Wessex Voices
local healthwatch working together
NHS

# Are health services working for everyone?

## A literature review of patient engagement around barriers to accessing healthcare

### Review to inform how cancer referrals from primary care might be increased

**March 2022**

## Introduction

Wessex Voices was asked by the Wessex Cancer Alliance to carry out a review of patient insights into the barriers to people accessing health services that exacerbate health inequalities. The aims are to provide recommendations as to how the Alliance can increase cancer referrals from those who are less likely to go to their GP and build the confidence of patients to access cancer services in light of the ongoing COVID-19 pandemic.

## Review methodology

This review aims to support health colleagues to take action to address as many health inequalities as possible. Between August and December 2021, we conducted a systematic review of barriers to accessing health services literature. This has been compiled from a variety of recent sources - published since 2014 - and includes peer-reviewed journals, grey literature, reports from charitable and research organisations, governmental and health departments, and other online sources. 113 relevant sources have been included in this review. Due to the nature of the topic this has expanded beyond just cancer patients to encompass as much information as possible on potential barriers and challenges to accessing health services. As this review naturally focuses on the more negative aspects and experiences of accessing services – due to the review topic - it is suggested that a sister paper is created along similar lines but looking at enablers to accessing healthcare including examples of good practice.

## The current situation

GP surgeries and GPs in the UK are experiencing significant and growing strain with rising demand; practices are struggling to recruit staff; and patients are having to wait longer for appointments. Alongside these long-term trends, GP practices have been at the forefront of the response to COVID-19, whilst maintaining non-COVID care for patients. There are 1,803 fewer fully qualified FTE GPs in 2021 than there were in 2015. There are now 0.45 fully qualified GPs per 1,000 patients in England

in 2021 – down from 0.52 in 2015. At the same time, the number of practices is also falling as many have merged or closed for other reasons. [54] [49]

The 2021 GP Survey showed some really positive findings: [81]

- 94% of participants said their needs were met at their last appointment (the same as in 2020).
- 96% of participants said they had confidence and trust in the healthcare professional they saw (against 95% in 2020).
- 93% of patients were involved as much as they wanted to be in decisions about their care and treatment (the same as in 2020).

However, from the same survey, people from the most deprived areas were less likely to report their needs being met, had a poorer overall experience and a worse experience of making an appointment. Patients in deprived areas are more likely to have multiple long-term conditions, resulting in a greater level of care and making their needs more difficult to meet. At the same time, the Health Foundation reported general practice being “underfunded and under-doctored” in deprived areas. There is an imbalance between resources and levels of need. [6]

## Recommendations

In our more detailed literature review (a reduced summary of which is given in Appendix A), we outline several themes concerning why people might not be accessing health services at the moment, as well as how they might be empowered to seek help in the future.

The geographical area of Wessex includes around 3 million people covering local government areas in Bournemouth, Christchurch and Poole (BCP), Dorset, Hampshire, Isle of Wight, Portsmouth, Southampton, and South Wiltshire. The recommendations below are based on collated evidence from this review for active

consideration by respective stakeholders in this area. Not all issues listed below are anticipated to apply to all areas of Wessex. We also acknowledge that geographical and regional variations within Wessex might impact on how some recommendations can be implemented and that stakeholder knowledge will be key in helping to move these suggestions forward.

| Issue | Recommendations |
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| **A service fit for everyone** | |
| **Low levels of collaborative communication with patients, public and members of staff** | • Adopt a model of continual improvement using feedback from patients, public and members of staff as there is no such thing as a 'perfect' service.<br>• Make sure that any improvements are communicated to everyone as they occur.<br>• Ensure that disadvantaged groups' voices are heard and that services are designed to meet their needs. |
| **Trust** | • Ensure all communications are clear, understandable for everyone and from local sources.<br>• Ensure Patient Participation Groups (PPGs) and other engagement and participation groups are fully representative of the local community.<br>• Involve local community groups to support engagement to help build trust. |
| **People's understanding of services** | • Review service communications regularly with a diverse range of patients/public and implement their suggestions.<br>• Ensure communications are in line with the Accessible Information Standard and usable for all members of the community. |
| **Digital Exclusion** | • Ensure that any resources saved by going digital are utilised to help those who are excluded. |

