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Research into “Good Access” in Community Pharmacy, NHS Dentistry and Allied Health Professional Services

Executive Summary

1. Research aims and methodology

1.1 The Welsh Government commissioned Miller Research in spring 2023 to conduct research into what ‘good access’ means to the general public in relation to community pharmacy, NHS dentistry and Allied Health Professional (AHP) services[1].

1.2 The research aims were to identify key barriers to accessing these primary care services and to explore people’s expectations of what constitutes good access to these services.

1.3 The methodology for the research was entirely qualitative, involving a literature review of relevant research reports, evidence papers and academic articles; scoping interviews with key stakeholders in the Welsh Government and Public Health Wales; and focus groups with members of the public residing in each of the seven health boards in Wales.

1.4 This document summarises the key findings relating to access to AHPs, NHS dentistry and community pharmacy. It also includes a section summarising principles of good access that were common across these areas of primary care.

[1] For the perspective of this research, this included nine of the allied health professions. The included professions are art, music and drama therapists, dietitians, occupational therapists, physiotherapists, podiatrists, psychologists and speech and language therapists. These are the professions currently most frequently working in primary and community services. Paramedics are also frequently deployed in primary and community services. However, because the general public most commonly recognise paramedics in relation to their emergency services work, they were excluded from this initial research because the methodology would not allow sufficient clarity of role. It needs to be further noted that a limitation of this research is that it is not always possible to be assured that when participants identified interactions with ‘psychologists’ and ‘psychology’ these were in fact registered psychologists. These could have been references to a wide range of mental health practitioners or third sector staff.

2. Allied Health Professionals

2.1 The AHP services focus group participants had accessed in the last two years included services to support both physical and mental health by physiotherapists, dietitians, podiatrists, occupational therapists and arts therapists.

The referral process: experiences, preferences and barriers

2.2 Respondents typically accessed AHPs through their GP or after receiving treatment in secondary care (principally for physiotherapy, following surgery). Participants had mixed experiences of the referral process through GP surgeries. Many cited difficulties in accessing GP services in order to obtain a referral, often having to phone repeatedly to get an appointment.

2.3 Self-referral by e-form was considered difficult, given the challenge of reflecting the nature of their condition in writing. Walk-in or drop-in surgeries (e.g.: for physiotherapy) were reported as convenient and bypassed complex and lengthy referral processes. Pharmacies and charities were also considered potential referral routes.

Waiting times and communication

2.4 The length of waiting times for AHP services was consistently raised as an issue and barrier to access. A critical factor in frustrations over waiting times was a lack of communication, including communication about the reason for the wait, support available in the meantime, and the actual – or even estimated – length of the wait.

2.5 Participants also shared experiences of poor communication once they accessed services, for example not receiving any notice that they had been discharged from the service or given any guidance on additional support they could seek if issues persisted.

2.6 Participants suggested that more could be done to keep patients fully informed, for example including a feature on the NHS Wales App where patients can check their position on a waiting list.

Format of care and continuity of care

2.7 The feedback from participants was that flexibility over the format of AHP care is essential. Individuals both liked and disliked video, phone and in-person consultations depending on either their condition or their individual preferences.

2.8 Continuity of care is also important, and participants were clear that they preferred an approach to receiving care that ensured they would not need to relay the same story repeatedly. Appropriate sharing of data between health professionals was widely deemed to be of value in helping to avoid this.

Physical access

2.9 Participants expressed a preference for convenient local access to an AHP appointment, in some cases due to previous experience of participants in rural areas with poor public transport and/or no access to a car, or those on low incomes. Some participants expressed a preference for access outside of standard work hours (i.e.: 9am – 5pm).

Access to Welsh language services

2.10 Participants reported limited access to AHP services in Welsh. Welsh speaking participants reported challenges with having to communicate with AHPs in English, where having a more limited vocabulary in the medium of English restricted their ability to describe their experiences or symptoms.

