In some places there are pharmacy projects which deliver medication to housebound older people.
Volunteering
This is an area in which the development of the use of volunteers might be particularly useful. Volunteer Development Scotland has a primary care volunteering grants fund which supports a range of projects. In addition to transport, these include elements of health promotion, for example through a health information point, childcare, crèche facilities, and signposting to local voluntary organisations. Many of these grants are being used on an LHCC basis.

Another way of improving transport, particularly to out-of-hours services, may be to move towards more consistency between out-of-hours services.

3.3 Physical accessibility

Our survey of primary care trusts suggested that there was a fairly high percentage of GP practices which were considered by the respondents to be accessible to people with mobility problems. The lowest percentage given was just over 70% in Orkney, while several PCTs said that all the premises in their area were accessible. This seems likely to be an exaggeration, as, when disability audits of premises are carried out, a wide range of factors tend to be uncovered, well beyond the recognisable aspects such as the availability of ramps or wide doors.

The figures for dental practices were lower, with only four trusts claiming that all their dental practices were accessible. Other trusts ranged from estimates of 38% to 82%, with eleven saying that more than half of their premises were accessible.

Focus group findings
While there were some problems in accessing doctors’ surgeries, these tended to be greater in respect of dentists’ surgeries, which are often up stairs. Barriers can be caused by the location or physical layout of the surgery, which may be compounded by impairments experienced by older people or people with disabilities: for a practice to be accessible, it must be close to public transport, have car parking available and have few steps and ideally a ramp for wheelchair users.

Physically disabled people described a range of problems associated with getting into the surgery and getting to a doctor’s surgery, including physical barriers which prevented or made access difficult with a wheelchair: for example, steps at the entrance, double doors, and ribbed flooring. The problem of physical access is a factor which puts them off going to the doctor. One disabled woman said there was no wheelchair available at the surgery for her to get down the corridor to the doctor’s office.

Access was a problem in one rural area because the practice was on a busy narrow road. This, however, was being addressed with the building of a new health centre.
Travelling people said that barriers put up to try to control the number of travellers using an unofficial site could affect the ability of doctors or health visitors to get to them.

**Towards solutions**
The Disability Discrimination Act 1995 makes it unlawful for service providers to treat disabled people less favourably than they would treat other people, for a reason related to their disability, when offering or providing goods, facilities, or services. This clearly applies to health service providers, and extends not only to the physical accessibility of premises, but also to how information is produced and how communication is used. In relation to their premises, primary care providers are under an obligation to take reasonable steps to make their premises accessible.

**Examples of practice**
We received information about disability audits being carried out in two LHCCs.

Drumchapel Health Focus is a community consultation project being carried out on behalf of Drumchapel LHCC. One issue which emerged in the consultation was the significant physical barriers to access in the health centre. Three members of a local disability organisation, two of whom were wheelchair users, were invited to carry out an audit of the premises. The audit revealed a range of problems including serious concerns about fire safety, a lack of signposting for visually impaired people, and heavy double doors. The report concludes “If the health centre remains a hostile environment for disabled people and continually deters patients from seeking advice and treatment then this can only have a negative impact on their health and well being”.

It seems clear that primary care providers must address the issue of physical accessibility, although many primary care trusts did tell us that many of their premises are already accessible.

**Recommendations**

*Primary care trusts and LHCCs should raise awareness of the implications of the requirements of the Disability Discrimination Act 1995.*

*Primary care trusts and LHCCs should encourage disability audits of all their premises which should, wherever possible, involve local disability organisations.*
3.4 Lack of respite or childcare

*Focus group findings*

The carers we spoke to tend not to go to the doctor for themselves because they have to stay at home with the person they care for. An additional concern was that they did not want the doctor to think that there was something wrong with them, in case the doctor thought that this would affect their caring role. The consequences of being ill might be that the person cared for had to go into a home. There was a strong feeling that there was nobody to care for the carer in these circumstances, and many struggled to continue in their caring role.

They felt that a sitter service, or other form of respite, would allow them to get out and get an appointment for themselves. They would also like to see some back-up help if they themselves did get ill and had difficulties in continuing with their caring role.

*Towards solutions*

This is another area in which volunteering has a role, and there is at least one example of the provision of a “granny service” for young parents, and play services at several practices in Dundee.

The Scottish Executive has a Strategy for Carers which was introduced in November 1999, and is currently consulting on proposed carers’ legislation, which could affect the availability of respite care.

3.5 Not being registered, or being without a permanent address

*Literature*

People who are less likely to be registered include travelling people and homeless people, who do not have a permanent address. Both these groups are at risk of poor health, and lack of access to services is particularly serious. Research has shown that homeless people are not well received by health service providers; that they find it hard to register or re-register with a GP; that negative self-images deter homeless people from seeking services; and that such services as are available are often undermined by poor living conditions.

Travellers are at risk of suffering poor general health and conditions linked to poor sanitation. They may be unable or unwilling to register with a GP and receive little health education or family planning advice. While a recent survey showed a large majority of female travellers were registered, over a quarter had been refused registration at least once. Health professionals have also reported that travellers had been refused registration at GP practices.

There is also evidence in the literature that people with learning disabilities find it hard to register with a doctor.
People who are not registered as dental patients may experience particular difficulties in obtaining out-of-hours emergency care. A recent phone survey of UK health authorities found that there were no formal out-of-hours dental care arrangements for as many as five million unregistered people at weekends, and nineteen million on weekday nights. Research has shown a particularly low level of registration for dental services amongst lower socio-economic groups in the most deprived areas, with half of unregistered people living in deprived areas.

**Focus group findings**
The difficulties identified in the focus groups appeared to involve either a perception of discrimination against certain groups, including travelling people and people with learning disabilities, or practical difficulties for people who did not have a fixed address, in particular travellers and homeless people. There was an additional limitation of choice for those who wanted to be able to register with a doctor who was in sympathy with their culture or lifestyle. This was a problem for some people from ethnic minority groups and for some gay people.

**Towards solutions**
Suggested solutions to these problems include practical changes, such as allowing travelling people to carry their own health records, and to have access to walk-in clinics, without being registered, as well as specialist services targeted at this group. The research also suggests the need for equality awareness training, in relation to race, disability and sexuality.

Most commentators agree that the best way to deliver healthcare to travellers is through health visitors, and through improved interagency working.

Pharmacists may play a particularly important role in relation to mobile populations who are not registered with a GP, as well as for visitors. Pharmacists have argued that they have a better ethnic mix than GPs and so are more able to provide a service to people from ethnic minorities.

**Policy initiatives**
Relevant policy initiatives in this area include the Rough Sleepers Initiative and Social Inclusion.

At the end of 2000 it was announced that the Scottish Executive would appoint a health and homelessness co-ordinator. The post, which is for three years, is intended to support primary care trusts and health boards in dealing with the health needs and problems of Scotland’s homeless population.

**Examples of practice**
There are several initiatives across Scotland which encourage access for those who are not registered. Hand-held records are being used in initiatives in Dumfries and
Galloway and Forth Valley, while a Primary Care Outreach Service for travelling people in Highland operates through an open-access clinic at which travellers are encouraged to register for services.

The Edinburgh Homeless Practice provides GP and nursing services to patients, as well as co-ordinating provision with other agencies (social work, housing and resettlement are housed in the same building). The aims of the Edinburgh Homeless Practice also include facilitating patients’ transition into mainstream primary care services, participating in joint working arrangements with other agencies, and developing the scope of nursing practice and advanced nursing, including prescribing and triage. The initiative provides data on health and healthcare needs of homeless people in Edinburgh.

Many of the projects are fairly new and information on outcomes and evaluation is only available from two initiatives. A Personal Medical Services (PMS) pilot in Dundee seeks to provide a full medical service to homeless substance abusers. The pilot was evaluated after two years and it was found that the patients felt they could obtain medical treatment from one practice.

Two Glasgow-based projects working with asylum seekers have experienced a shortage of interpreters which they cite as their main problem. The Glasgow project, Services to Asylum Seekers, based in Pollokshaws and Thornliebank, aims to register asylum seekers with GPs and have their health needs assessed by a health worker. Managing Asylum Seekers, based in Westone LHCC practices are finding a high incidence of mental health problems amongst asylum seekers.

Sources of funding for the initiatives are varied and include the Scottish Executive, primary care trusts, Primary Care Development Fund, local development schemes and General Medical Services income.

**Recommendations**

The training of primary care staff should include equality awareness training covering disability, gender, race, and sexual orientation. Training should cover the particular needs of asylum seekers and refugees.