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| | • Engage with local communities to encourage the passing on of messages to those without Internet access.<br>• Ensure there is no stigma attached to being 'digitally excluded'. |
| **Ensure everyone can and is registered with a GP** | • Use PPGs, Healthwatch and local community groups to suggest routes to finding people not registered.<br>• Ensure reception teams are clear about rules for eligibility and provide consistent support and information to everyone.<br>• Publicise information about eligibility to NHS services.<br>• Be clear as to how personal data is shared across services and government. |
| **COVID-19 environment** | |
| **Messaging** | • Clearly communicate that the NHS is open for business.<br>• Clearly communicate how to access services.<br>• Keep repeating that 'we will keep you and our staff safe during all stages of the pandemic'.<br>• 'No one is a burden' – if you are concerned about your physical or mental health contact your GP or call 111 or, in an emergency, 999. Don't hesitate. |
| **Making Appointments** | |
| **Service website accessibility** | • Review regularly with PPGs and implement their suggestions.<br>• Ensure website is kept up to date and all links work.<br>• Have routes to access the information for those who have poor English literacy.<br>• Communicate and adopt best practice models from other service websites. |
| **Phone queues and menu choices** | • Understand the consequences of delays on getting through and menu choices on the phone for patients |

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| | and review with PPGs, especially for people using pay as you go services.<br>• Consider: different phone numbers for different services, time slots for different services, call back, queue numbering, alternatives to the phone for those who are phone-anxious.<br>• Share good practice across the region to develop consistency for primary care. |
| **Apps (E-consult) for those who prefer online** | • Work with people to ensure that all health apps are accessible and suitable for groups like those who have learning disabilities, are Deaf or hearing impaired, blind and visually impaired, or have poor English literacy.<br>• Remember that Apps are not accessible to all, so **should not** be the only source of access for service appointments. |
| **At the GP Practice or Service** | |
| **Lack of choice for appointments** | • Patients be able to access face to face, phone or video consultations based on their preferences, as well as medical need. |
| **Providing information multiple times** | • Keep a patient record of accessibility requirements so that they are available for every appointment at the GP or in onward referral.<br>• Reduce patient frustration by asking them to tell their story only once.<br>• Make sure all forms are relevant to a patient's care. |
| **Timing of phone or video appointments** | • Provide adequate and accessible information regarding the phone appointment.<br>• Give accurate time slots or a pre-call for a telephone appointment to ensure the patient is ready. |
| **Lack of staff training** | • Make sure that all members of staff engaging with a patient have received training on supporting people |

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| | with disabilities, mental health conditions as well as people from different faiths and cultural backgrounds. |
| **Support Network for patients** | |
| **Wider impact for cancer patients and their supporters** | • Healthcare professionals should consider how a diagnosis of cancer may impact on family and friends and build this into care plans. These contacts should also be provided with all of the necessary information. |
| **Future Scoping Work** | |
| **Wider scoping of local examples of good practice** | • Further work should be commissioned searching for and documenting examples of good practice within the Wessex region which address removing barriers to accessing healthcare and improving access (as this is sometimes not documented at a regional level). |

# Appendix A: People's experiences of services

This section provides more details about people's experiences and provides links to the sources of information in brackets. The structure reflects the journey people go through to access services - from their initial understanding of health issues (including specific impacts on different groups); making an appointment; and their experiences of attending services.