3. NHS Dentistry

Reasons for accessing NHS dentistry services

3.1 Participants cited routine check-ups, any necessary treatment identified during check-ups and emergency care as the main reasons for accessing NHS dentistry services. Some participants stated that they only attend the dentist if they require emergency treatment.

Experience of accessing NHS dentistry

3.2 Most participants had experience of seeing an NHS dentist in the last two years, primarily for routine check-ups and treatment from a primary care dentist; however, in some instances respondents did not have a regular dentist but had accessed emergency, out-of-hours dental treatment from a hospital or respondents were parents who had taken their children to community dental services.

3.3 Respondents valued attending the same practice and seeing the same dentist at each routine check-up and suggested that continuity of care was as important with a dentist as it is with a GP. Participants who had not accessed an NHS dentist in recent years saw this as evidence of poor access to NHS dentistry and a reflection of the widespread lack of practices taking on new NHS patients in Wales.

Barriers to accessing NHS dentistry

3.4 Reported barriers to access included a limited number of appointments (even for those who considered themselves registered with a practice), slow booking systems and a lack of reminders to book/attend appointments, long travel times to access a dentist and a lack of knowledge and information on how to access emergency treatment, especially for those without a regular dentist.

Appointments and recall intervals

3.5 When making appointments, respondents valued receiving text notifications, either informing them of the need to make an appointment for a check-up or reminding them of an upcoming appointment. Participants were critical of the need to book check-ups months in advance, when they cannot guarantee they will be free and may forget the appointment.

3.6 A widely cited criticism was a lack of communication (and therefore patient understanding) around recall intervals between check-ups. Some respondents felt six months is an appropriate recall interval, particularly for children.

Emergency care, quality and transparency

3.7 The consensus was that in a dental emergency, people should be seen on the same day and that emergency appointments should take priority over routine appointments. It was suggested there could be an NHS target on emergency dental care.

3.8 Across a number of the groups there was a general lack of confidence in the integrity of NHS dentistry; people described dentists as being “more about money than care”, “wanting to tick a patient off the list” and even “recommending unnecessary treatments”. None of the participants who reported receiving poor quality treatment were aware of how they could make a formal complaint about their dentist and/or dental practice.

4. Community Pharmacy

Advantages and barriers to accessing pharmacy services

4.1 Participants across all groups had accessed community pharmacies either for clinical services (including the Common Ailments Scheme) or dispensary services. The main reported advantages of going to a pharmacy for clinical services or advice (when compared with going to a GP, for example), included greater flexibility (i.e.: not needing a fixed appointment) and potentially longer opening times (e.g.: weekends).

4.2 Despite the cited strengths of pharmacy services, participants also identified a number of issues that may prevent them seeking support from their local pharmacy, including concerns about pharmacies being busy and understaffed, undefined wait times to speak to a qualified pharmacist, lack of medication stock and unwillingness to discuss sensitive subjects with pharmacists due to a lack of an exsiting relationship.

Participant experiences of accessing pharmacy services

4.3 Participants who were generally happy with the service received at their local pharmacies reported being able to be seen quickly and easily at a time which best suited them. Participants reported good and bad experiences of collecting prescriptions via collection boxes. Whilst it is convenient and accessible 24 hours a day, some participants had concerns that patients must remember to ‘tick’ the repeat prescription request and post it

back into the collection box; otherwise, their prescriptions will not be available the following month.

4.4 There were mixed views on getting pharmacist advice on health issues. Some participants trusted pharmacists as 'qualified health professionals', fully capable of giving appropriate healthcare advice. Others, however, cited previous poor experiences where they felt the advice given had been too generic or even inaccurate, or where the pharmacist had not treated certain conditions with the appropriate degree of sensitivity and confidentiality.

The Common Ailment Scheme

4.5 Across all groups, awareness of the Common Ailment Scheme (CAS) was limited; participants were unaware of the full scope of conditions covered by the scheme and whether there was a cost associated with accessing treatment through the CAS. Very few respondents had experience of accessing the CAS, and some negative experiences were reported.

