# Our Voice Citizens' Panel

Survey on the use of digital technologies for healthcare improvement, using and sharing personal health and social care information and access to healthcare professionals other than doctors

Third Survey Report, January 2018




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**www.scottishhealthcouncil.org**

# Contents

## Foreword

Welcome to the report of the third Our Voice Citizens' Panel for Scotland.

The Our Voice Citizens' Panel is one way that health and social care support services in Scotland can listen to the views of the Scottish public – and having listened, make improvements to the services they provide.

I would like to thank the individuals who have volunteered to be part of the Panel, who together make up a representative 'slice' of the population of Scotland.

This survey has asked questions about the use of digital health and care technologies, how personal health information is shared and managed and about the use of depersonalised health information for research and development. It also enquired as to public perceptions of availability and access to healthcare professionals other than GPs and as to the role of GP practice receptionists, and awareness of local optician services.

The Our Voice framework promotes engagement at three levels:

- Individual – My Voice
- Local – Community Voice, and
- National Voice.

There are Our Voice initiatives at all these levels and the Our Voice Citizen Panel is part of the national voice gaining the views of the Scottish public.

Another initiative is the recently launched Our Voice website that not only provides information about Our Voice but offers polls, surveys and links to ongoing consultations about health and social care (www.ourvoice.scot). The Our Voice Citizens' Panel reports, and all the questions used in previous Our Voice Citizens' Panel surveys can be found on the website.

Once again, thanks to the members of the public who have volunteered to be part of the Panel and provided their views and experiences.

I hope you enjoy reading this report.

**Pam Whittle, CBE**
Chair, Scottish Health Council

## Acknowledgements

My thanks to the Panel members who have taken the time to respond to the third Our Voice Citizens' Panel survey for health and social care. We value you sharing your views, opinions and experiences of a wide range of services, and your help to shape policies and future improvements to services.

Thanks to everyone involved in developing the Our Voice Citizens' Panel and in the work involved in developing questions, disseminating the survey and analysing the results as well as producing this report. This includes the Health and Social Care Alliance Scotland (The ALLIANCE), and the Scottish Government's Primary Care Division, Digital Health and Care Division, and their Directorate for Healthcare Quality and Improvement.

Particular thanks are due to our consultants Research Resource and to the Social Researcher in Scottish Health Council, Wendy Brown, who manages the Citizens' Panel Research.

Best wishes

**Helen McFarlane**
Our Voice Programme Director

# Executive summary

## What is a Citizens' Panel?

A Citizens' Panel is a large, demographically representative group of citizens regularly used to assess public preferences and opinions. A Citizens' Panel aims to be a representative, consultative body of residents. They are typically used by statutory agencies, particularly local authorities and their partners, to identify local priorities and to consult the public on specific issues.

## Background and context

The Our Voice Citizens' Panel was established to be nationally representative and has been developed at a size that will allow statistically robust analysis of the views of the Panel members at a Scotland-wide level. At present there are 1,216 Panel members from across all 32 local authority areas. Panel members were randomly selected from the general population and invited to join the Panel. Some targeted recruitment also took place in order to ensure that a representative Panel was recruited. This is the first time a national Citizens' Panel of this nature, focusing on health and social care issues, has been established in Scotland.

This report details the findings from the third full Panel survey which included questions on the use of digital technologies for healthcare improvement, using and sharing personal health and social care information and access to healthcare professionals other than doctors.

A total of 496 responses (41% response rate) were received, either by post, email or by telephone. This level of return provides data accurate to +/-4.4%[1] at the overall Panel level. All comparisons that are made in this report are statistically significant, unless otherwise stated.

This executive summary details the key findings from the research. More detailed information on the profile of responses can be found in Appendix 3.

## Key findings

<u>Digital health and care</u>

- The survey opened by asking Panel members about their use of various digital communication and information devices. The majority of respondents used a mobile or smart phone (91%), a desktop or laptop computer (86%) or a tablet (62%). A small proportion of respondents used wearable technology such as a smart watch or Fitbit and only 1% of Panel members did not use any of these things.
- Digital communication tools that were used most regularly (at least once a day) included email (72%), the internet (59%) and social media (51%). On the other hand, web-based communications such as Skype were used less regularly with only 16% stating they use this at least once a day and 41% stating they never use this.

[1] Based upon a 50% estimate at the 95% level of confidence

- All Panel members were asked to rate on a scale of 1 to 10 "how confident they feel using digital communication technology" (where 1 was not confident at all and 10 was very confident). Just under 4 in 10 Panel members (37%) said they felt very confident (i.e. gave a rating of 10 out of 10), and on the other hand, only 5% said they were not at all confident (i.e. gave a rating of 1 out of 10).
- The vast majority of Panel members (85%) believed there were benefits to using digital communication tools and technologies to access health and social care services.
- Just under three quarters of Panel members (74%) said there were disadvantages in using digital communication tools and technologies to access health and social care services.
- Half of Panel members (50%) felt it would be useful to share health and wellbeing information from their devices or apps with their health professionals or care providers, 14% said this would not be useful and 36% were unsure.
- The survey included a question which asked Panel members about their (or their family's) use of digital health and social care services in Scotland. Services which have been used most by Panel members were NHS 24 (41%), GP surgery website for information (31%), and online repeat prescriptions at their GP practice (29%).
- Services that had not been used but where awareness was highest included NHS 24 (56%), Technology Enabled Care (45%) and health and wellbeing apps (45%).
- Video access to services (77%), Care Information Scotland (69%), remote monitoring of long-term conditions (62%) and NHS Inform (59%) were services which had the highest proportion of respondents unaware of their existence.

<u>Use of information: Personal</u>

- Over 8 in 10 Panel members (83%) believed that "professionals should – with the appropriate safeguards – be able to share your medical information with other health and social care professionals who are involved in your care, in order to support your ongoing healthcare." On the other hand, 5% disagreed with this statement and 12% were unsure.
- All Panel members were asked to rate on a scale of 1 to 10 "how much they trust health and social care professionals in Scotland to manage their information securely to support their care" (where 1 was no trust at all and 10 was complete trust). Just under 20% gave a score of 10, i.e. said they completely trusted health and social care professionals in this respect compared to just 1% who said they had no trust at all.

Use of information: Research and development

- On a scale of 1 to 10 (where 1 was very uncomfortable and 10 was completely comfortable) respondents were asked how comfortable they felt about researchers accessing anonymised or de-personalised health and social care information from the Scottish population, in order to support and inform design and delivery of health and care services. 34% said they felt completely comfortable in this respect, compared to just 4% who said they felt very uncomfortable.
- Eight in ten Panel members (80%) agreed that in the context of service improvement and public health, there were benefits to sharing health and social care information that has been made anonymous. On the other hand, 5% disagreed with this statement and 15% were unsure.

Community health and care services

- The vast majority of Panel members (97%) said that GP Practice Nurses were available at their practice. Just under 6 in 10 Panel members (59%) said Phlebotomists were available at their GP practice and 37% said that Midwives were available.
- Panel members also indicated which services were unavailable at their GP practice. Pharmacist (48%) and Physiotherapist services (30%) had the highest level of reported unavailability.
- Panel members were most likely to be unaware of the availability of Health Care Support Workers (67%), Occupational Therapists (64%) and Mental Health Specialist Nurses (63%).
- Six in ten Panel members (60%) agreed that they would take an appointment with another healthcare professional if they were offered this when phoning their GP practice for an appointment with a doctor, 10% said they would not take the appointment and 29% were unsure.
- The vast majority of Panel members (78%) said they would consider going directly to other healthcare professionals if they had been happy with the treatment they received, 8% said they would not consider going directly to the other healthcare professional and 14% were unsure.
- Three quarters of Panel members (75%) said they would be more likely to accept an appointment with another health or social care professional if they understood more about their role, 8% said they would not be more likely to do this and 16% were unsure.

Receptionists in GP Practices

- Over 6 in 10 Panel members (63%) said they would feel very comfortable (19%) or comfortable (44%) sharing some basic information with their GP Practice Receptionist about why they need an appointment. On the other hand, 24% said they would feel uncomfortable and a further 13% very uncomfortable in doing this.