The Scottish Executive should consider how to promote the greater use of hand-held records, and walk-in access to primary care services.
3.6 Difficulties with phone systems

The telephone has a role both as a common route for accessing primary care services, and as a method of providing advice or triage. This section deals with the former, while the latter is discussed in section 6 on ways of reducing pressures on appointment systems. If the phone is an important first point of access then difficulties in using the phone can constitute a major barrier to accessing services.

Literature
Research has found resistance to the use of phones amongst ethnic minority groups and refugees, a factor which also contributes to lower rates of satisfaction with the out-of-hours service. Deaf people are also recognised to have particular difficulties in relation to using phones and the lack of text phones.

Focus group findings
Most patients make contact with the doctor’s surgery by phone to make an appointment. Some people in ethnic minority groups tended to make contact in person because of language difficulties, and most of the deaf group would make contact in person because of the difficulties in using the phone, although others will use the Typetalk service. Only one deaf participant reported his/her health centre as having a minicom. Where there was a minicom, it was often not switched on, or there was no-one who knew how to use it. Sometimes they are left in answering machine mode. The deaf group felt that a health centre of any size should have a minicom, while other means of making contact, such as fax or email, could be useful.

Some respondents had concerns about the way phone systems worked, for example being put on hold for long periods which was not only time-consuming, but also costly. The phone line being engaged was a particular problem for those with hearing impairments. This was particularly annoying if they were using the Typetalk service, which had to be booked in advance. They did not like having to talk to the doctor’s practice through a third party and saw the process as being time-wasting. The system also requires the surgery to subscribe to Typetalk which was a deterrent.

Some ethnic minority participants did not like automated phone systems which could be expensive to use, and respondents who had had bad experiences said that they would never make an appointment by phone, preferring to speak face-to-face with the receptionist. This was also the view of the majority of respondents in the inner city area, who felt intimidated on the phone.

Since much of the out-of-hours service is dependent on the use of the telephone, this makes it a difficult service for deaf people to use. They felt that there was a lack of awareness of deaf people by the out-of-hours service. They also commented that the telephone number for the out-of-hours service is not accessible and is not available in the surgery. They felt that they should be provided with information about what to
do in the event of needing a doctor out of hours. The service should also have a direct minicom or text number so that there is no need for Typetalk.

Recommendations

There should be a minicom available in all primary care settings, including out-of-hours services, with staff trained in how to use them.

Automated phone systems should be reviewed to take account of the experiences of patients in using them.

The use of plain English in automated systems should be promoted.

3.7 Lack of knowledge and awareness

Focus group findings
Before people can use a service they need to know that it exists, and have an awareness of the range of services which are provided. They also need to know that they are in need of services. The general population did not express a demand for more information about health services, but some of the ethnic minority groups, as well as the deaf and visually-impaired groups, would appreciate access to better information about services in an accessible format. There was also evidence of a lack of understanding of how the out-of-hours system operates and this is one area in which more effective information could be beneficial. People who have not been in the UK for long, particularly refugees, would benefit from clear information packs about how the health service works and what services are available.

There was evidence from the focus groups that some people had difficulty in using the sources of information which were available. It goes without saying that information needs to be presented in a format in which people can use it, for example on video with BSL for deaf people, in large print or on audiotape for those with a visual impairment, or in ethnic minority languages.

There was evidence of a lack of awareness of what to do in an emergency situation, both in relation to medical and dental care, particularly amongst ethnic minority groups.

Some groups particularly sought information about services outside the health service, for example information about support services for people with mental health problems. Sometimes patients fail to identify the person who is best able to help them. It has been suggested that people with mental health problems may not always recognise that primary care can provide them with help.

People with learning difficulties have an additional problem of knowing when they should go to see a health professional, and may be dependent on someone else
identifying this. The primary care system is triggered by the patient, and a person with learning disabilities may lack the confidence or knowledge to initiate contact.

Towards solutions
Information has a role to play in educating people about how to use services effectively, for example by seeking help from alternatives to the GP. This will be discussed further in section 4.1 below, in the context of reducing the pressure on appointment systems.

The Patients’ Project is one policy initiative which will focus on information, and this has the potential to improve awareness of services.

At an individual level, the use of advocates or patient support workers can also assist patients who lack confidence about using health services.

Practice examples
One LHCC has produced a map of local health and community services which is to be delivered to every home in the LHCC area, and will be available in minority languages.

Patient support and advocacy is also being developed and used in various places.

People from three deprived areas in Edinburgh (Stenhouse, Broomhouse and Wester Hailes) have a patient support/individual advocacy support worker available to them. This worker provides advocacy for individuals to overcome difficulties in interaction with the NHS. Whinpark Medical Centre/Wester Hailes Health Centre in Edinburgh employs patient attendance support workers. These workers provide assertive support by contacting people with reminders and information (including travel information). The pilot has been funded by the primary care trust.

Recommendations

All primary care providers should review the accessibility of all the information they provide, to ensure that disadvantaged groups have access to appropriate information.

Information available for those who are recent arrivals in the UK, particularly refugees and asylum seekers should be reviewed to ensure that it meets the needs of those people. The possibility of a core information pack being produced by NHSScotland should be explored, and primary care trusts should support local service providers in providing local information in appropriate languages.
Out-of-hours services should review the information they provide to ensure that it is accessible to all those served by the service.

3.8 Cost

**Literature**
Costs associated with accessing primary care include the cost of phone calls, transport, prescriptions, any costs associated with child or respite care, and the cost of the treatment itself. Centralised out-of-hours services may cost more to access, particularly for those without their own car, who may have to use taxis. Cost is one of the three main barriers to accessing dental care, the other two being difficulty in finding and registering with an NHS dentist, and lack of information about dental services.

**Focus group findings**
This was supported in our focus groups, where cost was given as one reason for non-attendance at dentists, and for postponement of treatment, and there were concerns about equity, and the level of contribution towards NHS treatment. There was also concern about lack of information about costs, as well as confusion about the differences between private and NHS care. Cost was particularly mentioned by the ethnic minority groups.

There was some resentment expressed in focus groups about the cost of eye tests, and this, combined with the cost of spectacles, did appear to deter some people from going to the optician. This is important since the eye test can pick up serious illnesses. Groups which said the cost of both eye tests and glasses put them off going to an optician included the Chinese women, Afro-Caribbean group, homeless people and young people in a deprived area, even though some were aware that they might qualify for free eye tests. One respondent felt that the costs of accessing optical care meant that he was ‘discriminated against’ when other people with other kinds of disability or illness had access to free treatment.

The cost of using pharmacists as an alternative to GPs was mentioned by homeless people as they may not be able to afford the treatment suggested by a pharmacist.

**Towards solutions**
The *Action Plan for Dental Services* in Scotland, an initiative of the Scottish Executive, has proposed, amongst other things, that the dental access schemes will be reviewed and be promoted, particularly targeting deprived areas and those rural areas where services are currently difficult to access. Proposals for the establishment of drop-in centres in the major cities and the enhanced use of mobile services will be sought, while salaried dental services will continue to be established and developed in areas where they are needed. Advice on dental problems and about access to dental services will be included in the Scottish equivalent of NHS Direct.
Pilots in two parts of Scotland into providing over-the-counter medicines without prescription may help to address the problem of cost deterring people from seeking help from the pharmacist.

Practice examples
In addition to providing dental services in the ways outlined above, there will still be scope for smaller-scale initiatives, for instance oral health promotion at baby clinics in areas where there are low rates of registration for dental services.

Recommendations

Primary care trusts should ensure that information about who qualifies for free dental treatment is widely displayed. This information should be displayed prominently in healthcare premises.

There is a need for better information about dental services, including the cost of treatment and how to access emergency dental services out of hours. This information should be available in a range of healthcare premises.
4 Availability

This section covers factors which make it difficult to gain access to the services which exist. These include:

- Appointment systems and waiting times
- Receptionists
- Opening hours
- Factors which increase demand
- The effect of the range of services available.

4.1 Appointment systems and waiting times

The difficulty of obtaining an appointment, and how long people have to wait for an appointment, is one of the areas of greatest concern in relation to accessing primary care services. The appointment system is, in practice, the way in which demand for services in primary care is managed, or rationed.