## A service fit for everyone

### Patient Activation

Patient activation describes the knowledge, skills and confidence a person has in managing their own health and healthcare. It is a good predictor of health outcomes and can be raised through targeted interventions. [52] [53] [51]

Local ‘system partners’ collaborating with the design, delivery and signposting of services will play an increasingly important role in a fully engaged health service. [50] [31]

## Trust in NHS

Trust affects the desire for seeking help - people link together the notions of trust and transparency. Targeted messaging, especially when it comes from a central source (NHS, government, or even charities) can have the opposite effect as people might feel that they are being forced into a decision. [79]

Other factors that can lead to mistrust are conspiracy theories, previous negative experiences, conflicting information or a lack of information from other trusted sources, low confidence generally in vaccines, and specifically with the COVID-19 vaccine, or their manufacturing processes, low confidence in the pharmaceutical industry and apprehensions around impact on fertility or pregnancy. [4] [43] [5] [65]

There has been an increase in negative experience of accessing GP services during 2020 compared to 2019, with people reporting that feeling judged or stereotyped was a barrier to accessing services. [2] [80]

## People’s understanding of services

Almost half of the population are thought to have limited health literacy [82] with consequences on health inequality [11]:

- 42% of working-age adults in England are unable to understand and make use of everyday health information.
- 61% find health materials containing both text and figures too complex to understand.
- 43% struggle to understand instructions to calculate a childhood paracetamol dose.

Health literacy is lower for people with limited financial and social resources. It strongly correlates with deprivation. [11]

Examples of the consequences of health literacy: [76]

- a woman who sprayed her inhaler on her neck because she had been told to spray it on her throat.
- a man with diabetes who decided to stop taking his medicine because he had trouble understanding the instructions.
- a man who did not turn up for cancer tests because he did not know that the Radiology and X-ray department were the same thing.
- a woman who thought chemotherapy would not help because it was given into a vein on the other side of the body to where her cancer was.
- not knowing about the over-50 MoT health check. [32]

Suggestions for improving health literacy include:

- Local approaches targeting deprived areas or vulnerable groups. [82] [72] [69] [73]
- Better education for men, women and children from ethnic groups. [27]
- Improving digital literacy (see Digital Exclusion section).

## Information provided about health and services

There are good and bad examples around how information is provided and tailored to individual needs: [54] [33] [63]

Assumptions are made about communication preferences which can be invalid. For example, that young people prefer digital platforms for healthcare access and that they will always have access to the latest technology. [20] [71] [103]

The first point of contact for many people is the service website. There is a wide variation in terms of ease of use of service websites, which has become more widespread since the pandemic and the decrease in face to face communications. [88] [80] [85] [54] [75]

## Disadvantaged groups

In this section we highlight how different groups have reported their experiences of accessing health services. We only relate what was found in the literature, but equally important are the gaps in understanding of these groups' experiences of health services where more research is needed.

*Men*

Some of the consequences of 'toxic masculinity' where men stick to traditional gender roles are generally around not making time or not taking responsibility for health. Specifically, these include: limiting expression of emotions; elevating anger; sharing less feedback about their health and services received; being less likely to report mental health problems; relying on their partners to be proactive about their own health; and being less likely to approach their GP if they have signs of prostate problems. [40] [58] [59] [65]

*Women*

Considering digital exclusion, although the number of Internet non-users has been declining, in 2018, 58% (3.1 million) of these were women, a proportion that has remained broadly consistent over time. There is also a disparity between men and women in digital skills. Of those having zero basic digital skills in 2018, 61% were women. [103] [112]

*Students*

Students have expressed difficulties in registering for a GP based on the intermittent times that they are perceived to be in the local GP surgery area throughout the year. [22b]

*Religious or cultural beliefs*

Previous literature has highlighted that Health Care Professionals (HCP) needed to engage and collaborate with local minority and religious communities to help build trust and relationships. [74] [67 – *No URL*]

