SOCIAL RESEARCH NUMBER:
106/2023
PUBLICATION DATE:
13/11/2023

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

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

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Full Research Report: KilBride, K; Heron, S; Wheeler, S; Sterritt, H; Howells, J ; (2023). *Research into “Good Access” in Community Pharmacy, NHS Dentistry and Allied Health Professional Services*. Cardiff: Welsh Government, GSR report number 106/2013.
Available at: https://www.gov.wales/research-good-access-community-pharmacy-nhs-dentistry-and-allied-health-professional-services

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

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Glossary

Acronym	Definition
AHP	Allied Health Professional[1]
CAS	Common Ailment Scheme
GP	General Practitioner
NICE	National Institute for Health and Care Excellence

[1] Art therapists, Music therapists, Drama therapists, Dietitians, Occupational Therapists, Physiotherapists, Podiatrists, Orthoptists, Prosthetists and Orthotists, Paramedics, Psychologists and Speech and Language Therapists.

1. Introduction

Overview

1.1 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[2].

1.2 The objectives of the research were to;

- Identify key barriers and facilitators to accessing primary care across Community Pharmacy, NHS Dentistry and Allied Health Professionals.
- Explore what good access means to people and the expectations of what good access looks like in Community Pharmacy, NHS Dentistry and Allied Health Professionals.
- Explore perceptions of phone first and telephone consultations / triage.
- Explore perceptions of face-to-face appointments vs use of technology.
- Identify awareness of available options such as; NHS 111, Common Ailment Scheme; My health online and the NHS Wales App.

1.3 The rationale for this study was rooted in the 2021 to 2026 Programme for Government commitment to "Deliver better access to doctors, nurses, dentists and other health professionals". It builds on a 2019 study commissioned by Welsh Government on access to primary care services delivered in a General Practice setting[3], which identified a knowledge gap in relation to access to other areas of primary care.

1.4 A range of Welsh Government policies are already in place, or under implementation, to improve access to primary care. Policy leads were specifically interested in understanding

[2] 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.

[3] Accessing Primary Care services: Qualitative research

the citizen's view of what 'good access' means to identify any further opportunities for policy development.

Policy background

1.5 The Primary Care Model for Wales is the agreed approach to achieving the vision set out in A Healthier Wales: long term plan for health and social care. The Model is about equity of access to the right care, at the right time, from the right professional or service, at or close to home.

1.6 The Primary and Community Care Division of Welsh Government has been assigned the following three commitments in the Programme of Government 2021-2026:

- Invest in a new generation of integrated health and social care centres across Wales.
- Reform primary care, bringing together GP services with pharmacy, therapy, housing, social care, mental health, community and third sector.
- Deliver better access to doctors, nurses, dentists, and other health professionals.

1.7 The purpose of this research was to support the Primary and Community Care Division of Welsh Government to deliver these commitments by capturing evidence of what good access means to the general public. Finally, although the third commitment is the most directly applicable to the objectives of the research, each of the commitments are interconnected and drive better access, and therefore were considered in the development of the research.

Methodology

1.8 The following section details the methodology employed to undertake the research and produce the key findings. The research began with a scoping phase consisting of qualitative interviews with key stakeholders and a literature review, which collectively informed the sample structure and questioning framework for the main fieldwork phase, involving seven focus groups with members of the public from each of the seven health boards in Wales.

Scoping phase

Literature review

1.9 The literature review included research reports, evidence papers, and academic articles. The purpose of the literature review was to identify issues relating to access to primary care services in Wales, other parts of the United Kingdom, and internationally, to help further define the scope of the main fieldwork.

Scoping Interviews

1.10 Miller Research carried out targeted scoping interviews at the outset of the research to help frame the research and line of questioning to ensure it aligned with Welsh Government priorities and maximised the effectiveness of the research outputs. These were conducted with staff in Public Health Wales and Welsh Government with responsibility for AHP, NHS dentistry, and community pharmacy policy. These interviews focused on developing an understanding of the policy direction of these services, Welsh Government insights into access issues[4] and barriers and enablers to "good access" as well as identifying relevant existing literature and data sources[5] .

Fieldwork Phase

Focus groups with members of the public

1.11 In total seven focus groups were held (one with members of the public in each health board), with eight to ten participants in each involving a total of 59 participants. Each focus group was run as a 90-minute session on Microsoft Teams with 30 minutes devoted to each primary care service[6]. Each group was facilitated by two members of the research team and recorded with the consent of participants.

Recruitment of members of the public

1.12 Participants for the seven focus groups were recruited by DJS Research, a specialist recruitment company. Participants were selected based on a series of factors to ensure a range of representation, including geographic location (i.e.: residence in the relevant health board), experience of accessing the three services, age, gender, disabled people, or those caring for a disabled person, parents or carers of young children, and socio-

[4] In particular access challenges for certain groups, effect of Covid-19 on access, distribution of different access models across different areas, suitability of a Once for Wales approach and issues around workforce development and service planning.
[5] The topic guide for the scoping interviews is provided at Annex A.
[6] The topic guide used for the focus groups is provided at Annex C

economic group. The focus groups in the footprints of Powys Teaching Health Board and Betsi Cadwaladr University Health Board were conducted in the medium of Welsh. The sampling structure[7] was agreed with the Welsh Government prior to recruitment.

1.13 DJS Research shared the Privacy Notice with participants, provided them with links to the online focus groups[8] and a small payment was made to participants as compensation for their time.

Analysis and Reporting Phase

Analysis of qualitative data

1.14 Following each focus group, facilitators reviewed and refined the notes taken during the focus groups and compared against the recorded transcription, where necessary. The notes for each focus group[9] were then organised in a consistent format around the topic guide developed and agreed with Welsh Government in advance. These notes were then coded thematically using a framework that was based on the topic guide as well as new themes that emerged from the data and transferred onto digital whiteboards in Miro[10]. This was an iterative process through which thematic coding occurred as the notes were transferred and new codes developed as themes emerged over the course of the seven focus groups.

Reporting

1.15 The mind maps developed in Miro were then used to produce an initial slide-deck of headline findings, which offered an overview of opinions shared in the focus groups and structured by health board as well as by primary care service[11].

Full report

[7] The full sample structure is provided at Annex B.
[8] Miller Research did not at any point have contact details (telephone number or email address) for the participants.
[9] The brief for the commission was explicit – it was to capture feedback from members of the pubic on their perceptions of 'good access'. Whilst the scoping interviews were invaluable for providing context, it was important that feedback from policy leads was not conflated with the experiences and opinions of those participating in the focus groups in the final report.
[10] Miro (Miro.com)
[11] I.e.: community pharmacy, NHS dentistry and AHP.

1.16 Finally, we compiled this report, providing more detail on the findings from the focus groups. Examples and quotes have been used where illustrative of a theme or pattern identified within the focus groups.

1.17 This report is structured as follows;

- Section 2 focuses on AHPs
- Section 3 focuses on NHS dentistry
- Section 4 focuses on community pharmacy
- Section 5 focuses on principles of good access which were common across service areas and presents over overarching conclusions
- Section 6 presents recommendations from the research

1.18 Each of the three main sections (on AHPs, NHS dentistry and community pharmacy) are structured thematically and none of the issues identified in the report are attributed to any particular health board(s). This is to avoid giving the impression that the issues being reported (positive or negative) are an indication of the relevant health board being 'better' or 'worse' than others, given that this was a qualitative research exercise.

2. Allied Health Professional Services

2.1 Most focus group participants across the seven health boards had accessed one or more of the following services in the last two years: physiotherapy, dietitian support, mental health support, podiatry, occupational therapy, and art therapy, covering a wide range of the AHPs[12].