Local optician services

- Panel members were most likely to be aware that their local optician can give them advice and treatment on free eye tests (98%), free eye care prescriptions (88%), blurred or double vision (86%) and headaches when reading or watching television (80%).
- On the other hand, respondents were least likely to be aware that their local optician can offer advice and treatment for cysts and styes (49% aware) and if they had something in their eye (57% aware).
- Panel members were provided with the same list of optician services and were asked whether they had ever asked an optician for advice or treatment regarding any of these. Use of these services was highest regarding free eye tests (87%) and free eye care prescriptions (55%). On the other hand, very few respondents had asked an optician for advice or treatment regarding cysts and styes (3%), squints in children (6%) or if they had something in their eye (12%).

# Chapter 1: Introduction and context

## Background and context

Research Resource was commissioned by the Scottish Health Council as part of 'Our Voice' – a partnership involving Healthcare Improvement Scotland, public partners, the Health and Social Care Alliance Scotland (the ALLIANCE), the Convention of Scottish Local Authorities (COSLA) and the Scottish Government - to recruit a nationally representative Our Voice Citizens' Panel.

The Our Voice Citizens' Panel was established to be nationally representative and has been developed at a size that will allow statistically robust analysis of the views of the Panel members at a Scotland-wide level. The Panel is currently made up of 1,216 people spread across each and every Integration Authority and NHS territorial Board across Scotland. Panel members were randomly selected from the general population and invited to join the Panel. Some targeted recruitment also took place in order to ensure that a representative Panel was recruited. The Panel has been designed to be broadly representative of the Scottish population.

This is the first time a national Citizens' Panel of this nature, focusing on health and social care issues, has been established in Scotland.

This report details the findings from the third full Panel survey which aimed to gather the views of the general public to help improve health care services and social care services in Scotland.

## Questionnaire design

The first of seven sections of the questionnaire asked Panel members for their views on the **use of digital information and digital health and care technologies**[2].

The next two sections of the questionnaire asked Panel members for their opinions on **how their personal information is shared and managed** by GP practices and NHS National Services Scotland, and about **the use of information for research and development purposes**.

The survey included a number of questions on Panel members' **perceptions of access to healthcare professionals other than doctors**, for example; which professionals are available at their GP practice, how happy they would be to see another healthcare professional instead of their doctor, and about any further information that would be useful in affecting their decision to take an appointment with other health and social care professionals.

The subsequent section of the questionnaire aimed to understand Panel members' perceptions of **receptionists in GP services** and how comfortable they would feel sharing basic information with them about why they may need an appointment.

[2] www.ehealth.nhs.scot – for more information on the integrated Digital Health and Social Care Strategy 2017-22

In the next section of the questionnaire, Panel members were asked about their **awareness and use of local optician services**.

The final section of the questionnaire aimed to **update the personal information held on Panel members** to ensure that we have an accurate and up-to-date record of the representativeness of the current Panel. Information that was collected included, gender description, sexual orientation, religion or beliefs and regarding long term physical or mental health condition or illnesses. This information is not reported within this report, however demographic information on the panel profile can be found in Appendix 3.

A copy of the final questionnaire is available in Appendix 1. The update for Panel members that was also provided to Panel members detailing the findings from the last survey can also be found in Appendix 2.

## Response rates and profile

The Our Voice Citizens' Panel at the time of writing this report has a total of 1,216 members. The third Our Voice Citizens' Panel survey was sent by email on 4 September 2017 to all 975 Panel members with email addresses. On 8 September 2017 survey packs were sent to all Panel members without email addresses and those from whom a bounce back email message was received. A reminder mailing was sent by email on the 11 September 2017 to those who had not yet responded by email. On 15 September 2017 additional postal surveys were delivered to Panel members who had not responded to the email survey. A final email reminder was sent on 3 October 2017 in an attempt to boost the response rate from those with email addresses.

Through a combination of these methods a total of 420 responses were received to the survey. Postal responses continued to be accepted up until the 31 October 2017. A detailed analysis of the response profile identified that the survey was under-represented in terms of younger Panel members, defined as younger members aged 44 and under, and males. This was consistent with the last two Our Voice surveys and has also been the case in many local authority Citizens' Panels. It was decided that a targeted telephone boost be undertaken in an attempt to increase the response from these under-represented groups. A total of 76 telephone interviews were completed between the 23 September and 1 November 2017. This took the final response up to 496, a 41% response rate. This level of return provides data accurate to +/-4.4% (based upon a 50% estimate at the 95% level of confidence) at the overall Panel level.

Despite the attempts of the telephone boost, younger respondents and males were still under-represented. To ensure the data was representative by age and gender, survey data was weighted to adjust for this imbalance.

Full information on the response profile achieved and weighting can be found in Appendix 3.

Further information on Citizens' Panels can be found in Appendix 4.

## Interpreting results

The results of the research are based upon a sample survey, therefore all figures quoted are estimates rather than precise percentages. The reader should interpret the data with statistical significance in mind. It should be noted that analysis is statistically robust at the overall Panel level to +/-4.4%. All comparisons that are made in this report are statistically significant, unless otherwise stated.

Analyses of subgroups of the survey population will be less robust and should be treated with caution.

When reporting the data in this document, in general, percentages in tables have been rounded to the nearest whole number. Columns may not add to 100% because of rounding or where multiple responses to a question are possible. The total number of respondents to each question is shown either as 'Base' or 'n=xxx' in the tables or charts. Where the base or 'n' is less than the total number of respondents, this is because respondents may be 'routed' passed some questions if they are not applicable. The percentages reported are weighted percentages.

All tables have a descriptive and numerical base, showing the population or population subgroup examined in it. While all results have been calculated using weighted data, the bases shown give both the unweighted and weighted counts.

Open-ended responses have been coded into response categories in order that frequency analysis or cross tabulations can be undertaken of these questions. The process of coding open-ended responses begins with reading through the responses to get a feel for potential response categories. A list of thematic response categories is then created. These are known as 'codes'. The coding process then involves assigning each response to a code. Responses can be coded into multiple categories where more than one point is communicated. Response categories must be clear and easy for anyone reading the analysis to understand. To check the coding of open-ended responses, 10% of all responses are validated by a second person to check for any issues or errors.

## Report structure

This report details the key findings from the third full Our Voice Survey. The report is structured as follows:

- Chapter 2: Digital health and care
- Chapter 3: Use of information: Personal
- Chapter 4: Use of information: Research and Development
- Chapter 5: Community health and care services
- Chapter 6: Receptionists in GP practices
- Chapter 7: Local optician services
- Chapter 8: Next steps

- Appendix 1: Questionnaire

- Appendix 2: Update for Panel members on previous survey results
- Appendix 3: Response profile
- Appendix 4: About Citizens' Panels
- Appendix 5: Interpreting results

# Chapter 2: Digital health and care

## Introduction

### The Scottish Government is developing a new Digital Health and Social Care Strategy[3], which is summarised in the draft vision statement below:

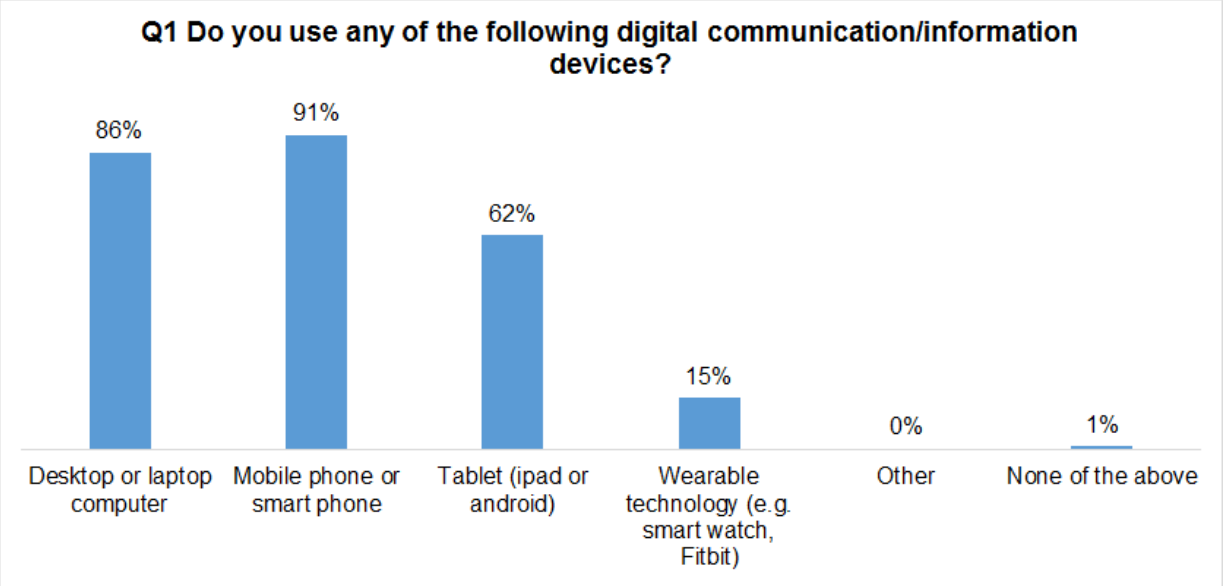
*"As a citizen of Scotland, I have access to the digital information, tools and services I need to help maintain and improve my health and wellbeing. I expect my health and social care information to be captured electronically, integrated and shared securely to assist service staff and carers that need to see it, and that digital technology and data will be used appropriately and innovatively to help plan and improve services, enable research and economic development, and ultimately improve outcomes for everyone."*

Views are being sought about the use of digital information and digital health and care technologies. This will help the Scottish Government to understand whether the above draft vision is right. This will inform further discussion during the development of the Digital Health and Social Care Strategy.

## Use of digital communication/ information devices

The survey opened by asking Panel members about their use of various digital communication and information devices. As can be seen below, the majority of respondents used a mobile or smart phone (91%), a desktop or laptop computer (86%) or a tablet (62%). A small proportion of respondents used wearable technology such as smart watch or Fitbit and only 1% of Panel members did not use any of these things.

**Figure 1: Use of digital communication/ information devices (multiple response)**




Base: Unweighted, n=466; Weighted, n=471; NB less than 1% used 'other' devices, these included digital radio, Sonos and digital hearing aids.

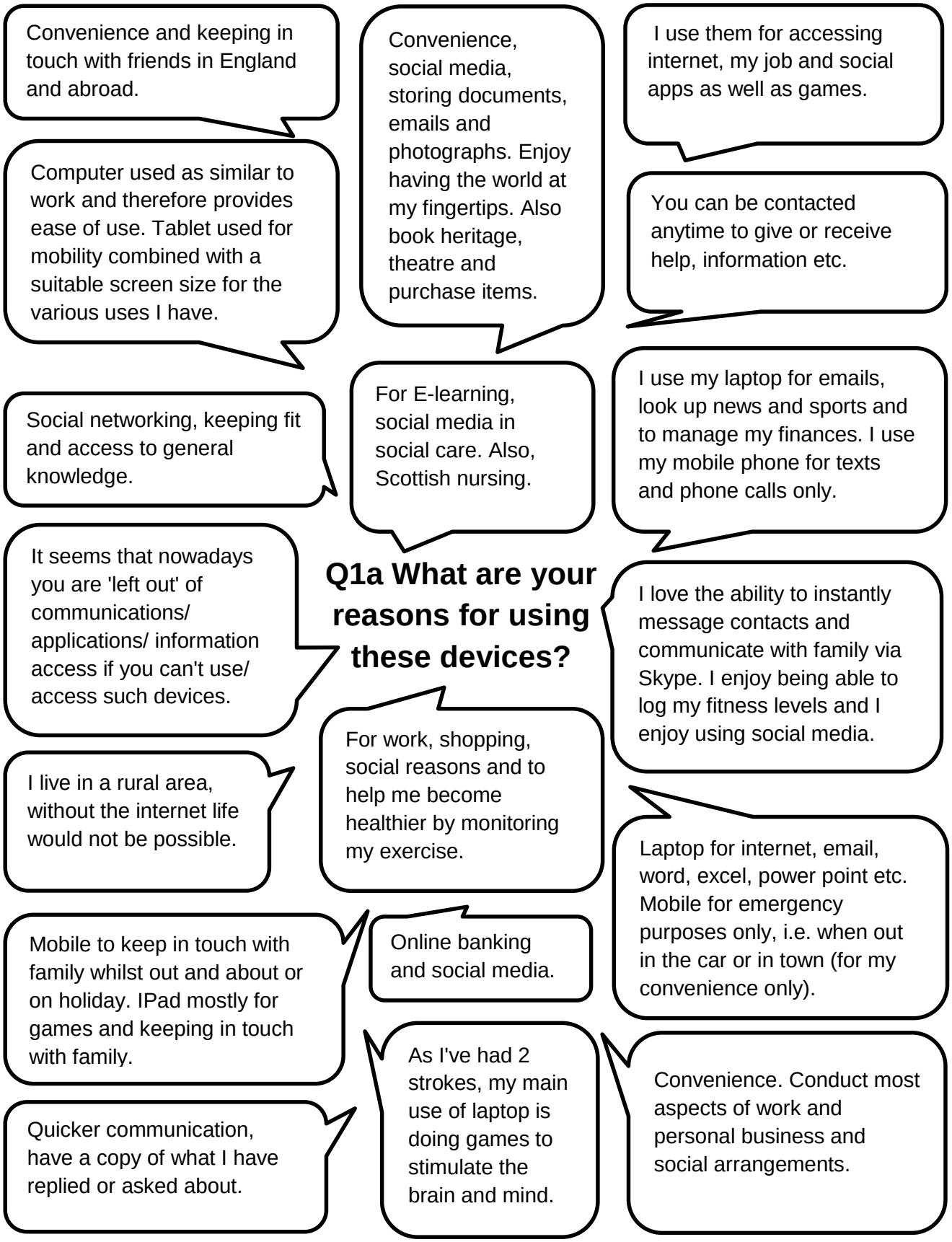
[3] www.ehealth.nhs.scot – for more information on the integrated Digital Health and Social Care Strategy 2017-22

Following on from this, Panel members were asked for their reasons for using these devices. A total of 435 respondents provided comments to this question. The open-ended responses received have been coded into common themes and are listed in the table below. Over half of Panel members who answered this question said they used digital communication and information devices for communication purposes, for example, phone calls or emails, 32% said they use them to access the internet, for information or news, and 22% use these devices for work purposes.

**Figure 2: Reasons for using digital communication/ information devices (open-ended response themes)**

| **Q1a What are your reasons for using these devices?** | |
|---|---|
| **Base: Unweighted, n=435; Weighted, n=440** | **%** |
| Communication e.g. phone calls/ email | 51% |
| To access the internet/ for information or news | 32% |
| For work purposes | 22% |
| For entertainment/ leisure purposes e.g. TV, reading, games | 21% |
| Social networking e.g. Facebook/ Twitter | 16% |
| Convenience | 15% |
| Online shopping | 9% |
| Fitness/ tracking health | 7% |
| Online banking | 4% |
| For studying/ e-learning | 3% |
| Other | 5% |