Focus group findings

Not surprisingly, this was an area which was very extensively discussed, and in which there was not a very high level of satisfaction with processes and waiting times. Average waiting times were often considerably longer than the 48 hour target towards which NHSScotland is working for getting access to a member of the primary care team. Older people, carers, and parents of young children seemed to find it easier to get an appointment quickly. Some people appeared to be adept at “playing the system”, and in knowing how to get an earlier appointment. There was a desire for appointments with a GP to be long enough to be able to communicate effectively, and comments on how unsatisfactory it could be when a patient felt pressured by lack of time.

Most people recognised and accepted that if you wanted a particular doctor, then you would have to wait longer. For some people, continuity of care was particularly important and they wanted to be able to see the same doctor. This included people with particular communication difficulties, such as deaf people and those from ethnic minorities, those with long-term medical conditions, including disabled people, and those with mental health problems.

When people could not get an appointment in circumstances which they considered urgent, there was evidence that a significant number would go to an accident and emergency department. This was particularly common amongst the ethnic minority, deaf and travelling people, and in the deprived inner city area.

Appointments were also difficult for people with chaotic lifestyles, such as homeless people or those with mental health problems, who might find it difficult to remember
or to keep an appointment. The homeless people we talked to preferred services which provided open-access clinics.

There was a general acceptance that home visits were increasingly a thing of the past, but there was also evidence that those who had not been living in the UK for long did not know that such a service was even possible. Disabled people in particular would like some way of continuing to receive some healthcare in their own homes, while travellers felt that some health professionals were scared of visiting them at home.

A particular concern in this area was about the role which receptionists play as gatekeepers to doctors. This is discussed in more detail in the following section (4.2).

Related to the way the appointment system works is the question of how long people have to wait in a waiting room for their appointment.

The focus groups showed that some surgeries had a limited period of open access. However, open surgeries inevitably involved longer waiting times, of up to two and a half hours. Where a practice had an open surgery, it was often crowded. This was also the case in specialist clinics for homeless people, which operated an open-access system, resulting in waits of up to three or four hours. The waiting rooms for these services could be quite chaotic.

People’s experience was that even when they had an appointment, there was often a long waiting time, of up to an hour, and one side effect of an appointment running behind was pressure on the consultation itself.

**Dentists**

Experience of getting appointments with dentists varied. In the deprived urban area there were often waiting times. Respondents felt that, like health centres, some dentists practised over-booking resulting in long waits. One homeless person described being given two months to wait for an appointment.

**Towards solutions**

Much of the literature on improving access addresses different ways in which appointments can be freed up from inappropriate demand in such a way that patients get services which meet their needs. This could be by promoting the idea of graduated access, by changes in the way the workforce is used, or by the use of targeted services, amongst other things. These issues are discussed further in section 6.

It also raises the question of the role of open-access clinics as opposed to the use of appointment systems. Some examples of practice have combined an open-access clinic staffed by nurses with the normal appointment system for doctors. Examples are given in section 6.2.
At one GP practice in Dumfries and Galloway, patients requesting a same-day consultation are eligible to attend the practice-based nurse triage. The initiative, funded by the PCDF, has resulted in reduced numbers of patients needing a same-day consultation with a doctor and an increase in patients seen by the practice nurse.

**Recommendations**

**Primary care providers should review, with their patients, how their appointment systems are working and what patients feel about waiting times.**

**Primary care providers should be encouraged to indicate in waiting rooms how long patients may have to wait, particularly where there is an open-access clinic.**

### 4.2 Receptionists

**Literature**

There was not a great deal of reference to receptionists in the literature reviewed, although it has been found to be an issue for the frail elderly, who found it difficult to get past the receptionist, and were unclear whether discussion with receptionists was confidential. Travelling people were also reported as finding receptionists unsympathetic.

The role which the receptionist plays in the surgery contributed to the difficulties experienced by some patients, and acted as a potential deterrent to seeking services.

**Focus group findings**

The greatest concern in this area was about the role which receptionists play as gatekeepers to doctors. There was mention in all groups, apart from the carers group, of significant problems with receptionists. Receptionists were described as being poor, impersonal, and officious, and were perceived as creating a barrier to accessing care, particularly when someone wanted a home visit. Many patients resented being asked questions about their health by the receptionist. There were also examples of receptionists being rude and insensitive to the situation of patients, for example, if they were disabled. There were, however, also references to receptionists doing a good job, and trying their best to accommodate patients, particularly in the remote area.

People who had communication difficulties either because of deafness or because of ethnicity reported difficulties in communicating with receptionists. These difficulties were likely to be worse over the phone.

Deaf people also described not knowing when it was their turn to go in to see the doctor, and that receptionists often forgot about them.
Only the carers group felt that receptionists were helpful in getting them access to the doctor.

Towards solutions
Some practices now undertake training that involves team-building and communication skills-building. Incorporating into these courses training aimed at improving communication with the public and the kind of training that private companies employ to improve customer relations, could have considerable impact in developing a more client/patient-centred approach, particularly for receptionists, at the first point of contact with the practice.

Recommendations

There should be some common core training for receptionists, which should include equality awareness training.

4.3 Opening hours

Our survey of primary care trusts shows that the typical opening hours of general practice surgeries and health centres vary little between areas and all fall between 8.30am and 6.30pm. The majority are open between 9am and 5.30pm. The total number of GP practices in Scotland is 1056. Of these, 124 (around one in nine) offer early evening opening, after 6pm, at least once a week. Early morning opening, before 9am, is offered by 321 GP practices across Scotland at least once a week. Less than half of GP practices (506) are open on a Saturday morning.

There are 944 dental practices in Scotland, of which 304 are open after 6pm at least one day a week. Early morning opening (before 9am) is offered by 202. The total number of dentists open on Saturdays is 322.

The total number of pharmacies in Scotland is 1136. Of these, 386 pharmacies are open beyond 9am to 6pm Monday to Saturday. The greatest number of pharmacies with extended opening hours are in Greater Glasgow (179) and Lothian (96).

Focus group findings
While there was not huge demand for extended opening hours, there was a general feeling that as society in general was expected to work more flexible hours, this should also apply to the health profession. It was generally felt that it would be better for working people to be able to attend the surgery outside normal working hours, and that if surgeries were open until 7 or 8 in the evening and for a short time at the weekend, this would make a difference. This would be of benefit to people running small businesses. Where doctors provided extended opening hours this was appreciated.
Most people appeared still to make a clear distinction between out-of-hours services, and daytime clinics, and out-of-hours services are not seen as a method of extending or improving opening hours.

The opening hours of pharmacies were generally seen as satisfactory although some would like to see longer opening hours, for example in the early evening, while a few people would like 24-hour opening. Some people did comment that chemists located within supermarkets are opening for longer hours.

Opening hours of dentists were not raised as a major issue, although several people did suggest that weekend appointments would be helpful to those who work and who would normally have to take time off to go to the dentist. Parents of young children felt that weekend opening would be helpful. Some of the ethnic minority groups (including Chinese and Arabic groups) expressed a clear preference for longer opening hours to accommodate working people.

Providers’ views
It was accepted that there are certain groups who, for various practical reasons, had difficulties in using the services as a result of restricted opening hours. Examples were given of patients and parents not being able to access clinics for their children out of working or school hours. The problem was one of both location and timing.

Practical solutions such as extending opening hours, Saturday and evening surgeries were seen as more relevant to some services than others. In particular it was felt that baby clinics and immunisation clinics could be offered in evenings and on Saturdays. Extending opening hours and walk-in clinics, while good in principle, were considered likely to reinforce current problems with demand, and further exacerbate it. While it was cautiously agreed that there was a need to address flexibility of access, there was also a need to ensure that flexibility did not translate into increasing demand even further.

Towards solutions
Practice examples
We did not receive much evidence of providers extending their hours, but did receive information about late-opening physiotherapy and chiropody services, and about a health centre which operates an open clinic from 7am. One clinic described an integrated evening service. One out-of-hours service reported that it was extending the services available out of hours by having a community psychiatric nurse available at the centre.

Recommendations

Primary care providers should be encouraged by the PCT or LHCC to review their opening hours with their patients, as part of their public involvement strategy.
4.4 Factors which impact upon demand

The availability of services is affected by the level of demand, and is exacerbated by inappropriate demand and also, in Scotland, by poor health, which leads to higher levels of illness, and hence of demand on health services.

Providers’ views
GPs described their frustrations over people who did not attend for appointments (DNAs), people who made appointments for trivial conditions, and people who insisted on having an emergency appointment in situations which were not considered urgent by the provider. Providers recognised the consequences as making it more difficult for patients with a genuine reason to consult their GP to get an appointment.