2.2 Their experiences, preferences and perceptions of barriers that were specific to AHPs related to the referral process, waiting lists, communications and transparency, continuity of care, format of care offered (i.e.: face-to-face or online), physical access and availability of services in the medium of Welsh.

The referral process; experiences, preferences, and barriers

2.3 The two most common routes for access to AHPs cited were through the GP (particularly for mental health support), or a referral after receiving secondary care (principally for physiotherapy, following surgery). Participants had mixed experiences of the referral process through GP surgeries. Many cited difficulties in accessing GPs in order to obtain a referral, often having to phone repeatedly to get an appointment, which was a significant hurdle to accessing treatment.

2.4 In some cases, referrals from GPs proved ineffectual. For example, one participant was trying to access occupational therapy for a relative, but despite three GP referrals, they heard nothing. The participant then contacted Social Services and asked them to come and carry out an assessment, but they did not come. It was only following a fall and a hospital admission that the relative was seen by occupational therapy.

2.5 Alternative referral processes such as self-referral by e-form were found to be difficult even for those familiar with technology, given the challenge of reflecting the nature of their condition in writing. For some of those with a preference for referral via a GP the uncertainty of whether their condition was ‘severe enough’ to warrant a referral meant they were concerned about wasting health professionals’ time. Self-referral was considered convenient by some respondents, although concern was expressed about lack of

[12] For the purpose of clarity, the term Allied Health Professional / AHP was not used in the groups, given it is not widely familiar to members of the public. Instead, a list of the relevant services was shared on screen and participants asked about the specific ones they cited as having accessed.

knowledge of where to go without the involvement of the GP. Several participants stated that they had easier access to (private) AHP services through their employer than the NHS.

2.6 When participants were asked how they would prefer to access AHP services, they offered a range of perspectives and preferences, which were determined largely by the condition, the specific AHP and the individual, suggesting that referral routes must be flexible. Young people were more likely to feel comfortable booking appointments online due to its convenience (albeit the issue previously mentioned about feeling unconfident describing the condition independently was still relevant for some), but older and less technologically capable participants preferred booking appointments by phone or in-person. This was despite the widely cited challenge of obtaining an appointment with a GP in the first place, for any reason including for a referral to an AHP service.

2.7 For physiotherapy and mental health support, there was stronger support for self-referral, although some still preferred to go through their GP. Walk-in or drop-in surgeries (e.g.: for physiotherapy) were also presented as favourable alternatives, which were convenient and bypassed complex and lengthy referral processes. Pharmacies and charities were considered a potential referral route, particularly charities connected with mental health or eating issues, although there were concerns around how they would effectively triage patients and identify those requiring more specialist support.

Waiting times and communication

2.8 The length of waiting times for AHP services was consistently raised as an issue and barrier to access. Waiting times were raised by all participants, particularly in relation to mental health services delivered in both English and Welsh. One participant described his experiences of trying to access support for his Autistic Spectrum Disorder (ASD) diagnosis, when he was told that waiting times for an initial referral were considerably long (and that the timeframe could not be estimated), and this was followed by an open-ended waiting time to receive treatment following an initial assessment. Another relayed their experience of accessing podiatry with a waiting time of over 14 months for treatment as they were referred back and forth between practice nurses and podiatrists, during which time they were told that the podiatrist had “far worse people waiting”.

2.9 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. One participant stated that although their two-year wait for specialist mental health services was a negative experience, they did appreciate that this was because of healthcare professional recruitment issues. Knowing the reason for the delay improved their experience. Participants commonly reported that they were told the length of waiting times with no further communication unless the waiting time had been extended. Another participant was given a long waiting time that suddenly shortened with no explanation of why this happened, which was disconcerting, even if it did mean quicker access than expected. Participants shared negative experiences of accessing occupational therapy and dietitian services, where they did not receive any notice that they had been discharged from the service or given any guidance on additional support they could seek if issues persisted.

2.10 This lack of communication was a persistent issue with participants suggesting that more could be done to keep patients fully informed. One proposal was that the NHS Wales App could include a feature where patients can visibly check the waiting list they are on. It was felt this would lighten resources elsewhere, could be coupled with signposting information for support in the interim, and would help manage patients' expectations. Inconsistency around waiting times, poor communication, and the lack of information available to patients led to stress as they felt they could not make commitments such as booking a holiday "for fear of missing their appointment."

2.11 A consequence of this uncertainty and the long waiting times was that some participants were driven to access services privately. While this was often about getting support in a prompter manner, there was also the feeling that because you are paying, you are entitled to access the service, which one participant compared to the NHS, where they felt they had to 'justify how ill' they were to receive any care. The perception of the NHS being overburdened and under-resourced led to guilt, anxiety, and a reluctance to engage with services:

"I dread the wait times. You expect to wait ages which puts people off calling, and some people just use private services."

2.12 Participants thought that this may discourage people who cannot afford private healthcare from seeking any healthcare at all.

Format of care and continuity of care

2.13 Participants' experience of different formats in which they received care or treatment from an AHP demonstrated that flexibility is a core principle. Individuals both liked and disliked video, phone and in-person consultations depending on either their condition or their individual preferences. Some participants – particularly younger people – thought that telephone or video consultations were more convenient and would allow for more efficient access to a service. Common concerns expressed about telephone consultations, however, were that important information can be difficult to convey over the phone, some issues might not be picked up over the phone or they may not build a sense of trust and rapport with the health professional. Participants also expressed concern that with telephone or video appointments, they may not have access to dedicated space or time to speak openly about their health concerns without worrying about privacy.

2.14 The preferred format of care was reportedly closely connected to continuity of care. Participants were clear that they preferred an approach to receiving care that ensured they would not need to relay the same story repeatedly. They also noted, however that e-consult forms[13] had to be functional and allow space for patients to accurately reflect their health issues. It was felt that this would ensure the most appropriate format of care, in addition to limiting the number of times they would need to repeat themselves when coupled with data sharing across professions.

2.15 Appropriate sharing of data between health professionals was widely deemed to be of value; one participant spoke about their negative experiences of physiotherapy, where the physiotherapist who carried out their treatment was not made aware of their movement restrictions and instead pressured them to undertake exercises that were detrimental to their recovery. Seamlessness, communication, and continuity were seen as key to good access.

[13] E-consult is a form-based online consultation and triage platform that collects medical and administrative requests and sends them to the patients GP practice to triage and decide on the appropriate care. Some participants were concerned about their ability to accurately describe how they were feeling in writing and felt that they may have to repeat their story when speaking to a healthcare professional.

Physical Access

2.16 Overall, travelling for appointments was not seen as an issue that participants had experienced for AHP support, although convenient access at a local location was preferred. In particular, participants reported that those on low incomes or in rural areas with poor public transport and/or no access to a car might particularly struggle to travel for AHP care. Another physical access issue was appointment times; participants in a number of groups expressed a preference for access outside of standard work hours.

Access to Welsh language services

2.17 The experiences of Welsh speaking participants in accessing the full range of AHP services was relatively limited, particularly services delivered in Welsh. However, they raised a number of concerns around the availability of services, delivered in both Welsh and English.

2.18 For Welsh speakers, language barriers were a consistent issue with many AHP services not available, or difficult to access in Welsh. Mental health services in the medium of Welsh were singled out in particular as having lengthy waiting times and limited availability. A small number of participants whose language preference was Welsh reported having to communicate with the AHP in English, which they stated limited their ability to describe their experiences or symptoms because of having a more limited vocabulary in the medium of English. Welsh speaking participants also felt that services in the medium of Welsh were more likely to have limited capacity, which exacerbates barriers such as lengthy waiting times and availability of services.[14]

[14] It is important to note that this is the participant's experience or perception rather than an accurate reflection of availability of Welsh language services.