*Homeless*

Digital exclusion is high and complex among homeless communities. Their exclusion from traditional health services may be due to self-exclusion or health

providers failing to meet their needs – as an example, a quarter of the homeless people Healthwatch Croydon spoke to had struggled to register with their GP [1]. Although Healthcare for Homeless cards have allowed some to access the support they need, local Healthwatch have consistently reported homeless people encountering difficulties when trying to register with a GP practice [80]. Considering their environment, homeless people might lack a device, cannot always afford data or locate free Wi-Fi, lack access to suitable charging locations, are likely to sustain more mobile phone damage due to sustained use and are at increased risk of device theft and device related harassment. Some homeless people have reasonable digital skills whilst others have low digital skills and low literacy - others don't trust technology. [19] [103]

*Gypsy, Roma and Travellers*

Gypsy, Roma and Traveller communities have long been recognised as socially excluded, experiencing significant health inequities such as higher morbidity, mortality and infant mortality. In the UK where these communities are still mobile, different solutions are employed to allow communities to connect digitally – largely connectivity is achieved via mobile devices. In relation to remote and virtual health, a 2018 exploration of digital access amongst these communities revealed high levels of digital inequality. In addition to issues around low literacy and lack of skills and confidence, the barriers the authors identified were data running out, device cost and lack of signal - linking back to rurality access concerns. [103] [104] [105] [106] [107]

*Cultural stigma*

For different cultures 'stigma' becomes an important facet of accessing health services. This includes: disclosure of mental health issues; fear of mastectomy and its marital consequences; the whole topic of cancer particularly in Asian communities; stigma around vaccination and sexual activity for the HPV vaccine; and for men around physical prostate examinations and homophobia. A lack of cultural awareness in health care services, and a lack of community where people can talk about these things, can exacerbate the consequences of such stigma. [79] [61] [87] [86] [89]

*Language*

A lack of proficiency in English is a major barrier to accessing health care services. Translation services might be unavailable and written word information is only available in English, particularly where the terminology used is complex. Communication is more difficult for people who are not native English speakers when talking over the telephone or video conferencing, which has become more prevalent since the start of the COVID-19 pandemic. [11] [80] [78] [38]

*Asylum Seekers & Refugees*

Asylum seekers and refugees housed in a local hotel as part of the Home Office's pandemic response had in many cases not been signed up with a local GP. When considering digital exclusion, asylum seekers and victims of trafficking might not have access to phone credit (or in some cases, phones). It is also possible that English might not be their first language. [80] [103]

*Rurality*

There is a clear urban-rural digital divide in the UK and poor digital connectivity threatens the social and economic health of rural areas [107]. There is pre-pandemic evidence that patients with cancer living in more remote, rural locations do not have equal access to virtual solutions like video and online consultations. This is exacerbated where travel is not possible and, as a consequence, people living in remote areas are missing out on essential services. [12] [10] [37] [14] [80]

*Substance Abuse*

The main message around people in addiction or recovering from addiction is one of stigmatisation by health care professionals, which leads to difficulties in accessing services, including mental health services. This goes beyond health care access and can prohibit recovery and reintegration into society. [101] [112]

*Dementia*

In addition to finding that many healthcare services and GP practices aren't 'dementia friendly', communication issues affecting this group include security around telephone consultations and answering calls where the number is withheld. [26] [18] [97] Suggestions for what changes GP surgeries could make to better support people with dementia are [96]:

- Improve the environment.
- Longer appointments.

- Increase dementia awareness for all staff.
- Better community engagement.

*Chronic Mental Health*

Mental health awareness and the reduction in stigma has led to improvements in attitudes and behaviours. However, there are still issues obtaining referrals without escalation and, particularly for this group, being seen by different GPs is problematic. [24] [25] [90] [16]

*Hard of Hearing*

Service users who are deaf, and those with additional communication needs, find it hard to access services – many GP Practices don't have hearing loops installed, appointments are cancelled if a BSL translator isn't available, and some GPs won't accept interpreters without vocal permissions. The use of face masks without windows particularly affects people who are hard of hearing. [94] [80] [35] [93] [26]