Focus group findings
Some respondents in the focus groups recognised that the system was burdened by a general decline in the nation’s health through poor eating and lack of exercise; the dependency culture; an increased awareness of risk, for example of meningitis, and a resulting need for reassurance; social deprivation leading to worse mental and physical health; the increasing elderly population; higher expectations and time-wasters.

Poor health clearly impacts on the demand for primary care services. This question was raised in at least one group which discussed how social and economic factors affected the demands made on the local health service. Some of the other groups also raised the question of health screening and general health checks, which many in the groups would welcome, and which could encourage healthier lifestyles. Some people had found it difficult to get a general health check-up, and some people suggested a particular need for men’s health check-ups.

One of the discussion groups was held with young homeless women who were attending a healthy-living course which aimed to enable them to access services and ultimately to improve their health.

On a related point, people with mental health problems felt that if occupational health checks were taken more seriously, potential cases of work-related stress could be identified early and more serious problems prevented from developing.

Examples of practice
There are clearly many examples of practice throughout Scotland which focus on health improvement, including community health projects and diet-related initiatives. Healthy living centres also aim to contribute to this wider development of a healthy Scotland.

We were sent some information about a proactive assessment of all practice patients being carried out in a surgery in Edinburgh, and of a well person health review at another practice, and these are likely to be typical of other work in other parts of Scotland.
4.5 Range of services available

While traditionally a range of services could only be accessed through a GP, there are now moves towards encouraging direct access to services like physiotherapy and podiatry, for instance in one Glasgow LHCC. This issue was raised in the focus groups, but very little comment was made.

There is some evidence that the value of having other services available is being recognised, with, for example, practice-based counselling for people with mental health problems.

Recommendations

**Primary care providers should review with their patients what services they would value being available in the GP surgery or health centre.**

Primary care trusts should review the ways in which services such as physiotherapy and chiropody are accessed, with a view to improving access.
5 Acceptability

This third aspect of access deals with the way in which people may fail to access the services they need because of the way that service is provided. While this may be seen to relate to the quality of service rather than its accessibility, it is important to realise that the effect of a service which does not meet people’s needs in some way may result in them failing to access any service at all. Someone who is unable to communicate with the service provider may be as effectively excluded from the service as someone who faces a physical barrier, or someone who lives in a place without such services. The factors which are considered here include

- Difficulties with communication
- Language or cultural barriers
- Concerns about privacy and confidentiality
- Attitudes
- A combination of factors making access difficult
- The extent of interagency working.

5.1 Difficulties with communication

*Literature*

Effective communication is essential to a satisfactory interchange between patient and healthcare provider. Where communication has failed, this will constitute a barrier to seeking services in the future. Certain groups of patients have particular communication needs. These include people with learning difficulties, those from ethnic minorities, and deaf people. Work with people with learning disabilities has shown that there is a need for training in communication skills for healthcare professionals. Some patients lack confidence in their own communication skills and may need the support of an advocate to ensure effective communication.

Looking at access broadly as involving the ability to obtain a relevant, appropriate and effective service, problems with communication impact very directly on how satisfied patients are with their experience of primary care. The extent to which patients feel that a doctor has really listened to what they have said impacts on the nature of the relationship between them, and indirectly on the likelihood of the patient following the doctor’s advice, and of returning to seek further help. This is substantiated in much literature on what matters to patients in their dealings with the health service.

Research has shown that problems involving communication are particularly acute for deaf people, with up to one fifth of deaf patients leaving a doctor’s surgery unclear about their diagnosis. Deaf people also experience difficulties in communicating with opticians while bright lights are being shone in their eyes.
Focus group findings
Communication was a major area of concern for very many of those spoken to during this research. While communication could be seen as an aspect of quality of care or service, it has very direct links with access in its broad sense: there is a link between the way in which appointments systems are structured, affecting the time available to explain a patient’s problem; and there is also clear evidence in the focus group discussions that many patients are discouraged from approaching or returning to primary care services because of their difficulties in communicating with health service staff. Failures in communication can have direct consequences on patients’ health, for example where it leads to medicines being used in the wrong way, as was described in some of the groups.

Some groups had particular needs in relation to communication. The deaf groups and people from ethnic minority groups would welcome interpreting services being available, and organised through the primary care provider. Deaf people would like to be able to rely on minicoms being available, being in use, and staff being trained to use them. They would also appreciate more people being able to use sign language. Advocates can significantly improve communication for people with learning disabilities and people from ethnic minority groups.

There was a general dissatisfaction with the amount of information provided by doctors about patients’ conditions and treatment, and evidence of a failure to understand much of what the doctor said, particularly in the more deprived groups.

Many people spoke of the pressures placed on communication by the lack of time in the appointment.

Towards solutions
The training of primary care staff must recognise the need for better communication skills. There is also a need to ensure that appointments are long enough, particularly for those for whom communication is more difficult. Extending the length of appointments has implications for how many appointments can be made, and for staffing and other resources.

Examples of practice

The primary care trust in Glasgow has a community nurse practitioner with special responsibility for culture and ethnicity. She provides support to other health and social care professionals working with people with learning disabilities from black and ethnic minority groups.

The use of patient attendance support workers and advocates can help in this area. One example of practice sent to us was of a video on cervical screening for people with learning disabilities.
TANDEM advocacy project was set up in 1997 in Greater Glasgow with primary care development funding to support and encourage patients from black and ethnic minority groups to have greater access to primary care through the use of advocates who act as “champions” to effect the patient’s journey through the NHS.

Recommendations

Primary care providers should review the length of appointment times to ensure that those with communication difficulties, as well as the general population, have long enough for effective two-way communication with the service provider.

Primary care providers should be responsible for ensuring that patients understand the information and advice they have been given.

Primary care providers should ensure that there is a minicom available for use by those with hearing impairments, and that staff are trained to use the minicom.

The new NHS boards should ensure that advocacy services are available in their areas, and that these are well publicised.

The Scottish Executive should consider how to promote a wider knowledge of British Sign Language amongst primary health care providers.

5.2 Language or cultural barriers

Language may affect communication, as discussed above, particularly for older people from ethnic minority groups. More women than men, and more older people than younger from ethnic minority groups experience difficulties as a result of language. There are particular problems in relation to asylum seekers and refugees, for whom the out-of-hours service may be virtually inaccessible as it is dependent on the use of the phone, something particularly difficult in a strange language (see section 3.6 above).

Language is also relevant to how information about services is made available. People need to know about services before they can access them, and if the information is not available in languages they understand they may never find out about them (see further section 3.7).

Difficulties with language can also result in the need for a translator or interpreter in health care settings. Such support is often given by family members, but this is not always appropriate, and many have argued for the need for effective independent interpreting services.
There is evidence of a lack of primary care providers being able to use British Sign Language (BSL), and of a shortage of interpreters.

Cultural barriers to services can be created by attitudes to the health service which deter the patient from attending, for example the reluctance of travellers to go to the doctor unless it is really serious. Or they may be associated with cultural attitudes not directly related to health, for example the strong preference among Asian groups to see a doctor of the same sex, which our focus groups showed was as much the case with men as with women, although the smaller numbers of women GPs makes this more of a problem in accessing services for Asian women.

Examples of practice
We were sent examples of practice at primary care trust level from several parts of Scotland, particularly the provision of interpreting services, sometimes provided in association with a local authority. One PCT is providing deaf awareness training for management and care staff, and an interpreting service for hearing impaired users. A multi-cultural health development programme in one trust encompasses a range of measures including one-stop clinics and advocacy services for people from ethnic minority groups.

In Glasgow a one-stop clinic outreach facility acts as a specialist referral centre for individuals and groups who are vulnerable to a variety of health, social and environmental conditions, in addition to racism. One objective of the clinics is to ensure that communication is in a language which all understand.

Recommendations

The new NHS boards should ensure that advocacy services are available in their areas at a level to meet the demand for those services.

NHS boards should ensure that there are interpreting services, including BSL interpreters, available in their area at a level to meet the demand for these services.

The Scottish Executive Health Department should consider investing in phone interpreting for use in primary care consultations with patients with limited command of English.

The Scottish Executive should consider how to encourage the recruitment of a more diverse primary care workforce including more ethnic minority staff.
5.3 Concerns about privacy and confidentiality

Research with young people in Scotland as part of the Walk the Talk initiative has shown that fears about confidentiality is one of the five main concerns of young people about primary healthcare services. Confidentiality is also a major concern of gay men and lesbians, particularly in relation to revealing their sexuality to their doctor. Confidentiality can also be a concern of people who are dependent on a family member or friend to act as an interpreter or advocate.