3. NHS Dentistry

Reasons for accessing NHS dentistry services

3.1 Across all groups, participants cited routine check-ups, any necessary treatment identified during check-ups and emergency care as the main reasons for accessing NHS dentistry services.

3.2 Another cited reason for seeing the dentist was to prevent oral health problems and to establish good habits, which was considered particularly important for children:

> *"it's good practice … important to do and pass on to your children so they get in habit. Nothing worse than a toothache … trying to avoid that [by having check-ups]."*

3.3 One respondent compared a dental check-up to an MOT on a car in terms of identifying emerging issues and preventing problems from developing or escalating. Others described the main purpose of a check-up as providing reassurance that their oral health is at a good standard.

3.4 Some participants stated that they only attend the dentist if there is a reason for them to go, for example in an emergency. Primarily this was accessed via an emergency out-of-hours service and not from a primary care dental practice. These were largely younger people (under 25 years old).

3.5 One older participant reflected that people "of my generation" would prefer regular, sixth-monthly check-ups, in the interests of prevention, but that it is not possible to get an appointment.

Experience of accessing NHS dentistry

3.6 Most participants in each group (at least six) had experience of seeing an NHS dentist in the last two years. In most cases this was for routine check-ups and treatment from a primary care dentist; however, in some instances it was people who did not have a regular dentist but had accessed emergency, out-of-hours dental treatment from a hospital.[15]

[15] NHS dental services are provided by primary care (General Dental Services), community (Community Dental Services), and hospitals (Hospital Dental Services). Each service has different commissioning, contractual and management arrangements. This research has primarily focused on access to primary care, or General Dental Services, however, on occasion participants referred to Hospital Dental Services and Community Dental Services.

Some participants – typically parents referring to their experience of taking their children to the dentist – described having accessed community dental services.

Availability of NHS dentists

3.7 In terms of examples of good access, people talked about the value of 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. One older man, for example, really valued the fact he has been seeing the same dentist for 17 years.

3.8 Every group included some participants who had not accessed an NHS dentist at all in recent years[16]. In most cases, they 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.

3.9 One parent reported that her daughter's last two appointments had been cancelled and she felt that "children [are] put on backburner." Another parent reported that her son had been waiting for a root canal treatment on a cracked tooth for three years, with no explanation for the delay. In another case, the participant's daughter had additional learning needs but was unable to access NHS dentistry services due to lack of dentist experienced in treating children with additional needs in their area.

3.10 Some people cited a lack of specialists in the local area for children with additional learning needs, as well as patients of any age with a genuine phobia of dentists. One respondent felt dentists could have a "panic room to calm people down" or could even "offer CBT [cognitive behaviour therapy] or something to help people".

3.11 On the other hand, several parents reported that they really valued being able to get an appointment for a check-up for the whole family at the same time. A couple of parents also described NHS dentistry services that catered very well for children with additional needs. In one instance, their disabled child had been able to access a mobile dentistry unit from Community Dental Services offering same-day appointments. Another participant had a dentist who was aware of their child's additional learning needs and both reception staff and clinical staff treated them with gentleness and compassion, which helped alleviate their child's anxiety.

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[16] At least six participants had to have accessed an NHS dentist in the last two years, meaning up to four may *not* have had this experience.

3.12 A lack of opportunity to access a nearby dentist was noted by a few people. In one instance a participant was offered access to a practice outside the region:

"When I went online to see where nearest NHS practice was and was told it was near Gloucester!"

3.13 Another person was still with the dentist where she registered as a child and where her own children have subsequently registered:

"The kids grumble because have to travel 45 minutes to get there … but I think don't move [dentists] no matter how far away it is."

3.14 It was widely suggested that the main barrier is limited availability of NHS dentists that are open to new patients, an issue that is exacerbated by growing numbers of dental practices no longer providing dental care on the NHS. A limited availability of Welsh speaking NHS dentists was also cited as a barrier, especially by participants in North Wales.

3.15 Other commonly cited issues included a limited number of appointments (even for those who consider themselves registered with a practice), slow booking systems and a lack of reminders to book/attend appointments, low levels of trust in the integrity of the service, 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.

3.16 Another significant barrier reported by those who had inflexible work schedules is the limited opening hours of dentists (e.g.: 4pm closure) which requires patients to take time off work. One individual suggested that that some employers are happy for people to attend a GP appointment in work time, but dentist appointments are considered a choice.

3.17 For some patients, poor access is a combination of factors:

"Dad doesn't go [to the dentist] because it's more painful he says and he [doesn't want to] pay someone. Rather pull out his own tooth."

3.18 One individual was under the impression that NHS dentistry was only available to people on benefits and that if you had a job, you had to go private:

"Don't think I have been to an NHS [dentist] since school. Never thought it was an option."

Making appointments

3.19 Some participants talked about the process of booking appointments and receiving reminders as being commendable. One individual reported her practice had an “excellent online booking system”, which others in the group also felt they would value this as a better alternative to having to phone in a very limited window of time (e.g.: first thing in the morning). People also described receiving text notifications, either informing them of the need to make an appointment for a check-up or reminding them of an upcoming appointment, which was considered advantageous:

> *“A reminder that you are due for a routine check-up is so helpful. [We’re] busy people, forget things like that.”*

3.20 Several participants were critical of the need to book check-ups up to a year in advance, when they cannot guarantee they will be free and are very likely to forget the appointment.

3.21 People also reported having been taken off patient lists[17] because of not arranging a check-up, something they felt was unfair:

> *“How are you to know when your routine appointment is due? A year goes by so quickly – that’s the moment you are struck off.”*

3.22 A couple of respondents (in different focus groups) said they had lost their place with their dentist (in their hometown) whilst away at university. In one instance this was because they had not booked a check-up; in the other case the (then) student had been sent an appointment by letter to their home address but did not open the letter until after the appointment date had passed.

3.23 Other people reported being taken off the patient list for missing appointments despite extenuating circumstances. For example:

> *“I rang just before my appointment to say my car had blown up on the way there and I wouldn’t get there – and they kicked me off!”*

3.24 The general consensus was that it should be possible to book routine appointments in a few weeks’ time, whereas the reality was that most appointments had to be booked many

[17] Throughout this research it has become clear that there are common misconceptions on how NHS dentistry works. This was particularly true in relation “patient lists” and “registrations”. NHS dentists have not had registers since the introduction of the UDA contract in 2006. Since then, practices are at liberty to accept patients or not and once a course of treatment has been provided, they have no obligation for ongoing care unless the treatment fails (e.g.: a filling falls out) within two months.

months in advance. Respondents felt it was easier to remember appointments that were not so far in the future and said they were often dependent on text reminders in the days before the appointment.

3.25 There was some interest in being able to book routine appointments online as well as being able to simply phone up. Others felt it was easier to book a check-up in person at the end of the previous appointment as they could just add it to their personal or work calendar.

3.26 One participant suggested that NHS check-ups should be available to all once a year, but that individuals could pay a nominal amount should they wish to be seen more often.