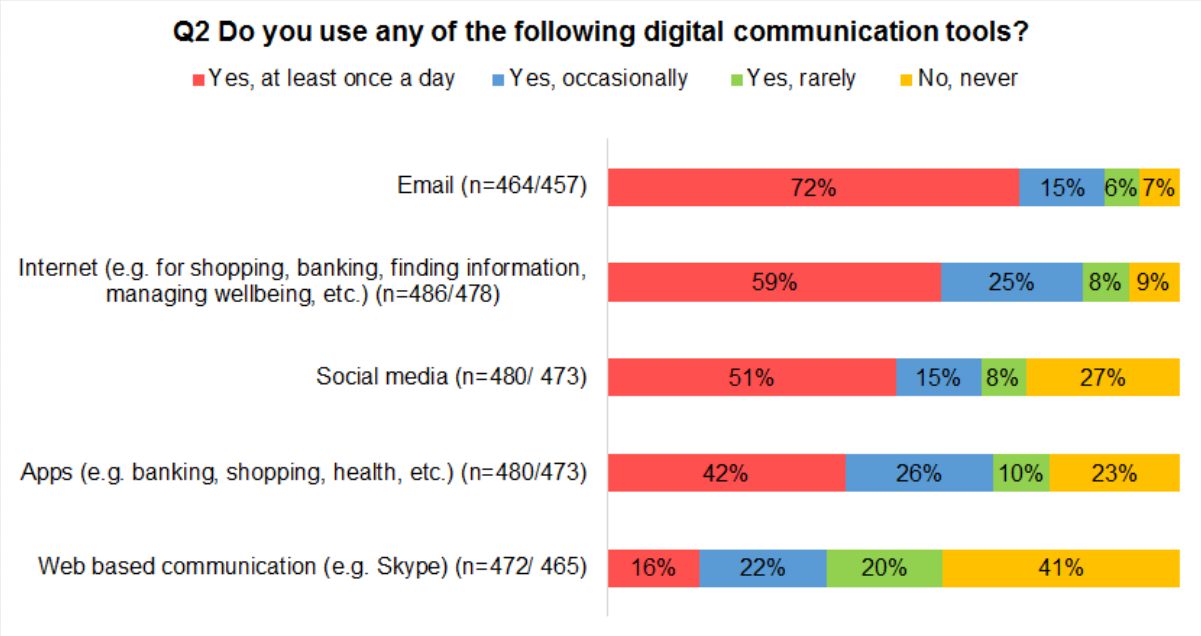
Some examples of the open-ended responses provided by Panel members to describe their reasons for using digital communication and information devices are shown below:



## Use of digital communication tools

Following on from this, respondents were asked how often they used a range of digital communication tools. Digital communication tools that were used most regularly (at least once a day) included email (72%), the internet (59%) and social media (51%). On the other hand, web-based communications such as Skype were used less regularly with only 16% stating they use this at least once a day and 41% stating they never use this.

**Figure 3: Frequency of use of digital communication tools**

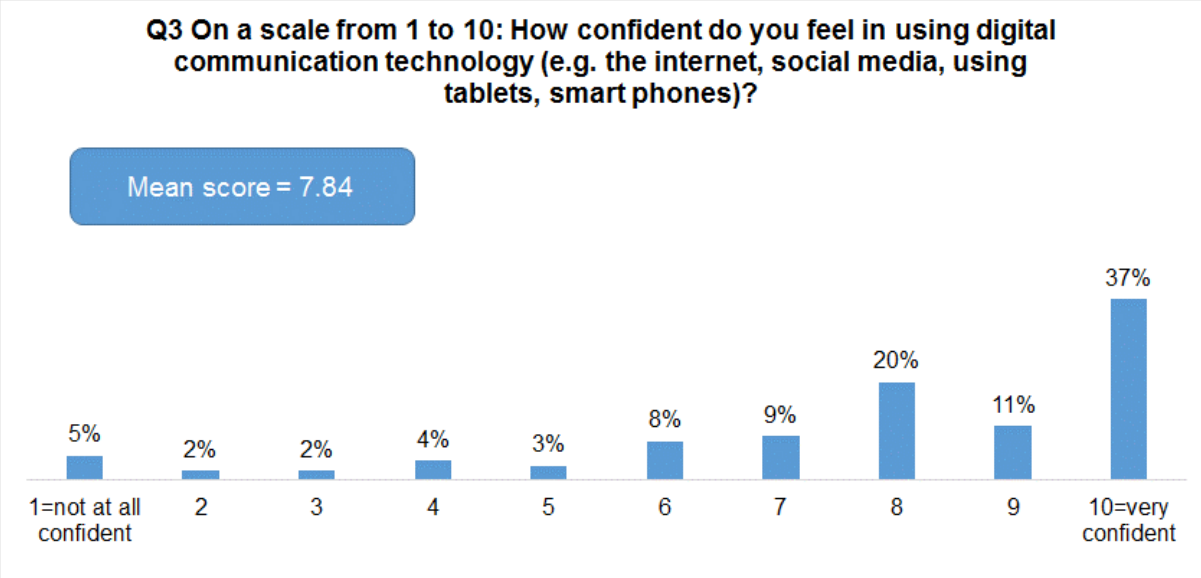



NB The first base figure provided in the chart above is the unweighted base, and this is followed by the weighted base.

## Confidence in using digital communication technology

All Panel members were asked to rate on a scale of 1 to 10 "how confident do you feel using digital communication technology" (where 1 was not confident at all and 10 was very confident). Just under 4 in 10 Panel members (37%) said they felt very confident (i.e. gave a rating of 10 out of 10), and on the other hand, only 5% said they were not at all confident (i.e. gave a rating of 1 out of 10). The mean score given to this question was 7.84, indicating a high degree of confidence in the use of digital technologies.

**Figure 4: Confidence in using digital communication technology**

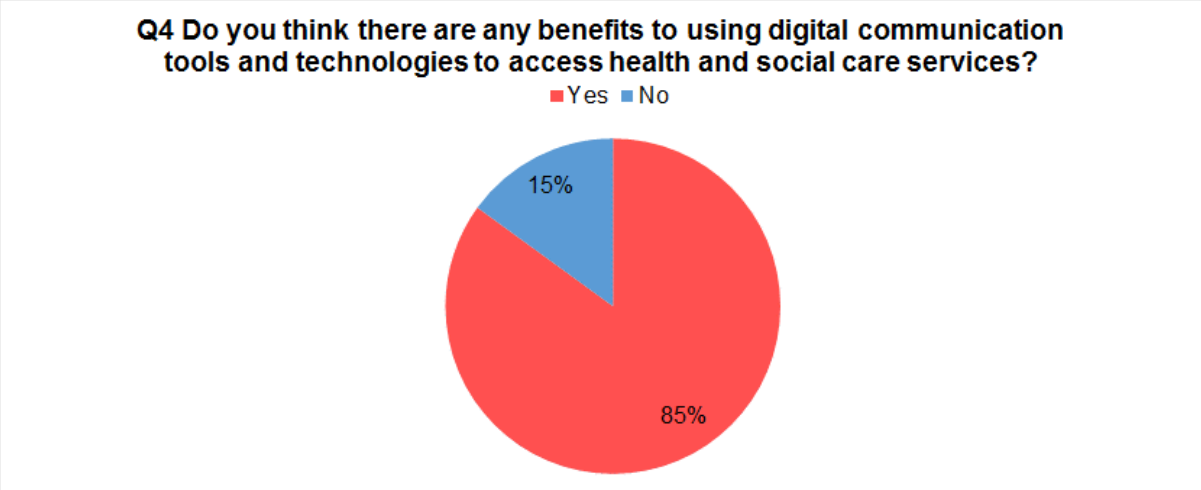



Base: Unweighted, n=480; Weighted, n=482

## Benefits to using digital communication tools and technologies to access health and social care services

The vast majority of Panel members (85%) believed there were benefits to using digital communication tools and technologies to access health and social care services.

**Figure 5: Perception of benefits to using digital communication tools and technologies to access health and social care services**




Base: Unweighted, n=477; Weighted, n=479

Where respondents answered yes to this question, they were asked to provide more detail on what they considered to be the benefits to using digital communication tools and technologies to access health and social care services. A total of 372 respondents provided comments to this question. The open-ended responses received have been coded into common themes and are listed in the table below. The main benefits were speed and easier access to services (45%), improving access to health and social care services (31%) and to be able to access further information and/ or support on health conditions or services (30%).