**Focus group findings**
Many people already made use of pharmacists for advice on health matters, although a range of concerns were expressed, including the need for greater privacy and assurance of confidentiality.

Relationships with doctors were also affected if patients believed that information provided to the doctor was not confidential. Gay men and lesbians had concerns in this area, particularly that their sexuality would be recorded in a way which might be passed on to employers, insurance companies or hospitals.

**Towards solutions**
One way of tackling patient concerns about confidentiality is to have clear statements about confidentiality and equal opportunities displayed in primary care premises. Language should be used in a way which indicates that service providers will not be making judgements about their patients, for example the use of “partners” as opposed to “husbands or wives”. Service providers should be clear about what information is included in someone’s health record.

**Examples of practice**
One pharmacist described the creation of a private consultation area in the community pharmacy.

**Recommendations**

- **Primary care trusts and LHCCs should encourage primary care providers to draft and display an equal opportunities policy.**
- **Primary care trusts should encourage pharmacists to create private spaces for consultation.**
- **Primary care trusts should encourage primary care providers to take part in equality awareness training.**
5.4 Attitudes

Research has shown that some health service staff have poor attitudes towards deaf people, and also to ethnic minority deaf people. People from ethnic minorities perceive some discrimination against them.

**Focus group findings**

One of the most frequently mentioned barriers to accessing care was health professionals’ attitudes towards their patients.

Many groups felt that doctors had little understanding of their lifestyle or culture, and some groups even felt discriminated against as a result. Sometimes this perception was created by the apparent reluctance of the doctor to take time with a patient. As with communication, the effect of poor attitudes is to impair the development of a trusting and supportive relationship with the healthcare provider, and may be a deterrent to seeking services. Amongst those who felt discriminated against by their GP were some older people, travellers, and people from ethnic minorities.

As discussed above, participants also often commented on the attitudes of receptionists, who some found unsympathetic and officious.

**Towards solutions**

Many attitudinal problems can be addressed by an increased awareness on the part of the health professionals, much of which could be achieved by training. Equality awareness training covering race, sex, sexual orientation, disability, deafness etc should be included as part of the professional training and continuing professional development of all primary care staff.

**Examples of practice**

While not necessarily focusing on changing attitudes, one solution to the difficulties in accessing services caused by poor attitudes can be the use of targeted projects or services, thus diverting certain groups away from mainstream services. Examples include travellers’ projects, health centres focusing on the needs of gay people, and one-stop shops for prostitutes.

The West Highland Travelling Person’s Project is aimed at traditional travelling people descended from the Highlands who tend to be denied primary care access in many areas (approximately 300 people). Based in North Argyll and Lochaber the project features ‘open access’ and staff are trained to help illiterate and deprived people. The project is not funded and relies on ‘a lot of excellent volunteers’. Outcomes to date include decreased mortality and an increase in child immunisation.
Recommendations

Primary care trusts and LHCCs should support and promote equality awareness training for all primary care staff.

5.5 Combination of factors

This refers to situations where a variety of things contribute to people finding it difficult to access primary care services. This might be the difficulties experienced by teenagers living in a rural area seeking information or advice about sexual health, or the combination of prejudice, low self-esteem, and fear which would deter drug users. More generally, men in some environments have, for a variety of reasons, found it difficult to seek help from primary care, or have chosen not to. A range of initiatives is taking place to make it easier for people in these situations to get access to the kind of services they need.

Focus group findings
There was some comment in the groups about the particular difficulties which men experience when they have emotional or mental health difficulties.

Examples of practice
Information about ten projects which target young people or teenagers was returned. All of the initiatives seek to provide a service to young people in a setting which will be more accessible to young people than typical health service settings. Of the ten initiatives five aim to meet the health needs of young people with the provision of information and advice, while three have a particular focus on sexual health and teenage pregnancy.

Fife’s Improving Teenage Sexual Health is run in a variety of accessible settings including schools, youth venues, community facilities and a community flat. The project features greater involvement of school nurses in a providing service, a youth worker targeting young people in a range of venues, a health promotion bus, and a teen web site which has been designed by students and includes a virtual drop-in.

The Park Avenue Medical Practice in Dundee is using PMS to develop ways of increasing partnership with social work services to provide seamless care packages. The focus is on drug addicts and homeless people.

A salaried GP initiative in Tayside provides a service meeting the clinical needs of drug users, using a multi-disciplinary approach. Difficulties had been encountered in caring for drug-abusing patients alongside other patients, and a solution was found by using alternative accommodation.
Base 75 is the joint health and social care service for female prostitutes that operates six nights a week in the red light area of Glasgow. The hours are arranged to suit the needs of the women using the service and services include a methadone clinic and counselling.

Recommendations

Primary care trusts and LHCCs should consider the use of targeted services for groups who are likely, for a variety of reasons, to experience difficulty in accessing primary care (see section 6.3 below).

5.6 Extent of inter-agency working

Focus group findings
GPs were criticised for not knowing what services are available which would support or help people with learning disabilities. The group discussed the issue of services only becoming available when there is an emergency and argued that if families and GPs were aware of what was available beforehand then many health issues could be addressed at an earlier stage rather than when they reached crisis point.

A very similar point was made by people with mental health problems, which were rarely susceptible to medical solutions. Medication tended to be viewed more as ‘psychological elastoplast’ rather than something likely to resolve their problems in the long term. Primary care service providers were generally seen as having too few referral options, such as counselling or self-help groups, insufficient time and a tendency to treat patients’ mental health problems in isolation from their health as a whole and from the rest of their lives.

The same observation was made in relation to services for young people at risk of social exclusion. Projects such as the Foyer projects throughout the UK, which provide a holistic service to at-risk young people, were considered not to be sufficiently well known amongst GPs, who could usefully refer young people to this service, which, because of its cross-cutting nature, is funded in Scotland through Scottish Enterprise.

Examples of practice
Eight initiatives described ‘partnership working’ as their main feature. This is sometimes called ‘interagency working’, ‘integrated care’ or ‘one-stop shops’, and sometimes the client can access a number of services from one access point. Health and social services work together to provide a ‘seamless service’ and in some instances this involves working with other agencies such as housing, voluntary agencies or even the police.
The Barlanark Community Health Shop offers an innovative approach to providing community-based health services. This is a joint venture between several partner agencies including Greater Glasgow Primary Care Trust, Greater Glasgow Health Board, the Benefits Agency & Scottish Homes. Clinics provided at the health shop include stroke, cancer, heart disease awareness, sexual health, education and support on HIV and AIDS, stress counselling, money advice, a milk token initiative, personal development training, alcohol advice, benefits advice, young people peer education training, healthy cooking classes, breast-feeding and therapeutic massage/aromatherapy.

Based in Greenock health centre, Partnerships in Public Health is a group comprising health visitors and other interested parties. Specific initiatives target unemployed and low income people in deprived areas and others target local employers and deal with health promotion in the workplace. The primary feature of the project is ‘partnership working’: professionals work closely with lay workers and the ‘Scotland Health at Work’ co-ordinator. The project is not directly funded and this has resulted in problems, for example computer equipment has not been purchased.
6 Managing demand and improving access

In this section the different factors affecting access are drawn together and presented in a more structured form. The structure of this section reflects the diagram on page 38. This diagram contains nine different zones which are relevant to the way in which demand is managed, and access facilitated or improved. The four boxes near the top of the diagram describe ways in which demand from the public can be either reduced or managed. Work to improve health has an obvious effect on demand, while targeted projects for particular groups can siphon demand from these groups away from mainstream services, as well as provide more appropriate services for those groups. Influencing demand is a bigger challenge, but is the area in which there is considerable potential to improve the existing situation.

The five zones in the lower half of the diagram relate to the “supply side” of the equation, and deal with changes in structures, and in the workforce, as well as technology and good practice, which can all have an impact on the way in which the demand for services is managed and access provided.

6.1 Improving health

Focus group findings
The focus group findings were discussed in section 4.4 above, and indicated a demand from members of the public for the opportunity to take part in screening and health checks.

Examples of practice
Some targeted projects for particular groups contained a health promotion element. For example the Multicultural Development Programme in one primary care trust promotes access to underused services by building trust with the community and helping to break down the reluctance of some people to use services for a variety of reasons. Health promotion initiatives can be introduced and explained in this environment.

Health promotion has an important role to play in relation to access, but it is beyond the scope of this research to explore in any detail the impact of health promotion on demand for primary care services.

Recommendations

NHS boards should recognise the importance of promoting public health and its relationship to the question of access to services.