Waiting times

3.27 Amongst those who did not have a regular dentist, there was reported frustration about a lack of communication over waiting lists. One respondent was told she could pay privately on a monthly basis or wait for the waiting list for NHS treatment to open; however, the timeframes for the latter were unknown:

> *"It's ridiculous that they can't just book you in as they know how many spaces there are going to be over the next few months. They can't tell you how long you will be waiting."*

3.28 Even some of those who did routinely see an NHS dentist were dissatisfied with waiting times for treatment. One individual had been waiting for a filling for six months but had been told there were no appointments for several months longer. The tooth was starting to hurt, and she may have been able to get an emergency appointment, but she considered it ridiculous that it needed to get to the state of being in pain to receive the treatment she needed.

3.29 One individual gave the example of her teenage son's experience. When he went for a check-up after a long gap caused by the pandemic, the dentist noted he was missing several adult teeth. He received an emergency orthodontist appointment but was told "it was a four-and-a-half year wait for orthodontic treatment on the NHS." They therefore paid privately for him to have a brace, implants, and alignment.

Recall Intervals

3.30 A widely cited criticism was a lack of communication (and therefore patient understanding) around extended recalls:

"I used to see [my dentist] every six months, now it's every two years. I don't understand why."

3.31 Covid was considered by some respondents to have been the catalyst for recall intervals being extended from six months to a year, and almost all respondents were unaware of the role of National Institute for Health and Care Excellence (NICE) guidelines in setting recall intervals.

3.32 One participant was explicitly told that the fact he did not need to be seen so often was down to his good standard of oral health:

"The dentist said: "see you in two years – as you look after your teeth you shouldn't need to come before then." This participant felt this reflected poorly on access to NHS dentistry: "I don't think the service is as good as it was."

3.33 One participant had not been able to book an appointment at all during the Covid-19 restrictions which ran from March 2020 until December 2021. Two years on she needed several fillings and an operation on her gum but had to wait ten months between the initial check-up and the treatment, during which time her oral health was worsening.

3.34 Another person reported a similar experience. After initially receiving emergency treatment for a cracked tooth, she had since been waiting months for follow-up, whilst worrying the tooth was deteriorating:

"I can't get another emergency as it's the same tooth … I just want someone to tell me whether I can do damage [by biting on the tooth]".

Public preferences for recall intervals

3.35 The majority of respondents felt six months is an appropriate recall interval. This was almost unanimous amongst older participants, whilst some of the younger people felt "one year was okay". When asked specifically about frequency of check-ups being linked to standard of oral health[18], some respondents across the groups responded that they would

[18] I.e.: those with good oral health having less frequent check-ups.

be happy in principle with waiting longer for check-ups if they had no oral health issues, and as long as there was easy access to emergency appointments when needed.

3.36 Several participants expressed concerns about health issues being missed if they had less frequent check-ups (e.g.: every two years), particularly serious conditions such as mouth cancer.

3.37 Although some participants had experienced two-year recall intervals, their understanding generally was that this was due to the backlog associated with Covid and something that was – and should be – only temporary. One participant had been told that the reason for their two-year recall interval was due to their good oral health. However, not one participant across all seven groups supported two years as an appropriate recall interval: “so much could happen in two years, that is bonkers.”

3.38 In one group, a respondent suggested that having check-ups every 12 months was “now the norm in the NHS” and this was considered acceptable by the group in general as long as patients could access emergency treatment if needed. In another group it was suggested that moving to 12 monthly recall intervals (as opposed to six monthly) was understandable and aligned with a move to a more preventative approach. Across all groups the general consensus was that children should receive check-ups every six months.

Tensions with private dentistry

3.39 Several people described their existing dental practice going fully private and them not being able to afford to pay privately and so losing their dentist. A couple of participants reported having a dentist who did both private and NHS work and who encouraged NHS patients to pay privately in order to get treatment faster or to a higher standard:

> *“My dentist told me that he would do a better job if I went [with him] private.”*

3.40 Another participant reported receiving NHS treatment from a dentist who she felt was:

> *“…pushing more private treatments on me … there was nothing wrong with my teeth, but he was saying they can offer straightening and whitening.”*

3.41 It was generally felt that this undermines confidence in the quality and integrity of NHS dentistry. One participant who had opted to pay privately after having been an NHS patient expressed suspicion that patients receive substandard treatment on the NHS:

"I'm paying [privately] for it now, which means my fillings are done differently and I thought, 'why didn't I get this [higher quality] treatment when having it on the NHS?' It makes you a little bit cynical."

3.42 Respondents were critical of a lack of communication or clarity over why they were not, or no longer, able to access some services on the NHS, in particular scale and polish. One participant was under the impression that he was no longer able to receive a scale and polish because of Covid. He could not understand why it was still not available despite the fact that Covid restrictions had been lifted.[19]

Emergency care

3.43 Some participants reported being able to access same-day emergency treatment, either from their regular practice or out-of-hours service. In some cases, they described a very positive experience of phoning for an emergency appointment. For example, one individual said that every time they have been able to get an emergency appointment within an hour. Others noted that it can require persistent phoning, and that it often appears to be down to luck whether or not they secure an appointment.

3.44 One respondent found a lump inside her mouth and was convinced it was cancer. Despite not being in pain, she was given an appointment within two days and reassured by the dentist it was not something to worry about.

3.45 An older man, who did not have a regular dentist, had to phone for an emergency appointment, as a result of which he got put onto a waiting list for a new NHS practice for a short time and then received regular routine check-ups at this new practice.

3.46 Another respondent was aware of friends and family who were unable to access regular treatment from a primary care NHS dentist and so were relying on emergency out-of-hours services in hospital as a means of accessing treatment. Someone else stated that they

[19] This decision was not a result of the Covid-19 pandemic, rather a Cochrane Review of routine scale and polish for periodontal health in adults. One can take from this that the patient was not provided an explanation for the change and is indicative of poor access.

went to another country for dental treatment instead of waiting for treatment on the NHS and now gets regular appointments in the other country.

3.47 Participants were asked whether the process of accessing dental care should differ depending on the reason and if so, how it should differ. The unanimous view was that in an emergency, when people are in pain, they should not have to wait long to get through on the phone and should be seen on the same day, given the likelihood of patients being in extreme discomfort and suffering from lack of sleep and the potential for serious implications, such as the loss of a tooth. In one group, it was suggested there could be an NHS target on emergency dental care.

3.48 Several people expressed concern that emergency appointments are typically time-limited, meaning people receive only temporary or incomplete treatment that can result in any pain returning. That said, participants were unsure how to address this issue in a way that ensures maximum access and avoids dental practices becoming like “A and E waiting rooms”.

3.49 One participant reported that their dentist fits people in for emergency appointments in between routine appointments, which creates a backlog that is frustrating for patients who are missing work to attend an appointment that is then delayed.

3.50 One participant mentioned that emergency treatment is available at a hospital near them, which avoids the need to go to a community practice. The rest of the group was unaware of this, and the conclusion was that this should be publicised better, especially for people who do not have a regular dentist.

3.51 The consensus was that emergency appointments should take priority over routine appointments. Some participants said they would be willing to have their routine appointment postponed to free up their dentist’s time to cover an emergency for someone else, as long as there was good communication. They said they could also benefit in this way, should they ever require emergency treatment.

3.52 There were a wider range of views on reasonable expectation for waiting times for emergency treatment, ranging from one to 72 hours after calling the dentist.

3.53 Continuity of care (in terms of what dentist you see) was not considered as important for emergencies as for routine appointments. Several participants felt that if the problem cannot be solved on the day, a follow up course of treatment should be offered.

Quality and transparency

3.54 Several participants were critical of appointments being too short, resulting in the dentist running out of time and having to deliver a temporary fix that can make the problem worse. In one instance the participant was told the dentist would “just have to pack it [the tooth]” and she would have to come back in a couple of months’ time. She ended up losing the tooth[20], which she felt could have been avoided with more time and a proper filling at the initial appointment. Another participant described being “fobbed off” with antibiotics when they needed restorative treatment. A couple of individuals were critical that their dentist seemed to be “less preventative and more reactive.”