*Visually Impaired*

Issues around accessing health care for visually impaired people relate to all the visual aids used with technology – including screens showing which patient is next in a waiting room, and the many apps used to support patients. Equally traditional means such as leaflets, written instructions and printouts may be inaccessible if adequate time isn't allowed in the appointment for them to be read. These issues can lead to heightened anxiety, services being missed and side effects not being understood. [100] [35] [93]

*Learning Disability*

The starting point for health care for people with a learning disability is the annual health check, and it is clear that many LD people don't know about this and are not getting one. In addition, anxiety around technology may sometimes prevent this group from using digital services. [98] [99] [78] [80] [18]

*Wheelchair user*

Research from the Healthwatch network suggests that there are multiple issues of concern for those with mobility problems including a lack of access to buildings and accessible toilet facilities. Disabled people find it difficult to book same-day

appointments if their GP practice requires them to physically attend the surgery and queue in the morning. [93] [94] [95]

*Age - Elderly*

Early studies concerning levels of older adult use of the Internet highlighted the relevance of psychological factors - higher levels of computer anxiety, frustration with user interfaces, negative attitudes toward technology and heightened security concerns (including entering personal data online) [103]. Interviews have also shown that old age and disability can impact people's confidence and prevent them from accessing technology and digital healthcare platforms. There is also the issue of technological development and design, as research has noted that products can be poorly designed for older adults and therefore difficult, uncomfortable or unmanageable. Older people typically have more health problems than younger people and therefore require information in a format that works for them. Digital information is problematic for members of this group and hard copy delivered through trusted sources of support is likely to be more effective in some cases. [2] [34] [78] [71] [110] [111]

*Age – Young People*

A growing evidence base demonstrates that there are still significant inequalities in young people's ability to access and use the Internet [103]. There is a proportion of young people who do not have Internet access at home, or sufficient digital skills to engage online in ways that are meaningful to them [108].

*Affordability of accessibility equipment*

Those living in deprived areas are one of the groups least likely to go online. [34] This can lead to a lack of willingness to engage with services altogether and has led to significantly poorer cancer and other health risk factors and outcomes. [34] [78] [68]

*Lesbian, Gay, Bisexual and Trans (LGBT)*

This community has experienced a significant level of inequality in terms of access to services, predominantly related to a fear of prejudice and understanding from health care professionals. LGBT people would rather access support from an LGBT organisation than elsewhere. [29] [91] [92] [28] [29]. Not all transgender and non-binary people will be aware of their need to go to for screening. Concerns have previously been raised that cancer screening programmes were regularly failing to

identify eligible transgender individuals who ‘remain susceptible to cancers of reproductive organs that are no longer in alignment with their gender’. There is also no national gender identity data collection, which makes an automated call-recall system for transgender people almost impossible. Until corrected, cancer screening for transgender people remains underreported and underdiagnosed, and the risk of cancer is high. [74]

## Digital Exclusion

In their scoping review to inform understanding of the use of digital health technology and health inequalities Honeyman et al. found no evidence to clarify whether the increasing reliance on digital health technologies affected health inequalities between social groups. An overarching gap noted was the lack of research addressing the relationship between digital technology and the use and outcomes amongst different population groups and underlying factors. [109]

Many health care organisations now proceed as if access to the Internet is universal, which, coupled with the closure of public libraries and online learning centres during lockdown, affects those who require assistance and support to access online public health information. However, there are many groups that are less likely to be online including: older people, disabled people, homeless and those on low incomes. For others it might be based on personal choice or privacy concerns. There is evidence that digital exclusion has a negative impact on health outcomes. [21] [11] [3] [78] [16] [34] [80] [18] [68]

## Ensuring Everyone is registered to a GP

People have struggled to register with their GP practice (this includes students who live away from home). For example, they were told practices were full, that they lived outside the catchment area, that additional identification was required or that practices only registered people during set times of day (such as during working hours). Some have experienced confusing online registration procedures which had to be followed. [80] [8] [22b]