6.2 Influencing demand

Primary care providers believe that the demands and expectations of patients are increasing, with more patients expecting a faster and more accessible service. The
pressure of this demand makes it difficult for service providers to improve the quality of services in the ways they would like, particularly in the way they manage chronic disease, and when the boundaries between primary and secondary care are changing.

**Graduated access**

The concept of graduated access is that there should be a range of ways of accessing primary care, so that advice or treatment is received at the “lowest” level necessary for effective care. At the lowest level, self-care can be encouraged in a variety of ways, for example through greater availability of over-the-counter medicines, alternative medicines and home-testing kits. Self-care manuals could be more widely used, combined with access to advice and support over the phone. Self-help groups might be able to provide the level of support or advice which is sought.

NHS24 may have a role as a source of information and advice, and as a means of referring people to appropriate services. The next level might involve a consultation with a nurse practitioner, or a visit to a community pharmacy.

The literature shows that nurse-led triage is well established in many countries, and is becoming more common in general practice in the UK, with out-of-hours services being increasingly nurse-led. However, research in Scotland has shown a lack of public understanding of nurse triage, and a suspicion of telephone diagnosis. This research is broadly supported by our work with focus groups. Some work has already been done on the effects of the introduction of nurse telephone consultation, which shows that it reduces the overall workload of GPs, while allowing callers faster access to health information and advice. It is not associated with an increase in adverse events. There is debate over the cost-savings associated with nurse telephone triage, but one study showed cost-savings of £80,000 over the trial year.

**Examples of practice**

Restalrig Medical Centre has used PMS funding to increase the number of nurse practitioners and facilitate a practice-based nursing team to allow doctors to delegate a significant amount of time-consuming consultations.

A nurse practitioner runs a nurse-led service for minor illness & injury at Muirhouse medical group in Edinburgh for children and families registered with the practice. The service offers open access to a nurse practitioner between 9am and 6pm, Monday to Friday, for same-day consultations and telephone triage. Patients are now deciding to consult with nurse practitioners for minor illness rather than the GP. Initially the project was funded by the Scottish Office Development Fund and since the success of the project was evaluated, it has been funded by Lothian PCT.
The government’s goal, throughout the UK, is to set a target of 48 hours, within which it should be possible to see either a GP (England) or a member of the primary care team (Scotland). The BMA has argued that to make this a reality would require an additional 10,000 GPs. However, 100 GP practices which have been working on speeding up access have found that 62% have been able to meet this target simply by measures such as changing the way appointments are made, offering telephone consultation or referring patients to a nurse. Another piece of research has described how waiting times can be reduced, by reducing backlogs, reducing the need for triage to distinguish between urgent and routine cases, and making optimal use of consultation time (the concept of doing “one more thing” in each patient encounter).

One of the key features in the changes in out-of-hours provision is the increase in the proportion of calls dealt with by giving telephone advice. One study has shown lower overall levels of patient satisfaction with telephone advice, and warned that a shift to more telephone advice might lead to lower satisfaction, particularly among patients with language difficulties. People who cannot afford a telephone and those with hearing problems, the elderly and those with inadequate language skills, may be disadvantaged by an increasing use of the phone.

However, the introduction of NHS Direct has been shown to be associated with a halting of the upward trend in demand for out-of-hours services, and a survey of those who had used NHS Direct found that 95% had found the advice they had received very or quite helpful, and most (85%) followed the advice given. Many callers found the advice helpful because it offered reassurance.

A service which is accessed through the phone may be of benefit to people who find it difficult to be registered with a GP. This includes homeless people and travellers.

Focus group findings
The role of the telephone in accessing healthcare was discussed by many people in the course of the research. Apart from concerns about contacting surgeries by phone, there was the wider issue of the potential for getting more health advice over the phone. There was a mixed reaction to this, with some people feeling that a proper diagnosis could only be made in person. People with communication difficulties relating either to disability or ethnicity were more reluctant to seek advice by phone. On the other hand people with mental health problems would welcome telephone helplines providing a counselling service, or just someone to talk to.

Educating and informing the public about primary care
Encouraging graduated access to primary care services is dependent on educating the public. Service providers referred to the public attitude which still persists that the GP is the person with all the knowledge, and that the best care comes from the GP. They were supportive of the idea that health professionals themselves should be communicating better with patients about who could do what within the wider primary care team.
The introduction of NHS24 provides an opportunity to change people’s attitudes to how they seek help, and one possibility would be to send out a clear message that the first port of call in relation to any health problem should be NHS24.

**Recommendations**

The Scottish Executive should consider how it can educate the public about how to access information, advice and treatment within the primary healthcare system.

**Educating the public about risk management**

Concern was expressed by both service users and providers about inappropriate use of primary care services. Service providers spoke of the lack of confidence of patients in managing normal childhood illnesses, combined with an enhanced awareness of life-threatening illnesses, such as meningitis. Patients were unwilling to take risks with their or their children’s health. While the media clearly has a role in alerting the public to health risks, this has to be done in a responsible manner which does not create scare stories.

The public must be encouraged to take greater responsibility for minor ailments, either through self-care or through seeking advice from NHS24 or a pharmacist before seeking an appointment with a GP.

**6.3 Targeted projects**

The literature and the focus group work suggests that for some potentially excluded groups, the most effective way of improving access is to set up targeted projects. Many of the examples of practice which we received were of such projects, with many focusing on young people, travellers, homeless people, and to a lesser extent, ethnic minorities. The viability of such projects will depend on the size of the targeted group, and this will vary in different parts of Scotland. Projects focusing on the health needs of gay men and lesbians only exist in the most populated areas, and projects for ethnic minorities are more common in the large cities with sizeable ethnic minority populations.

Many of these projects do contain an aim to redirect their target populations towards mainstream services, for example the homelessness practice in Edinburgh.

**6.4 Workforce**

Service providers spoke of the practical difficulties of having the right people in the right place at the right time. This is particularly difficult in rural and remote areas. A team-working approach to chronic disease management adds to the difficulty of providing the best service to as many people as possible. Several people in the focus
groups suggested that more doctors were needed to ease the pressures on the primary care system, and this was also raised in the focus groups with service providers.

Morale among GPs has been widely discussed in recent months, and this was reflected in discussions with service providers, who described feeling as though they were fire-fighting. The stress they felt themselves to be under also affected the relationship they were able to develop with their patients.

There are, however, a range of initiatives and policy developments which may have a role in altering the traditional ways in which the primary care workforce has operated, and which may allow the primary care team to be used more effectively to ensure better access to services. These include the use of salaried practitioners, through the Personal Medical Services (PMS) scheme and the Dental Access Initiative. Several of the examples of practice we received were PMS pilots. Indeed, one of the aims of the PMS scheme is “to target particular patient groups not well served under existing arrangements, such as the homeless and drug misusers”.

**Nurses**

The majority of those taking part in focus groups were not averse to the idea of consulting a nurse, and some already did this in certain circumstances. However, perceptions that nurses are primarily qualified to give injections and apply bandages need to be changed to encourage a greater use of nurses. Older people and teenagers appeared less comfortable at the idea of seeing a nurse instead of a doctor. Reservations were also expressed about nurse triage if this meant having to explain everything twice.

The ethnic minority groups also had greater reservations about seeing a nurse, preferring the greater authority of a doctor, although the Punjabi-speaking women were sympathetic to the idea of more use being made of health visitors.

**Examples of practice**

A nurse-led service for minor illness and injury at Muirhouse medical group in Edinburgh for children and families has already been described in section 6.2. A very similar service exists at a GP practice in Dumfries and Galloway. Patients requesting a same-day consultation are eligible to attend the practice-based nurse triage. The initiative, funded by the PCDF, has resulted in reduced numbers of patients needing a same-day consultation with a doctor and an increase in patients seen by the practice nurse.

**Pharmacists**

Areas in which it has been suggested that pharmacy could contribute to improving access to primary care include:

- Increase access to drugs without prescription
- Allow pharmacists to prescribe over-the-counter drugs
• Repeat medication for chronic conditions provided direct by community pharmacist
• Minor ailments treated by community pharmacist
• Patients referred to community pharmacist by NHS24
• Community pharmacy as walk-in care centre
• Review of medication profile by pharmacist.

Focus group findings
Most of those taking part in the groups were reasonably happy with access to pharmacists. Many people already made use of pharmacists for advice on health matters, although a range of concerns were expressed, including the need for greater privacy and assurance of confidentiality. Some people suggested ways in which the service provided by pharmacists could be improved. These included longer opening hours, being able to prescribe medication, and being able to deliver drugs.