3.55 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”.

3.56 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.

3.57 Some individuals – primarily those who were anxious about seeing the dentist – suggested inconsistency in which dentist they will see (and lack of communication on this when making an appointment) is a barrier.

3.58 Others cited unexpected costs and procedures as a barrier; for example, one participant described being asked to pay for an X-ray privately, despite receiving an NHS Band 2 course of treatment[21]. She reported that she did not know she was going to have to pay extra for the X-ray and it made her nervous about going to the dentist again. Other participants felt that the cost of treatment in general was a deterrent, particularly now in the cost-of-living crisis.

[20] I.e.: she had to have it extracted.

[21] NHS Dental Treatments are categorised by Bands with x-rays included under a Band 2 dental treatment.

4. Community Pharmacy

4.1 Focus group participants across all seven health boards had accessed community pharmacies either for clinical services (including the Common Ailments Scheme) or dispensary services. These form two distinct services which share common issues as well as distinct barriers to good access.

Motivations for accessing pharmacy services

4.2 Participants were firstly asked why they would choose to receive support through a pharmacy. Participants noted the relative ease of access to a local pharmacist, particularly when compared to their local GP. More specifically, they indicated that there is far more flexibility with pharmacy services, given that they can walk in at a time that best suits them, rather than being tied to an appointment. This was considered particularly important for participants who were in employment or had caring responsibilities, making the pharmacy a more convenient option than going to a GP.

4.3 The types of services participants expected to receive from their local pharmacy included healthcare advice, collecting prescriptions, purchasing over-the-counter medication, receiving Flu and Covid vaccines and other non-emergency care.

Participant experiences of accessing pharmacy services

4.4 A number of participants were able to cite positive experiences they have had with their local pharmacy, noting that they were able to see a pharmacist more quickly and easily than at the GP, and therefore the pharmacist served as a useful first port of call for access to non-urgent care and advice.

4.5 Some participants, however, also noted a number of potential challenges that may prevent them seeking support from their local pharmacy, including concerns about pharmacies being busy and understaffed, resulting in undefined wait times to speak to a qualified pharmacist, lack of medication stock and lack of specialised services to meet patient needs. One participant explicitly stated that if they were seeking support for a child, they would go straight to their GP and not consult their local pharmacist.

4.6 Some participants noted that their local pharmacy had become busier in recent years and that this required them to either put in orders for repeat prescriptions at an earlier date or seek out alternative options, such as using online pharmacy services.

> *"[our pharmacy] used to be great. Never had any issues. Recently it has been a nightmare. I was there today. I phoned through my prescription last week. It took me 10 or 15 times. My husband had been trying for three days and thought their phone lines were down. He needed his beta blockers – I went to pick them up and they weren't there. Because he desperately needs it, we are considering doing the online one, so it gets posted to us because it's the same issue every time."*

4.7 Participants who were generally happy with the service received at their local pharmacy noted that they were able to be seen quickly and easily at a time which best suited them and their schedules. Participants who noted a more positive experience tended to live closer to urban centres and had a greater number of local pharmacies to choose from. Participants also felt more connected to their local pharmacy and many stated that they found them to provide good continuity of care, particularly for those who had to access their services regularly.

Ordering and collecting prescriptions

4.8 Some participants had access to drop box machines where they could receive their medication outside of regular hours and some found this more convenient than accessing it through the pharmacy. The only suggested issue with drop box machines was that patients need to remember to 'tick' the repeat prescription request and post it back into the drop box, which can be forgotten, resulting in prescriptions not being available the following month and patients having to request an emergency prescription (via their GP practice).

4.9 In general, participants had mixed experiences of ordering their prescriptions through their local pharmacy. Whilst some participants were happy with their experience, noting that they were able to pick up their prescription when needed or have it delivered conveniently through an online service, others cited incidents in which they had experienced delays in accessing their prescriptions due to misplaced paper prescriptions or a limited supply of medication.

4.10 One participant noted that they had felt pressured by their local pharmacy to move towards the online ordering system to help them manage their caseload but that the participant had been unable to do this due to technical issues with the registration process.

4.11 Another participant described the experience of his father who used to have his prescriptions delivered, but due to his poor hearing, he would not hear the knock at the door and so the prescription would be taken back to the pharmacy, meaning the participant would then have to collect it. They considered this poor access and thought that it demonstrated a lack of flexibility on the part of the pharmacy, although they were unable to suggest a suitable alternative other than not offering the delivery service in the first place:

"Theoretically it was more convenient, but actually I had to go and collect them anyway."

4.12 Another participant described a very positive experience when they forgot to take their regular antidepressant medication on holiday; they were able to access an emergency supply by calling their GP surgery and then picking up a week's supply of medication from a pharmacy in the area where they were staying.

Pharmacists and advice

4.13 There were mixed views about the ability of pharmacists to give advice on particular health issues. Some participants trusted pharmacists as 'qualified health professionals' with years of training to give appropriate healthcare advice. Others, however, expressed concerns about going to a pharmacist for advice on certain healthcare issues, citing previous poor experiences where they felt the advice given had been too generic or even inaccurate. Some participants had experienced pharmacists not treating certain conditions with the appropriate degree of sensitivity and confidentiality.

4.14 Finally, there was a perception that as commercial organisations some pharmacies may try to "upsell" treatments, which the patient does not necessarily need or where there may be a cheaper alternative, in the interests or profit. One participant, for example, described going into a pharmacy to ask for advice about indigestion and being recommended a branded antacid, which they then bought, despite indigestion being included under the

Common Ailments Scheme (see immediately below). Another participant had a similar experience when her young baby was suffering from nappy rash; again, she was recommended a comparatively expensive cream, having not been aware she could have received it for free under the scheme.

Attitudes towards the Common Ailment Scheme

4.15 Across all focus groups, awareness of the Common Ailment Scheme (CAS) was limited, with a particular lack of understanding of the full scope of conditions covered by the scheme as well as confusion over whether there was a cost associated with accessing treatments through CAS:

"I went in expecting to buy and they gave me what I needed free of charge under the scheme."

4.16 Participants noted that they would expect to hear about the scheme through key healthcare settings such as their local GP or the pharmacy itself. The finding that some participants had gone into a pharmacy to ask for advice and treatment for conditions covered by the CAS, but had not been made aware of the scheme, suggests that pharmacies could do more to promote it.

"Word needs to get out more what is available. If you go to chemist to buy one of these things, they should ask you if you've accessed this scheme."

4.17 Some participants suspected that pharmacies were not actively promoting the scheme because they did not want to lose out on sales of over-the-counter medication. One participant expressed concern that relying on members of the public to proactively ask for treatment under the CAS may create stigma around the scheme and a perception that people accessing it cannot afford to buy medication themselves.

4.18 Where participants had heard about the CAS, this was largely through word of mouth from friends and family or from social media. Only two participants across all seven groups indicated they had heard about the scheme through their GP or another healthcare professional.

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

"A few things on this list that would've saved [me] a small fortune if I had known I could've accessed it free of charge!"

4.20 However, some participants also noted that there were certain conditions covered by the CAS where they would be less willing to use it because of concerns that the pharmacy setting may not provide sufficient privacy and sensitivity for them to feel comfortable seeking advice. Additionally, due to the perception that pharmacists are incredibly busy participants felt that, and had experienced, pharmacists treating conditions without sufficient regard for their privacy. Whilst it was felt that access to private consultation rooms would allay some of these concerns, it was noted that smaller pharmacies may not have these facilities; others were concerned about a potential stigma around the use of private consultation rooms:

'[They] take people into the room and everyone knows why.'