### De-registration

GP surgeries had unexpectedly de-registered patients, leaving them without care when they had closed or changed boundaries. [14] [80]

## COVID-19 Environment

During the COVID-19 pandemic, many people avoid making an appointment through anxiety or because they are worried about being a burden on the NHS. This is particularly true for older people. [81] [80] [30]

COVID-19 has widened health inequalities in England by disproportionately affecting those already experiencing them, such as those in the most-deprived areas and people from ethnic minority backgrounds. The ongoing effects of the pandemic on the economy are likely to have a varying impact on different parts of the population and therefore widen health inequalities further. [7] [35] [80] [47] [16] [77] [70]

Anxiety has increased during the pandemic and has contributed to people avoiding making appointments. For people undergoing cancer treatment and testing, changes to these procedures during lockdown has added to their anxiety levels. [81] [51]

Problems have been reported when trying to set up electronic prescriptions with a pharmacy and surgery and the challenges of maintaining timely prescriptions through the surgery during COVID-19. [15] [44]

During the different lockdowns, services have been suspended to minimise face to face care. An example of this is the availability of B12 injections which affected people with pernicious anaemia. A similar level of confusion surrounded flu jabs where, in 2020, confusing communications led to people missing their jab, and in

2021 a shortage of vaccines led to last minute cancellations which were not properly communicated to patients. [17] [80] [20]

## Making Appointments

In a survey of almost 2,000 people in Great Britain, one of the most perceived barriers to seeing a GP was difficulty obtaining an appointment with a particular doctor (41.8%) [83]. In a separate survey [81]:

- 59% saw or spoke to someone at a time they wanted to or sooner (against 56% in 2020).
- 60% who wanted a same day appointment got one (against 62% in 2020).
- 71% say they had a good experience of making an appointment (against 65% in 2020).

Choice and satisfaction with appointment offered [81]:

- 40% were offered a choice of time or day.
- 24% were offered a choice of type of appointment.
- 14% were offered a choice of place.
- 8% were offered a choice of healthcare professional.
- 82% were satisfied with the appointment offered and accepted it.

### Telephone

In the GP Survey of 2021, the most common complaint heard was around the difficulty of getting an appointment in the first place [81]. Many reported that phone lines were busy, or appointments were fully booked when they rang first thing in the morning and the cost and time was off-putting. Long automated messages with different options were complex for those with limited English or hearing impairments and the right option wasn't always available. [78]

### Website/App

Online booking systems (such as eConsult) work well for some people, but for others they are time consuming or inaccessible. [17] [47] [16] [48]

In some cases, people who struggle with booking apps (such as AskMyGp) were not offered alternatives and abandoned attempts to seek care. [78]

### Lack of Choice for appointments

One of the most commonly perceived barriers for patients to see a GP is being offered an inconvenient time, which leads to people either avoiding making appointments or not attending them. [83] [81]

People who have paid carers were only able to attend appointments at certain times of the day. But this would not always coincide with the times available for same-day appointments [80].

Another issue, particularly around telephone appointments is that it can be difficult in some instances for the patient to find a quiet or confidential place to talk. Appointments can be offered with wide time windows so that this cannot be planned in advance. Although, some find the remote appointments easier to manage than having to visit the surgery. [3] [47] [102] [36] [80] [16] [18]

### Reception

Sometimes reception staff were perceived as ‘gatekeepers’ with comments including mention of blocking and being hard to get past. [37] [56] [84] [38] [13] [22a] [26] [39] [83]

## Attending Services

### Remote Appointments

In certain situations, people who were offered telephone appointments would have preferred video appointments, where information could be shared and seeing the health care practitioner would be beneficial. [3] [44]

In-person appointments are considered better where something has to be shown, a physical examination is necessary, confidentiality is essential, or for communicating bad news. During the pandemic, getting a face-to-face appointment might require a lot of persistence and escalation. For some groups, like autistic people, the lack of face to face appointments is particularly problematic. [18] [3] [78] [16]