**Figure 6: Examples given of benefits to using digital communication tools and technologies to access health and social care services (open-ended response themes)**

| Q4a If Yes, please list these benefits: | |
|---|---|
| **Base: Unweighted, n=372; Weighted, n=378** | **%** |
| Speedier access to services | 45% |
| Improved access to services e.g. more accessible for rural areas/ 24/7 access/ convenient/ can access from home | 31% |
| Further information and/ or support on health conditions/ services | 30% |
| To make appointments | 10% |
| To order prescriptions/ repeat prescriptions | 4% |
| Taking pressure off of GP surgeries/ hospitals/ free up resources | 4% |
| Inexpensive/ cost savings | 3% |
| Other | 5% |

Some examples of the open-ended responses provided by Panel members to describe the benefits to using digital communication tools and technologies to access health and social care services are shown below:

**Q4 Do you think there are benefits to using digital communication tools and technologies to access health and social care services, if yes please list these benefits**

Reduced pressure on expert staff and facilities. Rapid communication.

Easy to get access to up to date information. A great help when living in rural areas to be able to contact health professionals by Skype or VC.

Faster information can be updated more quickly and presented to users.

Access to what is available to myself and other people in different demographic groups e.g. disability, social care and services available. How to use for carers and family.

Much quicker transfer for medical records than in paper form, also everything is legible.

More up-to-date information accessible. Less errors in communication between services.

For rural areas – for younger people, doctors can deal with more people and more cost effective.

Information allows patients to be actively involved in their own healthcare. Understanding what they should expect from health professionals, and challenge/contribute where necessary.

Making appointments. Ordering repeat prescriptions. Access if you don't wish to speak in person.

I can be shy and lazy. The availability of digital communication tools would make me more likely to use services that are available to me.

Can save time. Immediate response to enquiries. If used for initial consultation with medical consultant. If living in a rural area could be more cost effective, than travelling to mainland hospital.

It's easier to access prescriptions as I work the whole doctor's surgery open hours.

Informing people. Mini surveys to help people gauge their health. Devices that provide information e.g. no of steps walked, heart rate etc.

Meetings. Training, patient can speak face to face with a clinician without leaving their home.

Making appointments. Getting information, finding out about practitioners and learning about services.

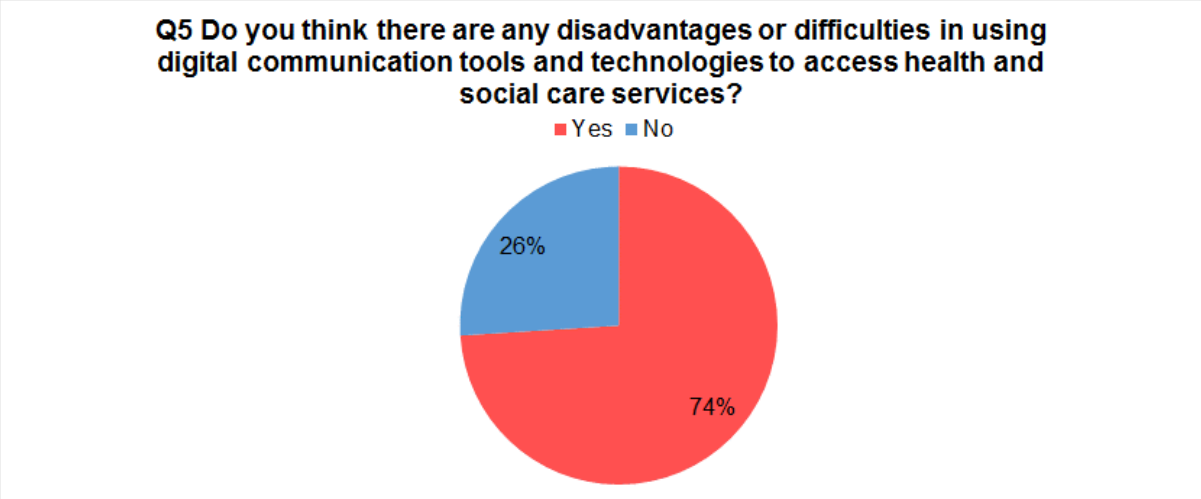
Can be more convenient, and fairly inexpensive to use.

24/7 access to services.

## Disadvantages to using digital communication tools and technologies to access health and social care services

Just under three quarters of Panel members (74%) said there were disadvantages in using digital communication tools and technologies to access health and social care services.

**Figure 7: Perception of disadvantages or difficulties in using digital communication tools and technologies to access health and social care services**




Base: Unweighted, n=474; Weighted, n=476

Where respondents answered yes to this question, they were asked to list the difficulties or disadvantages of using digital communication tools and technologies to access health and social care services. A total of 341 respondents chose to answer this question. Again, the open-ended responses have been coded into common themes for analysis purposes. Over three in ten comments (31%) were where respondents had concerns about lack of access to the internet or not being able to use the internet, 23% felt that having no human contact was a disadvantage and 20% said the risk of misdiagnosis or information being misunderstood or misinterpreted was a problem.

**Figure 8: Examples given of disadvantages to using digital communication tools and technologies to access health and social care services (open-ended response themes)**

| Q5a Do you think there are disadvantages or difficulties in using digital communication tools and technologies to access health and social care services? If yes, please list these difficulties and disadvantages. | |
|---|---|
| **Base: Unweighted, n=341; Weighted, n=347** | **%** |
| Not everyone has access/ confident in using digital communication/ older people/ disabled people may not be able to use it | 31% |
| No human contact/ less personal | 23% |
| Misdiagnosis/ self diagnosis is dangerous/ information being misunderstood/ misinterpreted | 20% |
| Issues re data security/ hacking/ data protection | 20% |
| Issues re internet connection speeds e.g. rural areas | 8% |
| System crash/ technical faults | 7% |
| Affordability/ cost to access services | 2% |
| Other | 5% |

Examples of the open-ended responses provided by Panel members to describe what they believe to be disadvantages to using digital communication tools and technologies to access health and social care services are shown below:

**Q5 Do you think there are disadvantages or difficulties in using communication tools and technologies to access health and social care services? If yes, please describe**

Loss of programs through technical faults, input errors.

Sometimes systems can crash etc. Also, some concerns about security of personal data using such tools.

Unless fully understood, information can be very misleading and distressing.

Not everyone has a computer. Elderly would be disadvantaged.

Ensuring patients use suitable sources of information. Data protection and cyber security area key concern. As is the management of this network of tools and technologies at a national level - a huge challenge.

Not everyone has access. Poor service levels and lack of infrastructure e.g. universal 4G reception. Slow broadband in rural areas.

I think you need personal communication to feel like a person, not a diagnosis/ number. You have to fit in tick boxes or you are not dealt with appropriately.

Lack of face-to-face contact could mean that things are missed or misinterpreted.

Interpretation of information may be complicated and require interpretation by a trained professional. Security of data.

Difficulty if problem with internet connection if using Skype etc for consultations.

Older members of community may not be confident and/or, may not have access to digital communications.

Personal contact is also necessary especially in difficult situations, when professional advice is essential and objective.

Rural communities often have slow or intermittent internet.

Probably for a sector of the community who are worried about digital security, and/or not confident in using technology.

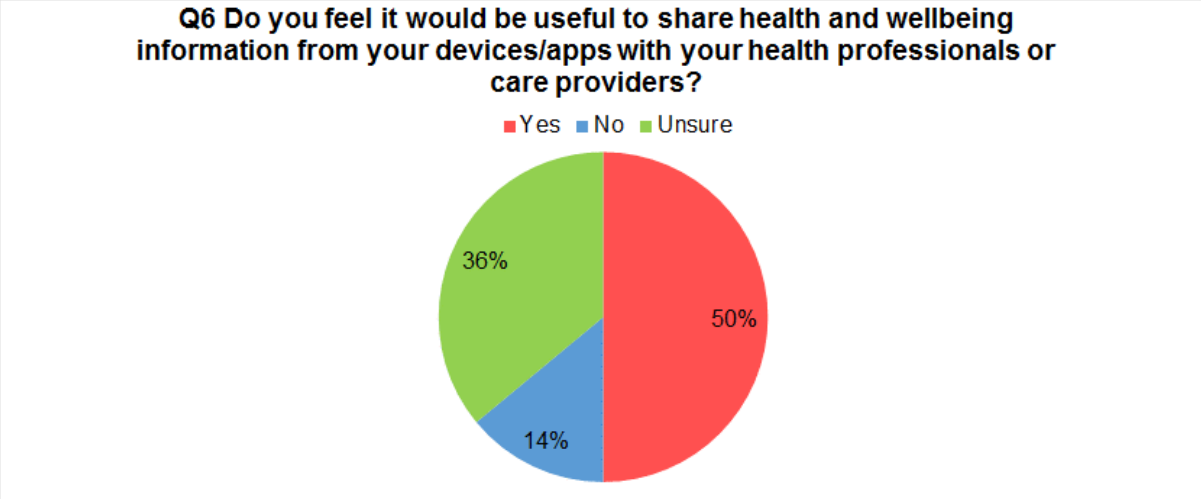
There are still many people who do not have access to such tools and technologies, or are not familiar with them and lack confidence working with them. This is particularly the case with the elderly, and those needing social care.