4.21 In addition to the main concerns participants noted in terms of accessing treatment through CAS, a number of other concerns were raised, both by those who were aware and those who were not aware of the CAS, including:

- Concern about accessing treatment in person for some contagious conditions (e.g.: chickenpox or diarrhoea); participants suggested that whilst it is acceptable to go to a GP surgery with something like this, they would feel "guilty" about going into a pharmacy, which was considered more of a public space than a clinical setting.
- Concern about medication strength – i.e.: that it would not be as strong or effective as medication obtained via a GP prescription.
- Concern about waiting times – given the need to consult the on-duty pharmacist[22] rather than being served immediately by another member of staff – and whether

[22] Who may not be available immediately.

CAS could be less convenient than buying treatment from general retailers – or the pharmacy itself – or even getting it on prescription from their GP.

- Concerns around accessing treatment for some sensitive ailments from a pharmacist of the opposite sex. This is something that was not considered such an issue with a GP appointment, for which they commonly have some choice over which GP they see. Furthermore, if they are seeing a regular GP, patients were more likely to report feeling comfortable with raising sensitive issues, even with a GP of the opposite sex.

Experiences with the Common Ailment Scheme

4.22 As awareness of CAS among participants was limited, only a few participants indicated they had experience of accessing treatment through the scheme. Their experiences were mixed. A couple of participants reported it being a quick and convenient process, where they were able to access a consultation with a healthcare professional and receive treatment free-of-charge at a time that suited them:

"I didn't have to wait on the phone to book a GP appointment."

4.23 Another participant, however, reported having seen the pharmacist a couple of times for cold sore treatment but found the topical treatment she received was ineffective. She ended up making a GP appointment and was prescribed a stronger tablet-form medication, which was much more effective.

4.24 Some participants reported a fairly negative experience that they or their family members had of accessing the CAS. One participant reported a member of staff in the pharmacy[23] had been rude and judgemental when asked about the morning after pill. Based on this experience, the participant said they would feel more comfortable accessing treatment of a sensitive nature from their GP with whom they had a more established relationship.

Good access preferences

4.25 Participants were asked what in their opinion constituted good access to pharmacy services. Participants broadly agreed on some general principles of good access, the primary principle being enabling patient choice to access treatment at a time and place

[23] Not necessarily the pharmacist – the participant was not entirely sure.

which is appropriate to their individual needs. However, individual preferences expressed over what constituted good access in specific detail were highly variable, depending on people's age, level of digital competency, work or caring responsibilities, location, and health conditions.

Preference for online or face-to-face

4.26 Participants who were younger, more digitally competent and in favour of convenience were more likely to prefer ordering their prescriptions online. In addition, it was noted that prescriptions that are more straightforward or are on repeat may be more suitable for online ordering. It was also noted that online ordering may facilitate better communication around when prescriptions are ready to collect. Other participants had a preference for face-to-face access to pharmacy services, particularly when asking about health conditions that were more serious and where receiving support in person would enable a more accurate diagnosis of the problem. In addition, one participant noted that they had a preference for face-to-face treatment as it helped them feel more comfortable and they were less worried about privacy concerns than having a telephone appointment which they may have to take at work or at home.

Preference for GP or pharmacy treatment

4.27 Many participants expressed a preference for receiving treatment from GPs as opposed to pharmacists. However, they noted the current challenges in accessing GP appointments and the need to avoid putting unnecessary strain on GP practices. Where participants expressed a preference for receiving treatment through their GP (as opposed to a pharmacist), a number of reasons were cited including:

- GPs may be more likely to give an accurate diagnosis
- Poor experiences of lengthy queues and waiting times and quality of treatment at pharmacies
- Greater opportunity for privacy than in pharmacies for sensitive/embarrassing conditions
- Pre-established relationship with and greater trust in a familiar GP
- Concerns that pharmacies may be financially motivated to push unnecessary treatment.

4.28 In contrast, a number of participants expressed a preference for accessing treatment through their local pharmacy, given the greater speed and convenience of accessing treatment, particularly for patients using the online prescription service.

4.29 Participants also noted that pharmacies can offer greater flexibility due to not having to make an appointment and offering longer opening times (e.g.: they can be open evenings and weekends).

Continuity of practitioner

4.30 A number of participants indicated that having continuity of care from a provider would for them constitute good access. Where participants were able to receive continuity of care or build up a relationship with their local pharmacist, they felt that they were able to receive better quality treatment which was more tailored to their needs:

'Like everything [you get] better service if they know you'.

4.31 A couple of participants provided specific examples of where a familiar pharmacist, who knew them, enabled exemplary access to pharmacy services. In one case the participant described a situation where he would collect his wife's prescription and the pharmacist would ensure it was a vegan medication because his wife was vegan. In another instance, an older participant went into the pharmacy for an unrelated reason and the pharmacist asked whether he had received a flu jab yet and if not, whether he would like it then and there. The participant commended this proactive and caring approach.

4.32 However, one participant indicated that they did not need to see the same person each time to receive sufficient continuity of care so long as there is sufficient record keeping and sharing between healthcare professionals to ensure they are aware of a patient's condition.

"I think provided that accurate and thorough notes are taken at your consult to enable someone to be able to pick up your case, then it shouldn't matter who you see."

4.33 Participants also considered patient choice and availability of alternative pharmacies a key component of good access, enabling the patient more options to access the healthcare treatment they need. If one pharmacy did not have access to the particular treatment or

service they needed or was unable to provide it due to limited capacity, they wanted to be able to go elsewhere for treatment without having to travel too far from where they live.

"There are quite a few [pharmacies] local to us so if they are out of stock, we can go next door."

"[The] pharmacy is great for me. I live in [named urban area] and there are four or five different pharmacies in the area anyway. Take your pick."

4.34 For participants who needed to pick up prescriptions, particularly those who needed repeat prescriptions, communication was a key element of what constituted good access. This included communication regarding the availability of stock at a given pharmacy and whether their prescription was ready to collect. It also included communication between the pharmacy and GP to ensure patients were still being prescribed the correct medicine and dose for long term health conditions.

4.35 Privacy and confidentiality were considered important to ensure that patients felt comfortable in disclosing the nature of their condition. It was suggested that part of this is about having access to a separate room to avoid having to discuss embarrassing conditions in a public space. It is also about the pharmacist treating the patient in a detached and non-judgmental way. This was considered particularly important for pharmacies in small villages where the patient may well be known to the pharmacist or is more conscious of people who they know hearing about their condition.

Summary of barriers to good access to pharmacy services

4.36 Participants highlighted a number of barriers they or people they know have experienced in accessing pharmacy services. Some of the main issues highlighted by participants related to the capacity of local pharmacies to cope with excess demand. Participants noted that recently they had found their local pharmacies were getting busier and/or less well staffed. This had consequences for access to services including longer waiting times, lack of stock to issue prescriptions and a sense being hurried and not being able to describe a health concern in full.

4.37 Access issues were particularly pronounced for participants who lived in rural communities with fewer pharmacies located nearby, with more limited opening times and therefore less flexibility for participants with work or caring responsibilities. The need to travel further to

access pharmacies in the most rural parts of Wales was noted as a barrier for people with limited transport options.