## Preparation

Receiving information in advance is important for participants, to ensure they are prepared and know what to expect. This includes guidance about how the appointment will work, how long it will take, clear joining instructions, how to use any technology and what to do if something goes wrong (such as technology not working). [3]

## Telling story multiple times

Participants are frustrated when they have to 'tell their story' multiple times or fill in lengthy forms with information that seems to be irrelevant or repetitive. This is not only irritating but can lead to poor continuity of care. [3] [32] [78] [15]

Seeing the same GP is particularly important for people who manage long term conditions such as cancer, or who need to speak about difficult and sensitive subjects. Patients highlight that building trust and working with their GP to manage health problems helps prevent the need for more specialty care. [16]

## Quality of Care

It is the quality of the relationships with professionals that defines the experience, and it is these qualities that can be uppermost in people's minds when relating the experience. The importance of compassion cannot be overestimated, not only for the person with a health condition like cancer, but also for their family and friends. [10] [38] [3] [81] [64] [62] [57]

## Time

People value their GP having time to listen to them and taking an interest in them as an individual (89% of people reported this in 2021) and don't like the appointment being rushed or, worse, having the consultation interrupted with a reminder for the GP of the time left. [16] [10]

## Referrals

People appreciate quick referrals to specialist services, as it gives them peace of mind when issues are investigated promptly. Follow-up calls from GPs are also important to people, as these enable them to raise issues quickly and easily. Positive examples described included organised pathways, treating the problem like it was important and the quick delivery of results. [16] [45] [39]

In 2020, Healthwatch England noted that GPs had either not sent referrals on time, or, had missed important details about the patient's condition in the referral [48]. They had also heard that GPs didn't always monitor and respond to consultants' letters following a patient's referral. [48] [9] [46] [44]

## Complaints

The quality of general practice complaint handling is mixed. [42] [41]

- 48% of people do not have the confidence that formal complaints were actually dealt with (60% of people for the 55+ age group).
- Over 54% of people who had a problem with health or social care in the last three years did nothing to report it.
- 49% of consumers surveyed had no trust in the system and suggested an independent and easily recognisable advocate to deal with complaints.
- 38% of those who made a complaint or gave feedback said they did not find it easy to complain.

The main reasons for having made a complaint about a GP related to poor communication and behaviour with nearly a third (32%) saying manner and attitude was their reason for complaining. [62] [57]

## Use of inappropriate services

Patients who cannot access healthcare when they need it from GP surgeries will migrate to other service providers such as local pharmacists, emergency departments and even web searches for diagnosis. This can cause potentially treatable conditions to become long term ones and put strain on other services accommodating the extra demand. [47] [38] [80]

With doctors' surgeries not able to take face to face walk-ins, Isle of Wight pharmacies were pushed into a more prominent position during the pandemic which led to large queues and long waiting times. [17]

## Removal of services

Removal of health services at regional and local levels can increase barriers to accessing health services and exacerbate health inequalities (for example those on low incomes or who have difficulty travelling). Locally, in Dorset, some GP surgeries are no longer contracted to do blood tests for hospital requests and hospitals no longer perform GP requested blood tests (predating the sample bottle issue of Autumn 2021). The net result is some surgery patients must now travel longer distances from rural locations into the conurbation and face more difficulties and queuing than attending at their local surgery. [21a] [21b] [21c]

Ear wax removal is another service which has been removed from some surgeries. If a local clinical commissioning group has decided not to commission an enhanced service – like ear syringing - this may relate to population needs and value for money [23] [63]. However, removing services like this can have a cost and quality of life impact on certain individuals - the economic effect for example, on those who rely on the service and may now have to pay for it.

Removal of services – and a lack of effective communication concerning their removal - can impact on local communities and risk increasing health inequalities and limiting access to healthcare. It might also have a wider impact than originally anticipated and therefore merits consideration and reflection at the time decisions are made.

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