Isolation of patients without digital access/expertise.

## Sharing health and wellbeing information from devices/apps with health professionals or care providers

Half of Panel members (50%) felt it would be useful to share health and wellbeing information from their devices or apps with their health professionals or care providers, 14% said this would not be useful and 36% were unsure.

**Figure 9: Usefulness of sharing health and wellbeing information from devices or apps with healthcare professionals or care providers**




Base: Unweighted, n=478; Weighted, n=480

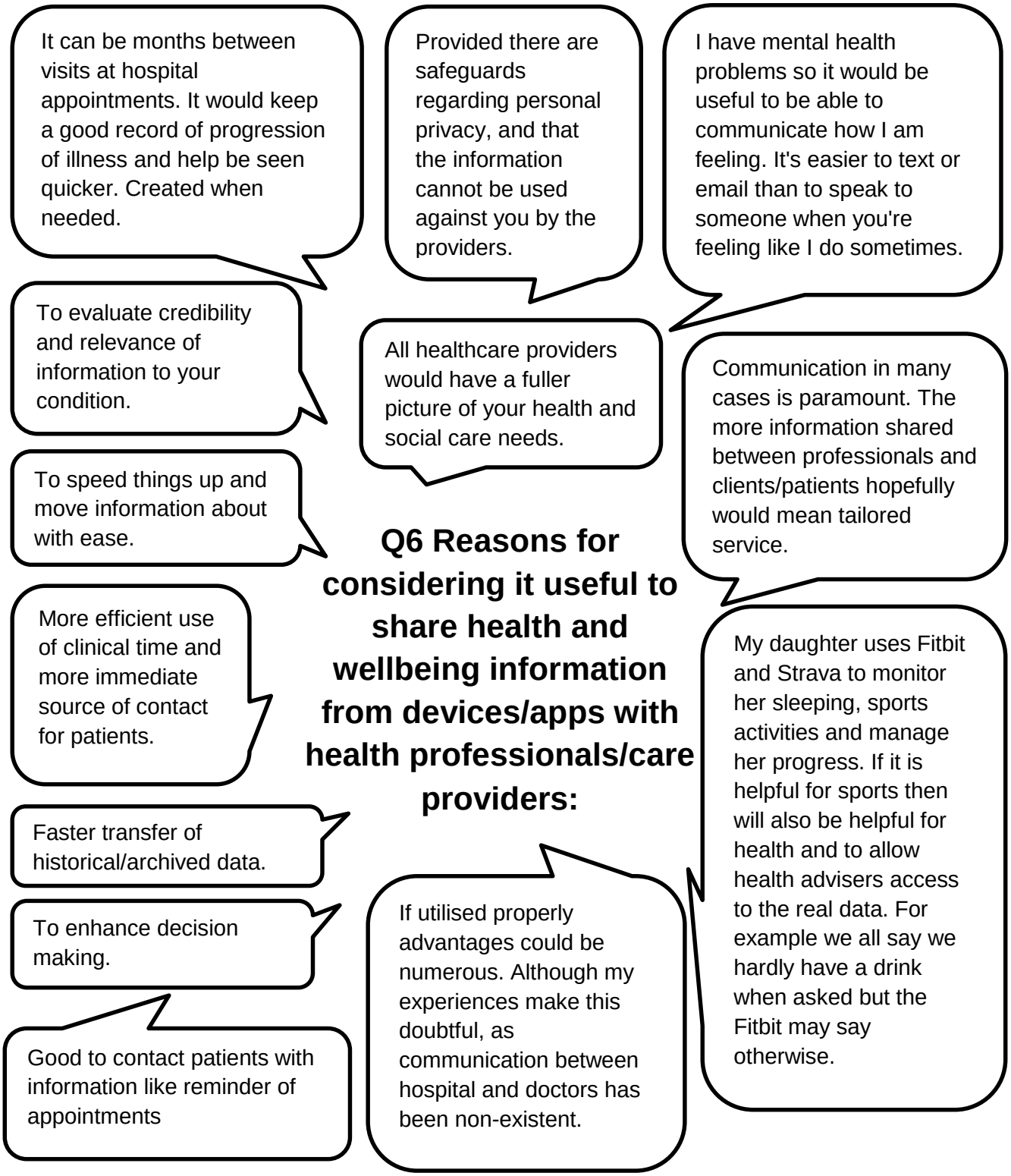
All respondents were asked to explain their reasons for their answer. A total of 389 respondents chose to answer this question, and the open-ended responses have been coded into common themes for analysis purposes. Positive reasons described for sharing their health and wellbeing information tended to be where respondents felt that more information would help health professionals or care providers make decisions or give them a full picture of treatment history of the patient (35%).

On the other hand, more negative comments or concerns about sharing information included confidentiality or data security concerns (18%), where respondents felt it would depend on the information, what would be involved or who would have access (15%) and where Panel members preferred face-to-face contact (6%).

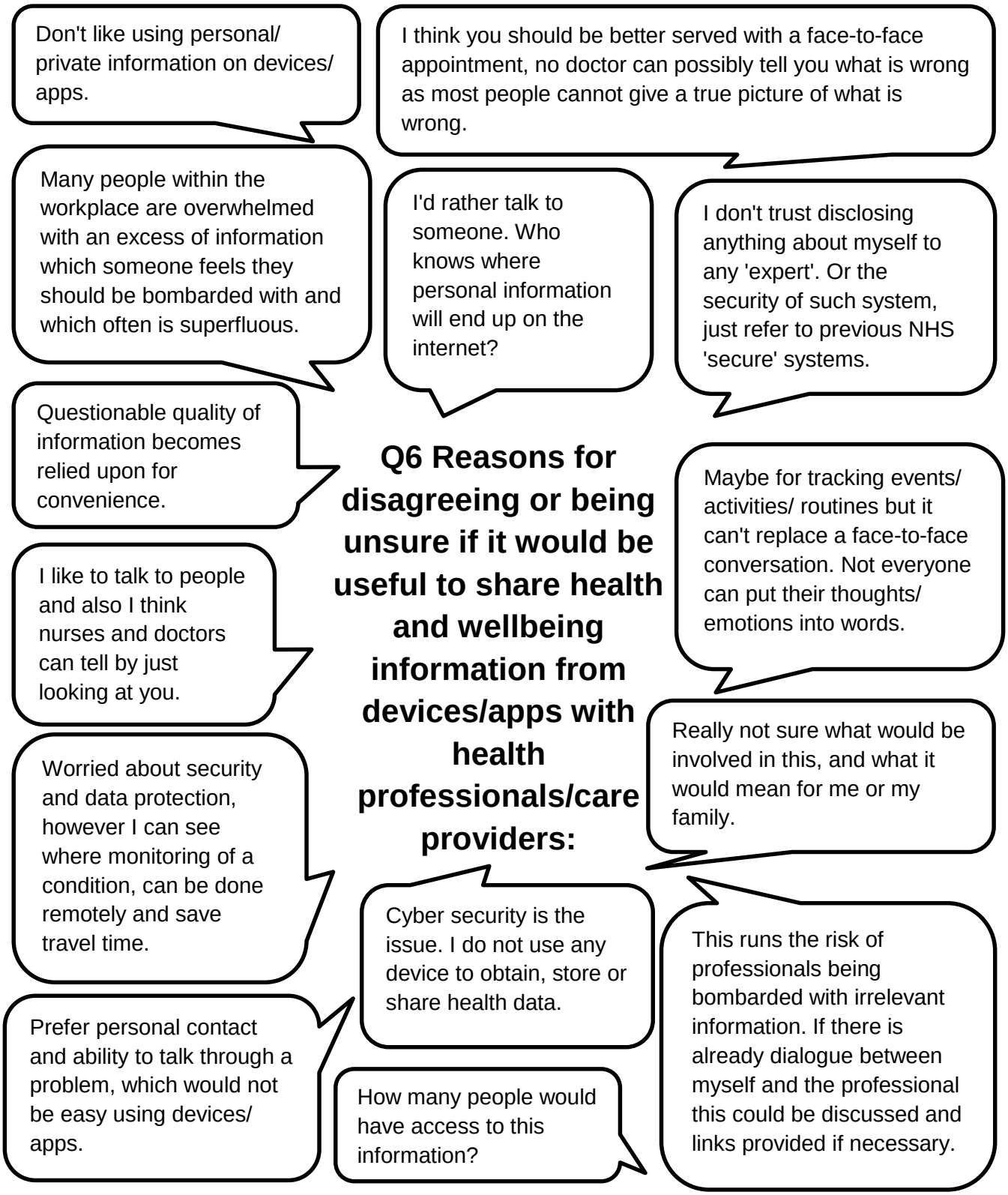
**Figure 10: Comments made about the usefulness of sharing health and wellbeing information from devices or apps with healthcare professionals or care providers (open-ended response themes)**