There was a widespread view in the service provider focus groups that pharmacists are an underused resource. There was strong support for more use to be made of their services, involving them more directly with health centres, and in the LHCC. Pharmacists themselves also supported such development of their role.

Examples of practice

Patients wishing to consult their pharmacist in private benefit from the provision of a private consultation area in the community pharmacy at the campus pharmacy in Stirling University. This facilitates a more active role for the community pharmacist in providing advice and support, in particular on sensitive issues such as contraception and sexual health, through the provision of improved facilities. A similar venture is proposed in the Highlands where 16 community pharmacies have been identified for the creation of areas where personal advice can be given.

Dentists
The Community Dental Service provides a managed, salaried service employed by primary care trusts to provide a service to priority groups, and to provide a safety net where General Dental Services are inadequate.

Summary
To sum up, in relation to the primary care workforce, there appears to be potential to:

• Develop the role of nurses and pharmacists within the primary care team
• Continue to use salaried GPs and dentists
• Develop the education and training of primary care staff including receptionists to make services more accessible.
However, it is also important to ensure that the basic infrastructure of primary care is adequately resourced in terms of manpower. Developing the role of nurses and pharmacists has implications for the numbers of staff needed, and for the education and training of primary care staff.

**Recommendations**

The Scottish Executive should consider how it can develop the role of nurses and pharmacists within primary care, and also how it educates and informs the public about these roles.

**6.5 Good practice**

The research highlights several areas in which the encouragement of good practice at both service provider and LHCC or primary care trust level could bring significant improvements in the accessibility of services. These include:

- training in communication skills
- equality awareness training
- support for advocacy
- the development of volunteering activity
- a greater degree of public involvement at primary care level, and
- the encouragement of accessibility audits of primary care premises.

**Equality awareness training**

This has been highlighted in earlier sections in relation to communication, attitudes and confidentiality.

**Support for advocacy**

It was recommended earlier in the report that NHS boards should ensure that there are sufficient advocacy services available. Primary care trusts and LHCCs should ensure that people know about these.

**Development of volunteering activity**

Volunteering has the potential to provide services in a primary care context which can directly contribute to improving access, particularly through transport services and childcare.

**Public involvement**

Public involvement is high on the political agenda, as part of the process of providing patient-centred services. At practice level, this could mean encouraging patients and members of the public to be involved in reviews of opening hours, the appointments system, the information provided by the practice, and the ways in which volunteers could add to the services available at the practice, or improve access to the service.
Service providers recognised the value of public involvement and described ways in which local populations and patient groups were being consulted about services.

6.6 Integrated systems

Access to care can be improved by better working between professionals, both within healthcare, for example with pharmacists and ambulance services, and between health and other disciplines such as social work and education. It is also important that NHS organisations recognise and acknowledge the potential of community and voluntary agencies to provide services. Certain groups have a particular need for intersectoral solutions – these include single homeless and those with severe disabilities.

The difficulties experienced by people with learning disabilities is another area in which a range of people need to be involved, for example by training carers working in day and residential centres to detect ill health in those with learning disabilities, and by providing information to families and carers to help them identify health problems. An English community health trust set up a primary healthcare project for people with an intellectual disability in 1995. It involved ongoing consultation and collaboration with various services and with people with learning disabilities and their carers. A worker was appointed to facilitate uptake of primary care services including the use of a health-screening protocol run in conjunction with GPs. People with learning disabilities were offered a health check. Many writers have emphasised that in order for people with learning disabilities to access primary care services, there must be multi-agency approaches, with ‘care pathways’ across all sectors of health services.

A whole systems approach recognises that, for example, access to social services may be an important way of reducing inappropriate use of primary care services. The kind of targeted projects described in section 6.3 often involve interagency working, particularly where the client group has a complex set of problems.

Examples of practice

The One Door Initiative was a national demonstration project to promote interagency responses to the needs of homeless young people. The collaborative approach allowed a range of agencies to work together, and the agencies involved identified advantages in the collaborative approach adopted, although the health service agencies found it hardest to participate fully in the partnership arrangements. The evaluation of this project suggested features which were needed for effective partnership working. These included specialist staff with dedicated time, an exclusive focus on the vulnerable young people, an “honest broker” to host the project, the ability to access funds from a variety of sources, financial independence from partner agencies, and freedom from the stigma of social services in the eyes of the young people.
For some people, the services that would help them to get on with their lives are not necessarily those provided by the NHS, but for some, it is only the crisis of ill health which leads to their discovering these services. The primary care team should be able to refer such people, for example people with learning disabilities and people with mental health problems, to such services, which might be provided by social work services, or by the voluntary sector. Such services may have an important role to play in maintaining health and wellbeing. Similarly, there are services for young people at risk of social exclusion, to which healthcare providers could usefully refer young people, if they were aware of them.

This suggests that it will be important that NHS24 has sufficient information about projects in other areas of provision, and particularly in the voluntary sector, to help direct members of the public to relevant and effective support services.

A related issue is the extent to which primary care itself diversifies from the traditional “illness service” which it predominantly provides. There are ways in which primary care premises can become the location for other services, such as counselling, benefits advice, and health promotion.

Examples of practice

The PCDF provides the money for a counselling service based in general practices in Shetland. The service is for patients with mental health problems including depression, bereavement, adjustment to disability, panic attacks, anxiety disorders, and alcohol and drug abuse. The service is intended to improve quality of life for patients and reduce use of secondary care. Initial feedback has shown that the project is very well received by both patients and clinicians.

Recommendations

Primary care trusts and LHCCs should promote inter-agency working, particularly in relation to services for people with learning disabilities or mental health problems, and for other groups such as homeless people and travellers.

6.7 Structures and settings

The new LHCCs have the potential to impact significantly on the accessibility of primary care services, as well as improving interagency working and work with the voluntary sector at a local level. The LHCC is also likely to have an important role in encouraging and disseminating good practice. Several of the examples of practice which were sent to us were about work at LHCC level. However, service providers pointed out the limitations on what LHCCs could achieve, in terms of changes to provision, as a result of the nature of the GP contract.
Other organisations like healthy living centres, community schools and community health projects can also affect the way in which mainstream services are used, as well as the longer-term impact of improved public health.

Service providers were sympathetic to the idea of taking services into the community where this is appropriate, for example baby clinics, screening services and speech therapy could be provided in schools, community schools or centres, or workplaces.

6.8 Technology

Developments in technology will have an impact on the way primary care services develop. Communication technology will affect the way services are provided as well as help to make systems work better. They include:

- Reducing/rationalising numbers and types of medical reports
- Increased use of electronic records
- Centralising some tasks at trust level, eg recall systems
- Streamlining the information flow between primary and secondary care.

Use of the phone

The role of the telephone in accessing healthcare was discussed by many people in the course of the research. Apart from concerns about contacting surgeries by phone, there was the wider issue of the potential for getting more health advice over the phone. There was a mixed reaction to this, with some people feeling that a proper diagnosis could only be made in person. People with communication difficulties relating either to disability or ethnicity were more reluctant to seek advice by phone. On the other hand people with mental health problems would welcome telephone helplines providing a counselling service, or just someone to talk to.

Technology could be useful for doctors, for example conducting their meetings online or by conference phone rather than being absent from the surgery, and carrying laptop computers with access to patient records whenever and wherever required (this would be particularly relevant for the after-hours service).

The telephone may also have a role in connection with the provision of centralised interpreting services.

Examples of practice

Electronic transmission of prescriptions is being piloted in Ayrshire, with the aim of improving the repeat prescription service, and of improving communication between doctor and pharmacist. This could potentially reduce demand on the GP surgery for repeat prescriptions.
The primary care trust in Lanarkshire has set up a helpline to encourage patients to seek advice and information about their health. The helpline also has bilingual staff who are ready to respond to the language needs of people from ethnic minority groups.

6.9 Resources

Many of the proposals made in this report have resource implications. Service providers raised this as an issue in our discussions with them, and there is a clearly articulated view amongst some service providers that the problem of demand and of access to services will not be addressed until there is a commitment to resourcing an increase in the number of staff available.

There is a need to ensure that the basic infrastructure of primary care is sufficiently resourced in terms of staff and premises, and to enable any possible developments in the way in which staff are used, for example a greater role for nurses in the primary care team.

Where projects have been shown to improve access for particular groups, or for the general population, these are dependent on resources being available, whether that is from the Primary Care Development Fund, from shared budgets with other agencies, or from initiatives like Personal Medical Services.