4.6 Participants were largely positive about the idea of accessing treatment through the scheme, on the grounds that it would be more convenient than making a GP appointment, reduce pressure on GP practices and save them money (if the alternative would be to buy over-the-counter medication).

4.7 A number of concerns about the CAS were raised, however, including the potential lack of privacy when asking about more embarrassing ailments, the risk of passing on contagious ailments to other people in the pharmacy, a perception that medication available on the CAS might be weaker/less effective than medication obtained via a GP prescription, the need to wait for an indeterminate time to see the on-duty pharmacist and reluctance to approach an unfamiliar pharmacist (especially of the opposite sex) about certain conditions.

5. Conclusions and recommendations

5.1 This section presents recommendations drawing on the aims and objectives of the review set out in the introduction and identifying areas for consideration.

Good Access Principles

5.2 The research revealed some common principles of 'good access' across some or all of the three areas of primary care (AHPs, NHS dentistry and community pharmacy). These included: flexibility, communication and transparency, better utilisation of the NHS Wales App, continuity of care provider, sharing of information and data. In addition, the research highlighted the central role the GP plays in facilitating access to some primary care services (in particular AHPs). GPs were widely identified by participants as the preferred first point of contact sand highlights the need for a streamlined referral process.

General

5.3 Ensure greater transparency and clarity on the patient journey, in particular about:

- Waiting times and progress on/changes to waiting times,
- Support, treatment and self-help while waiting, and
- Potential discharge arrangements.

5.4 Prioritise continuity of healthcare professional at each stage of the patient journey.

5.5 Enable secure data sharing between professionals to improve patient experience.

5.6 Ensure a flexible primary care system that enables patients to book appointments in a way that suits their needs (i.e.: booking online, in person or by telephone).

5.7 Ensure digital access routes complement traditional routes and are not considered an alternative, for example, referring a patient to NHS111 to support self-care whilst waiting on a planned appointment.

5.8 Maximise the use of the NHS Wales app as a way of sharing information with patients (e.g.: their position on a waiting list, signposting to alternative sources of support whilst waiting).

Allied Health Professionals

5.9 Undertake further research into accessing the different AHP services; given the breadth of AHP services and differences in the way they operate, it is challenging to draw generalised conclusions. It may be beneficial to consider categorising research based on need rather than professional distinction, for example considering AHP mental health support alongside other mental health provision.

5.10 Offer patients flexibility over the mode in which they receive services according their needs (i.e.: online, face-to-face or via telephone).

5.11 Provide a wider range of access routes to AHPs beyond referral through a GP (e.g.: walk-in services or self-referral, with clear guidelines).

NHS Dentistry

5.12 Provide more clarity to the public on the way in which NHS dentistry operates (i.e.: no patient lists, availability of emergency options, role of NICE guidelines in determining recall intervals, juncture between NHS and private treatment)

5.13 Improve public-facing information on availability of NHS dental services.

5.14 Ensure dentists complete a course of treatment in full, providing additional appointments where necessary, rather than providing temporary solutions (e.g.: temporary fillings).

5.15 Provide clarity on process for making a complaint about an NHS dental practice/practitioner, to ensure that patients receiving substandard treatment are aware of how to report it.

Community Pharmacy

5.16 Conduct research into the demands placed on community pharmacy to ensure they are adequately resourced for their increased responsibilities (e.g.: through CAS).

5.17 Publicise the CAS more effectively and ensure community pharmacies actively promote the scheme to the public.

5.18 Prioritise flexibility and patient choice over collection of prescriptions (e.g.: in person, 24-hour collection via collection box).

General Practice

5.19 Prevent the inability to obtain a GP appointment from acting as a barrier to accessing other primary care services by ensuring an integrated and co-ordinated care system in which the GP can act as a first point of contact and refer patients to appropriate services in a timely manner.

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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government

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