| Q6a Do you feel it would be useful to share health and wellbeing information from your devices/ apps with your health professionals or care providers? Please tell is why you feel this way. | |
|---|---|
| **Base: Unweighted, n=389; Weighted, n=395** | **%** |
| More information would help health professionals/ care providers make decisions/ deal with issues better/ give them a full picture of treatment history | 35% |
| Confidentiality/ data security concerns | 18% |
| Would depend on the information/ what would be involved/ who would have access | 15% |
| Time saving/ more efficient for health professionals/ care providers | 13% |
| I prefer face to face contact | 6% |
| Would reduce the need for appointments | 6% |
| Information not accurate/ prone to errors | 4% |
| Would be helpful for people with mental health issues who find it easier to communicate by text/ email/ those who aren't able to leave house | 1% |
| Information overload for professionals | 1% |
| Other | 6% |

Below are some examples of the comments provided by Panel members who said it *would be useful* to share health and wellbeing information from their devices or apps with health professionals or care providers:



Some examples of the comments provided by Panel members who said it *would not be useful* or were *unsure if it would be useful* to share health and wellbeing information from their devices or apps with health professionals or care providers are shown below:



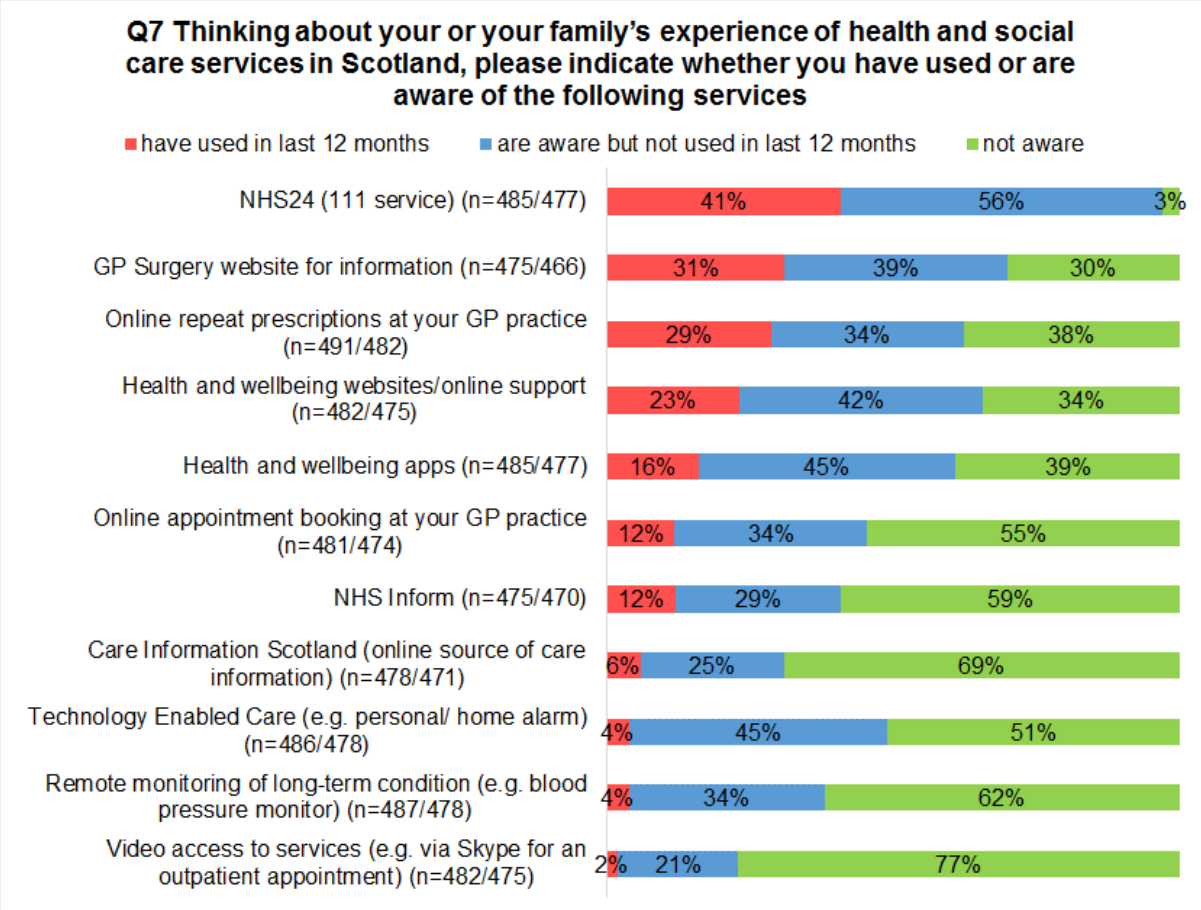
## Awareness and use of health and social care services in Scotland

The survey included a question which asked Panel members about their (or their family's) experience of digital health and social care services in Scotland. Services which have been used most by Panel members were NHS 24 (41%), GP surgery website for information (31%), and online repeat prescriptions at the GP practice (29%).

Services that had not been used but where awareness was highest included NHS 24 (56%), Technology Enabled Care (45%), and health and wellbeing apps (45%).

Video access to services (77%), Care Information Scotland[4] (69%) and remote monitoring of long term conditions (62%) were services which had the highest proportion of respondents being unaware.

**Figure 11: Awareness and use of health and social care services in Scotland**




NB The first base figure provided in the chart above is the unweighted base, and this is followed by the weighted base.

[4] In our first panel survey (distributed November 2016 – January 2017), panel members were asked about their awareness of Care Information Scotland as a source of information on care. Only 13% of respondents indicated that they were aware of this service. In the current survey (distributed September – November 2017), an increased proportion of panel members reported being aware of Care Information Scotland services. Here, 39% of respondents were aware of, or had used this service. Due to prior notification of this service, the awareness figure reported in the current report (39%) may not be indicative of wider 'public awareness'.