Many of the recommendations made in the report are about good practice development, for example equality awareness training and training for receptionists. None of these is cost-free, and there will be a need to ensure that adequate resources are available to allow and encourage such training to take place.

Recommendations

The Scottish Executive should ensure that the primary care system is adequately resourced, in terms of staff and premises.

The Scottish Executive should ensure that adequate levels of funding allow for innovative projects and initiatives in primary care.
Influencing demand
• Promote graduated access
• Educate the public
• Information about services
• Responsibilities as well as rights
• Awareness of risk

Improving health
• Support vulnerable groups
• Preventative work
• Early diagnosis

Targeted projects
• Travellers
• Gay men and lesbians
• Homeless people
• Young people
• Ethnic minorities

Practical things
• Hand-held records
• Volunteer initiatives

Good practice
• Communication skills
• Equality awareness training
• Advocacy
• Public involvement
• Access audits
• Length of appointments
• Equal opportunities statement
• Register of people with learning disability

Supply

Demand

Influencing demand

Workforce
• Role of nurses and pharmacists
• Use of salaried GPs and dentists
• Rural initiatives
• Receptionist training
• Education and training of primary care staff
• More BSL interpreters

Structures
• LHCCs
• Healthy living centres
• Advocacy services

Integrated systems
• Health and social work
• Role of voluntary sector
• Advocacy services
• Community planning (siting of health services, transport)
• Development of volunteering

Technology
• NHS24
• Telemedicine
• Telephone interpreting
• Automated phone systems
• Medical records
• Recall processes
• Use of email and internet
• minicom
7 Summary of recommendations

7.1 To primary care trusts and LHCCs

1. Primary care trusts and LHCCs should raise awareness amongst all primary care providers of the implications of the requirements of the Disability Discrimination Act 1995.

2. Primary Care Trusts and LHCCs should encourage disability audits of all their premises which should, wherever possible, involve local disability organisations.

3. Primary care trusts and LHCCs should encourage primary care providers to review their opening hours with their patients, as part of their public involvement strategy.

4. Information available for those who are recent arrivals in the UK, particularly refugees and asylum seekers should be reviewed to ensure that it meets the needs of those people.

5. Information about out-of-hours services should be reviewed to ensure that it is accessible to all patients and potential patients.

6. Primary care trusts should ensure that information about who qualifies for free dental treatment is widely displayed. This information should be displayed prominently in healthcare premises.

7. There is a need for better information about dental services, including the cost of treatment and how to access emergency dental services out of hours. This information should be available in a range of healthcare premises.

8. Primary care trusts should review the ways in which services such as physiotherapy and chiropody are accessed, with a view to improving access.

9. Primary care trusts and LHCCs should encourage primary care providers to draft and display an equal opportunities policy.

10. Primary care trusts should encourage pharmacists to create private spaces for consultation.
11. Primary care trusts and LHCCs should support and promote equality awareness training for all primary care staff.

12. Primary care trusts and LHCCs should consider the use of targeted services for groups who are likely, for a variety of reasons, to experience difficulty in accessing primary care (see section 6.3 above).

13. The use of volunteers should be encouraged and developed as one way of increasing access, for example through the use of volunteers to run transport schemes and to provide childcare facilities in primary care settings.

14. Primary care trusts and LHCC should promote inter-agency working, particularly in relation to services for people with learning disabilities or mental health problems, and for other groups such as homeless people and travellers.

7.2 To primary care providers

15. Automated phone systems should be reviewed to take account of the experiences of patients in using them.

16. The use of plain English in automated systems should be promoted.

17. All primary care providers should review the accessibility of all the information they provide, to ensure that disadvantaged groups have access to appropriate information.

18. Primary care providers should review, with their patients, how their appointment systems are working and what patients feel about waiting times.

19. Primary care providers should review with their patients what services they would value being available in the GP surgery or health centre.

20. Primary care providers should be encouraged to indicate in waiting rooms how long patients may have to wait, particularly where there is an open access clinic.

21. Primary care providers should be responsible for ensuring that patients understand the information and advice they have been given.
22. Primary care providers should ensure that there is a minicom available for use by those with hearing impairments, and that staff are trained to use the minicom.

7.3 To the new NHS boards

23. NHS boards should recognise the importance of promoting public health and its relationship to the question of access to services.

24. The new NHS boards should ensure that advocacy services are available in their areas at a level to meet the demand for those services, and that these are well publicised.

25. NHS boards should ensure that there are interpreting services, including BSL interpreters, available in their area at a level to meet the demand for these services.

7.4 To the Scottish Executive

26. The Scottish Executive should ensure that the primary care system is adequately resourced, in terms of staff and premises.

27. The Scottish Executive should ensure that adequate levels of finding allow for innovative projects and initiatives in primary care.

28. The Scottish Executive should consider how it can educate the public about how to access information, advice and treatment within the primary healthcare system.

29. The Scottish Executive should consider how it can develop the role of nurses and pharmacists within primary care, and also how it educates and informs the public about these roles.

30. The provision of respite care should be promoted and encouraged to enable carers to attend for primary healthcare.

31. The training of primary care staff should include equality awareness training covering disability, gender, race, and sexual orientation. Training should cover the particular needs of asylum seekers and refugees.
32. The Scottish Executive should consider how to promote the greater use of hand-held records, and walk-in access to primary care services.

33. There should be some common core training for receptionists, which should include equality awareness training.

34. The Scottish Executive should consider how to promote a wider knowledge of British Sign Language amongst primary healthcare providers.

35. The Scottish Executive Health Department should consider investing in phone interpreting for use in primary care consultations with patients with limited command of English.

36. The Scottish Executive should consider how to encourage the recruitment of a more diverse primary care workforce including more ethnic minority staff.
### Appendix 1

**Focus group details**

<table>
<thead>
<tr>
<th></th>
<th>Location</th>
<th>Age</th>
<th>Social class</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>People of working age</td>
<td>Working age</td>
<td>ABC1</td>
</tr>
<tr>
<td>2</td>
<td>People of working age</td>
<td>Working age</td>
<td>C2D</td>
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</tr>
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<td>16-19</td>
<td>Mixed</td>
</tr>
<tr>
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<td>16-19</td>
<td>C2DE</td>
</tr>
<tr>
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<td>Parents</td>
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<td>ABC1</td>
</tr>
<tr>
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<td>Parents</td>
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<tr>
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<td>55+</td>
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<tr>
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<td>Rural (Falkland)</td>
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<td>Older people</td>
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<td>55+</td>
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<td>Men</td>
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<td>Young women</td>
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<tr>
<td>28</td>
<td>Street homeless</td>
<td>Edinburgh</td>
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</tr>
</tbody>
</table>
Appendix 2

Members of Advisory Group

Robert Aldridge  Director, Scottish Council for Single Homeless
Donald Anderson  Co-ordinator, Information & Development, Centre for Independent Living in Glasgow
Fiona Angus  British Dental Association
Jackie Brock  Directorate of Primary Care, Scottish Executive
Gerris Campbell  Public Involvement in Primary Care Development Officer, Scottish Association of Health Councils
Farkhanda Chaudry  Racial Equality Unit, Scottish Council of Voluntary Organisations
Ian Cowan  Lloyds Pharmacy Regional Office
Brian Davidson  Primary Care and LHCC Development General Manager, Highland Primary Care NHS Trust
Linda M Dunion  Age Concern Scotland
Martyn Evans  Director, Scottish Consumer Council
Kieran Fallon  Royston Dental Practice
R Gardee  Consultant in Public Health Medicine, Greater Glasgow Primary Care NHS Trust
Cathy Gunn  Health Visitor, Greencroft Medical Centre
Douglas Hamilton  Policy Officer, Children in Scotland
Kenneth Harden  Chairman, Scottish General Practitioners Committee
Gregor Henderson  Director, Scottish Development Centre for Mental Health
Colin Hunter  Chairman, Royal College General Practitioners
David Love  Vice-Chairman, Scottish General Practitioners Committee
Sheena Munro  Executive Director, Highland Community Care Forum
Gill Robertson  Professional Officer, Royal College of Nursing
George Romanes  Chairman, Scottish General Pharmaceutical Council
Geoff Sage  Manager, Hamilton/Blantyre/Larkhall LHCC
Mairi Scott  Chairman, West of Scotland Faculty, Royal College of General Practitioners
Kim Walker  Chief Officer, Grampian Local Health Council
Hugh Whyte  Senior Medical Officer, Scottish Executive
John Wilkes  Director, Carers National Association