4.38 Communication – for example about the CAS – was raised as another key barrier to good access. There was little awareness in general of the CAS among participants and even amongst those who knew of the scheme, most had a very limited understanding of the full scope of treatment they could access directly from a pharmacy via the scheme. Some participants reported receiving conflicting information – from family and friends as well as pharmacies themselves – about which treatments they could receive through the CAS.

4.39 More generally, communication around when prescriptions would be available and ready for collection was an issue for some participants, although others reported receiving text updates from their local pharmacy, which they really valued, and they felt helped avoid wasted journeys to collect a prescription that was not ready.

4.40 Some participants noted that cost was a barrier for them accessing community pharmacy services on the grounds that over-the-counter medication in pharmacies is typically more expensive than medication available through general retailers. One participant was also critical of a significant discrepancy in cost of dressings that her husband required following surgery. One pharmacy had them for 13 pence each while another was charging £5. This participant could not understand the inconsistency or why they had not just been given dressings by the hospital.

4.41 Some participants felt that concerns about pharmacists not having parity of skills and experience to a GP would prevent them from going directly to a pharmacy for diagnosis and treatment. As an example, one individual described having been given the incorrect treatment twice for her child's ear infection and ending up having to go to the GP anyway.

4.42 Where participants were aware and able to utilise online options for ordering their prescriptions, they found it to be a quicker and more convenient process than over the phone or in person at their pharmacy. However, some participants felt that not everyone was aware of the option to order prescriptions online or had the digital capability to do so. One participant noted that they felt pressured by their pharmacy to order their prescriptions online despite their poor experience of the website and ID verification issues.

5. Conclusions

5.1 This research focused on three distinct primary care services, each of which were given dedicated time in the focus groups for a discussion solely on access. Nonetheless, the research has revealed some common principles of 'good access' across some or all of the three areas.

Flexibility

5.2 This research engaged with a cross-section of members of the public including people of different ages, from different locations in Wales, (including both urban and rural) and those with varying degrees of caring responsibilities. A key finding was that perceptions of good access varied according to individual preferences and circumstances. Offering different referral methods (AHPs), booking processes (dentists and AHPs), consultation / format of care[24] (AHPs and pharmacy) and flexible opening hours (all three) were considered fundamental to good access in these primary care services.

Communication and transparency

5.3 Uncertainty over waiting times to access AHP services and to get seen at an NHS dental practice was commonly cited as where better communication and transparency would be beneficial. Other examples where participants felt it would be beneficial included NHS dental charges (and what is included/excluded in the three charge bands), the rationale for extending recall intervals, the scope of the CAS and arrangements for discharge from AHPs.

Better utilisation of the NHS Wales App

5.4 Across the groups, participants felt that the NHS Wales App could play more of a role in improving access to services by maximising efficiencies (e.g.: being a mechanism for self-referral to AHPs, booking dental check-ups or ordering repeat prescriptions) and sharing information on waiting times for primary care services (in this case AHPs and NHS dentists).

Public Awareness

[24] I.e.: face-to-face, online or a combination of the two.

5.5 The research revealed notable gaps in public awareness of availability and eligibility criteria of some primary care services, which either negatively affected their experience of accessing these services or prevented them from accessing the service at all. Examples included awareness of the rationale for determining recall intervals for dental check-ups, the removal of patient registers in dental practices and the scope of dental treatment available in charge bands, the breadth of conditions covered by the CAS and the availability of self-referral routes to some AHPs. This suggests more could be done by Welsh Government, health boards and individual healthcare providers to raise awareness in these areas.

Continuity of care provider

5.6 Across all three primary care services, there was a general consensus on the importance of continuity in the health professional engaging with the service users. The only exception to this was emergency dental treatment, where it was considered less important by some to see their routine dentist. Participants said seeing the same healthcare professional means they are familiar with the patient's history and preferences, and it also helps to foster trust.

Sharing of information and data

5.7 Whilst not as widely held a view as some of the other common principles, some participants felt that effective – and secure – sharing of patient information and data between relevant healthcare professionals was important. They perceived it could help to prevent patients having to repeat their story, enable healthcare professionals to provide more accurate diagnoses and offer suitable treatment, and improve efficiencies for the NHS.

The central role of the GP

5.8 Although this project focused on AHPs, dentistry and pharmacy services, the role of GPs was repeatedly raised by participants when discussing access to primary care services – primarily AHPs and pharmacy services. GPs were discussed in relation to referral processes, system integration, continuity, and quality of care.

5.9 The most common route to AHP services was through the GP and this was expressed as both a barrier to access (given limited numbers of GP appointments) and a preferred route for some (providing familiarity, guidance, and reassurance).

5.10 Given the central role of the GP in the healthcare system, participants expressed the need for other primary care services to be integrated and seamless with GP services. This was not limited to the referral process but involved the sharing of patient data and communication between GPs and dentists, AHPs, and pharmacists to provide a more holistic health care offer and prevent patients having to repeat their story.

5.11 Whilst the role of pharmacy services – in particularly the CAS – and the role they can play in reducing GP workload was a key focus of this research, many participants stressed that they would continue to choose their GP as a first point of contact. This was due to either positive relationships with their GP and the desire for continuity of care with a familiar healthcare professional, or because of the perception that GPs have more training and competence compared to other healthcare professions.

5.12 Overall, the clear message from members of the public in this research is that good access in relation to these three other areas of primary care – particularly AHPs and pharmacy services – cannot be considered in isolation from GP services, a finding that endorses key principles of the Primary Care Model for Wales around seamless care and a coordinated care system.

6. Recommendations

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

General

6.2 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.

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

6.4 Enable secure data between professionals to improve patient experience.

6.5 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).

6.6 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.

6.7 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

6.8 Undertake further research into the different AHP services; given the breadth of AHP services and the differences in the way they operate, it is challenging to draw generalized 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.

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

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

NHS Dentistry

6.11 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)

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

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

6.14 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

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

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

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

General Practice

6.18 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.

7. Annexes

Annex A: Topic guide for scoping interviews

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

Scoping Phase

March 2023

Interviewee Name(s)	
Role	
Interviewer	
Date and Time	

Overview

MR has been commissioned by Welsh Government to explore the views of the general public in Wales on accessing primary care services and what 'good access' means to them in relation to community pharmacy, NHS dentistry and a range of Allied Health Professionals.

Interview Question	Answer
Introduction	
• What is your understanding of the rationale for the research? • Why is it being commissioned now?	
• How would you define 'good access' to primary care services in these areas?	
Existing evidence	

Are you aware of any evidence of particular groups within the general public who find it more or less challenging to access: • Community pharmacy? • NHS dentistry? • Allied Health Professionals (e.g., occupational therapy, physiotherapy, podiatry, speech and language therapy, dietetics)?	
Are you aware of any literature (published or unpublished) relevant to access – or *perception* of access to services amongst the population. *Probe for whether they can share with us.*	
Current issues around access	
What are the key barriers and enablers to accessing primary care in these three areas?	
What factors can enable or enhance 'good access'? - *To what extent is there sufficient resource in place to impact upon these factors?* - *Which of these factors are the most pressing to address?*	
What effect has the Covid-19 pandemic on access to these services? - *Isolation, workforce stress, decreasing number of staff, etc.*	
To what extent do you think access to primary care services meet patient expectations? - *Negative experience 'loop'?*	

To what extent is access to primary care services in the medium of Welsh an issue? - *Are Welsh services over-prescribed?* - *What about other languages?*	
To what extent is access to primary care services for people with a disability an issue? - *What are the biggest barriers?* - *To what extent can digital methods help overcome these barriers?*	
Implications for workforce development / service planning	
Do you have any thoughts on what these issues mean in terms of workforce development / service planning?	
What would be the advantages and disadvantages of expanding web-based/digital access to primary care services? What would mean this mean in terms of accessibility of services – particularly for those who are facing digital poverty?	
Scope of the research	
Do you have any thoughts on issues and themes to explore with members of the public?	

Thank you for your time.

Annex B: Final sample structure

Good Access in Pharmacy, NHS Dentistry and Allied Health Professions

Final sample structure

Group (8-10 in each)	Language medium[25]	Health Board footprint[26]	Experience of accessing NHS dentist in last 2 years[27]	Experience of accessing at least one AHP in last 2 years[28]	Experience of accessing community pharmacy in last 2 years[29]	Socio-economic group[30]	Disability[31] (or carer for someone with a disability)	Gender[32]	Age[33]	Ethnicity[34]	Parent/carer of child (under 16)[35]

[25] Identified from DJS database.
[26] Identified from DJS database (i.e.: local authority of residence).
[27] Screener question 1
[28] Screener question 2a and 2b
[29] Screener question 3
[30] Identified from DJS database.
[31] Screener question 4
[32] Identified from DJS database.
[33] Identified from DJS database.
[34] Identified from DJS database.
[35] Identified from DJS database.

1	English	Aneurin Bevan UHB	Yes = >6 participants	Yes = >6 participants	Yes = all participants	Mix of BC1 and C2DE	Yes= approx. 7-10 across all groups	Mix	Mix of ages (18-75)	Inclusion of > 7-10 people from Black, Asian and Ethnic Minority groups across all groups	Yes= approx. 20 across all groups
2	Welsh	Betsi Cadwaladr UHB	Yes = >6 participants	Yes = >6 participants	Yes = all participants	Mix of BC1 and C2DE		Mix	Mix of ages (18-75)		
3	English	Cardiff and Vale UHB	Yes = >6 participants	Yes = >6 participants	Yes = all participants	Mix of BC1 and C2DE		Mix	Mix of ages (18-75)		
4	English	Cwm Taf Morgannwg UHB	Yes = >6 participants	Yes = >6 participants	Yes = all participants	Mix of BC1 and C2DE		Mix	Mix of ages (18-75)		
5	Welsh	Hywel Dda UHB	Yes = >6 participants	Yes = >6 participants	Yes = all participants	Mix of BC1 and C2DE		Mix	Mix of ages (18-75)		
6	English	Powys THB	Yes = >6 participants	Yes = >6 participants	Yes = all participants	Mix of BC1 and C2DE		Mix	Mix of ages		

									(18-75)		
7	English	Swansea Bay UHB	Yes = >6 participants	Yes = >6 participants	Yes = all participants	Mix of BC1 and C2DE		Mix	Mix of ages (18-75)		

Screener questions

1. Have you had experience of accessing an NHS dentist in the last two years? NB: this can include either a routine check-up or treatment at your regular dental practice or emergency treatment (for example in a hospital).
2.
    a. Have you had experience of accessing any of the following NHS or local authority services in the last two years?[36] We don't want to know about any that you have paid for privately?
    - Art therapy, Music therapy or Dramatherapy
    - Dietitians
    - Occupational Therapy
    - Physiotherapy
    - Podiatry
    - Psychology or mental health support
    - Speech and Language Therapy

    b. (If yes to any of the above) Did you see the [service cited above] at home, as an out-patient in hospital or in a community setting?
3. Have you had experience of accessing a pharmacy in the last two years? NB: this can include either a pharmacy on the high street or a pharmacy located in your GP surgery. This could have been to collect a prescription or to access advice or treatment, for example via the Common Ailments Scheme
4. Do you consider yourself to be disabled or do you consider yourself to have a disability? Or do you care for someone with a disability?

Annex C: Focus Groups with members of the public

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

Focus Groups with members of the public

Topic Guide

May 2023

Interviewee Name(s)	
Role	
Interviewer	
Date and Time	

Overview

[36] We will monitor types of AHPs recruits have accessed to ensure a range is included across the groups.

MR has been commissioned by Welsh Government to explore the views of the general public in Wales on accessing primary care services and what 'good access' means to them in relation to community pharmacy, NHS dentistry and a range of other NHS health professionals.

Thank you for participating in this research. Your contribution will be anonymised through the analysis process and your contact details will only be used for internal record keeping.

Please can I confirm that you have received and read the Privacy Notice?

Teams etiquette – mute when not speaking, cameras on if possible, and if we move onto the next question and there's still something you'd like to say, please feel free to use the chat function.

Interview Question	Answer
AHPs 6pm	
What are your experiences in accessing any of the NHS health professionals listed on the screen? *(List will be included on shared slides)* Please note, we are only interested in services you have received via the NHS. *Probe: by 'access', we not only mean physical access to a building, but also things like language medium, digital access/booking systems, waiting times and availability of services.* Use experience to identify good and bad access. *Probe, what made this experience 'good' or 'bad' in your opinion? How could a bad experience have been improved? How typical was this experience in your view?*	
How would you have preferred to access [specified NHS health professionals]? *Probe, please consider the booking process, location of any appointment (including face-to-face versus online) etc.*	
What should happen when you need to access [specified NHS health	

professionals], in your view? *Probe, please consider things like how you initially reached the health professional (e.g., whether they contacted them directly or had to go via a GP), waiting times, booking process etc.*	
What might prevent you from seeking the support of any of the NHS health professionals listed on the screen? *Probe, for example time of day/location of appointment, language medium etc.*	
Offer a summary of what good access means to the group – 'stress test' our interpretation of consensus view of what good access looks like and provide an opportunity for participants to point out gaps in this summary.	
Dentistry 6.30pm	
What are your experiences in accessing NHS dentistry services? *Probe: by 'access', we not only mean physical access to a building, but also things like language medium, digital access/booking systems, waiting times and availability of services.* Use experience to identify good and bad access.	
How often should you go to the dentist in your view?	
For what reasons do you go to the dentist? *Probe, please answer in relation to visits to NHS dentists only.*	

What might prevent you from going to an NHS dentist? *Probe, for example time of day/location of appointment, language medium etc.*	
Should the process of accessing dental care differ depending on the reason? If so, how?	
What is a reasonable expectation for accessing NHS dentistry services? *Probe, in terms of length of waiting time for routine check-up, access to emergency treatment etc.*	
Offer a summary of what good access means to the group – 'stress test' our interpretation of consensus view of what good access looks like and provide an opportunity for participants to point out gaps in this summary.	
Pharmacy 7pm	
What are your experiences in accessing pharmacy services? *Probe: by 'access', we not only mean physical access to a building, but also things like language medium and availability of services.* Use experience to identify good and bad access.	
Why would you go to the pharmacy? What kind of services do you expect from the pharmacy? In your experience, how easy is it to access these services?	

Are there any of the following services that you would not choose to access advice from a pharmacist? • Treatment for minor ailments (provide list of all conditions in Common Ailment Scheme) • Sore throat • A urinary tract infection • A flu vaccine • For a supply of your medicines in an emergency • For the morning after pill • For regular contraceptive pills *Probe for reasons behind this. I.e.: why would they not expect / want the pharmacist to provide [cited services]?*	
How do you order and/or collect your prescription? What, if any, issues have you had with your prescription? How would you like to order and collect your prescriptions?	
Offer a summary of what good access means to the group – 'stress test' our interpretation of consensus view of what good access looks like and provide an opportunity for participants to point out gaps in this summary.	
Overall	
What are the principles of good access to services like those we have discussed today? Is there anything we have not discussed which should be included? *Probe, for example, how can technology improve access? How important is it to have face-to-face appointments?*	

Thank you for your time.