# Chapter 3: Use of information: Personal

## Introduction

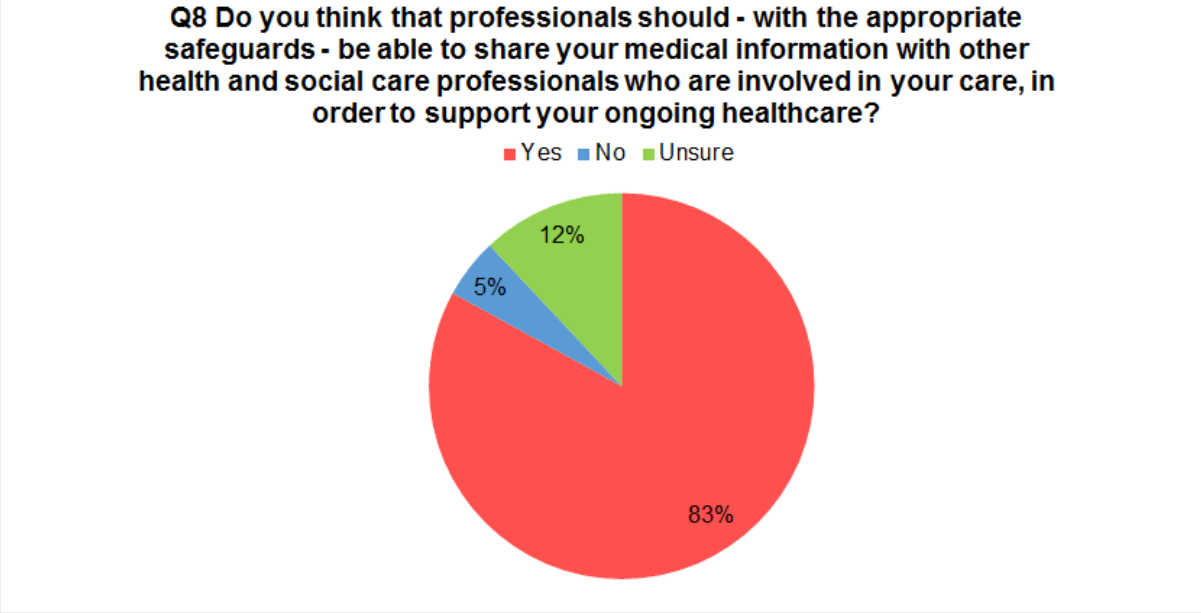
When you register with a GP practice in Scotland, you consent to your personal information being passed to NHS National Services Scotland where it is verified and held in a secure data centre on the Community Health Index (CHI). This information is used to register you, transfer your medical records between GP practices, make payments to GP practices for medical services provided, and to process and issue medical cards, medical exemption certificates and entitlement cards.

The survey aimed to find out Panel members' views regarding the use of personal information to support their ongoing health care.

## Opinions on the sharing of information between health and social care professionals

Over 8 in 10 Panel members (83%) believed that "professionals should – with the appropriate safeguards – be able to share your medical information with other health and social care professionals who are involved in your care, in order to support your ongoing healthcare." On the other hand, 5% disagreed with this statement and 12% were unsure.

**Figure 12: Opinions on the sharing of information between health and social care professionals who are involved in your care, in order to support your ongoing healthcare**




Base: Unweighted, n=478; Weighted, n=480

Following on from this, Panel members were asked to provide their reasons for their answer. A total of 391 Panel members provided further comments to this question and their reasons were coded into common themes and the responses shown in the table below. Positive comments about sharing information between health and social care professionals were where Panel members believed this would ensure the best or more effective treatment options for patients (25%), would help professionals identify the full picture in advance of providing treatment options (19%) and would result in time saving or more efficient treatment (12%).

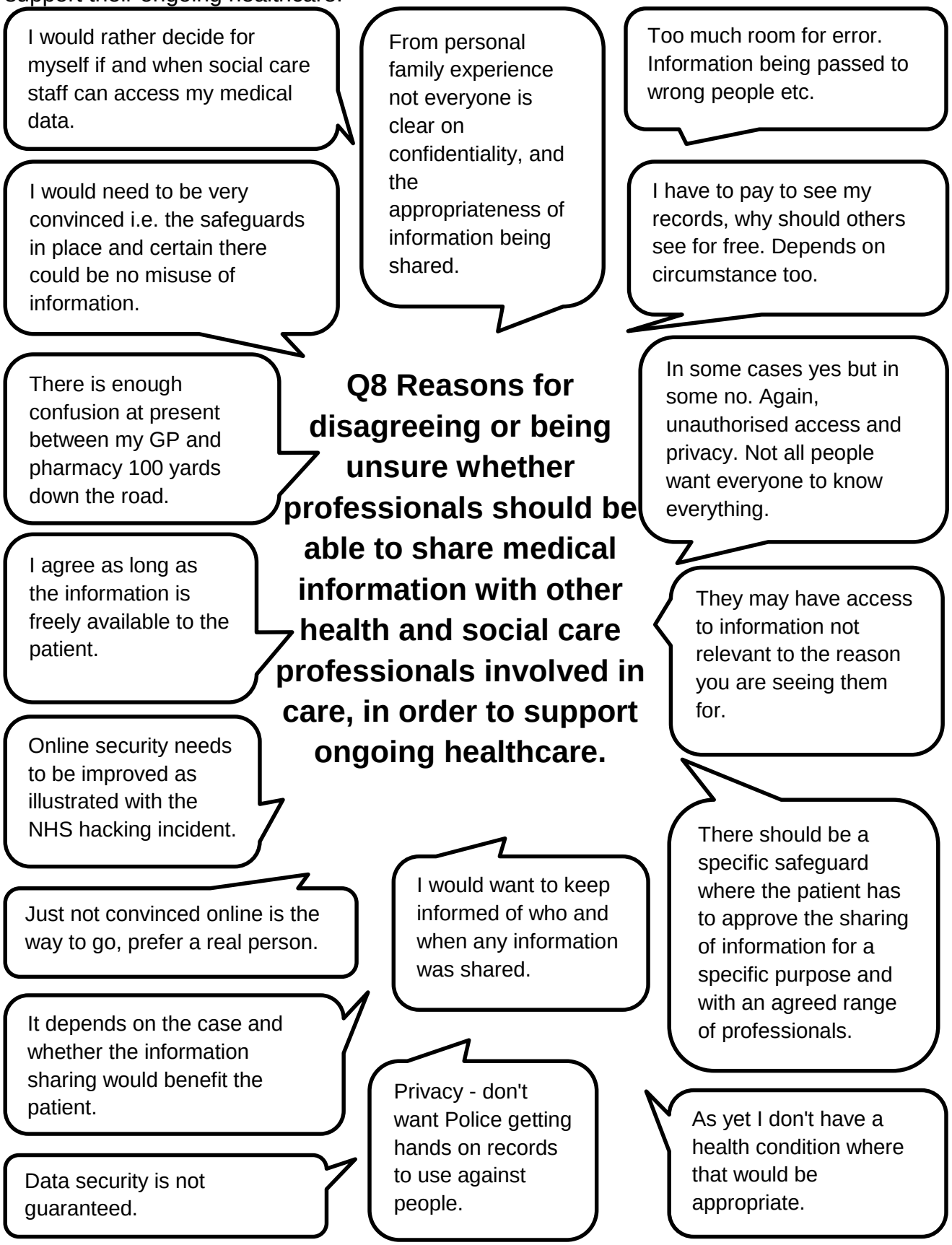
On the other hand, comments made by those who disagreed with the sharing of information between health and social care professionals were where Panel members expressed concerns about knowing who would have access to information and about the type of information being shared (22%) and issues regarding confidentiality or data security (9%).

**Figure 13: Opinions on whether professionals should be able to share medical information with other health and social care professionals who are involved in your care, in order to support ongoing healthcare (open-ended response themes)**

| **Q8a Do you think that professionals should - with the appropriate safeguards - be able to share your medical information with other health and social care professionals who are involved in your care, in order to support your ongoing healthcare? Please tell us why you feel this way?** | |
|---|---|
| **Base: Unweighted, n=391; Weighted, n=393** | **%** |
| To ensure the best/ most effective treatment options for patients/ better care/ outcomes | 25% |
| Would need to know who and what information is being shared | 22% |
| So all professionals can identify the full picture in advance of providing treatment options | 19% |
| Time saving/ more efficient/ quicker treatment | 12% |
| A more joined up approach/ integrated services | 10% |
| So patients don't need to repeat their treatment history at every appointment/ avoids duplicate information | 9% |
| Issues re confidentiality/ data security | 9% |
| Seems sensible/ makes sense | 7% |
| Other | 1% |

Some examples of the comments provided by Panel members who agreed "professionals should – with the appropriate safeguards – be able to share your medical information with other health and social care professionals who are involved in your care, in order to support your ongoing healthcare" are shown below:

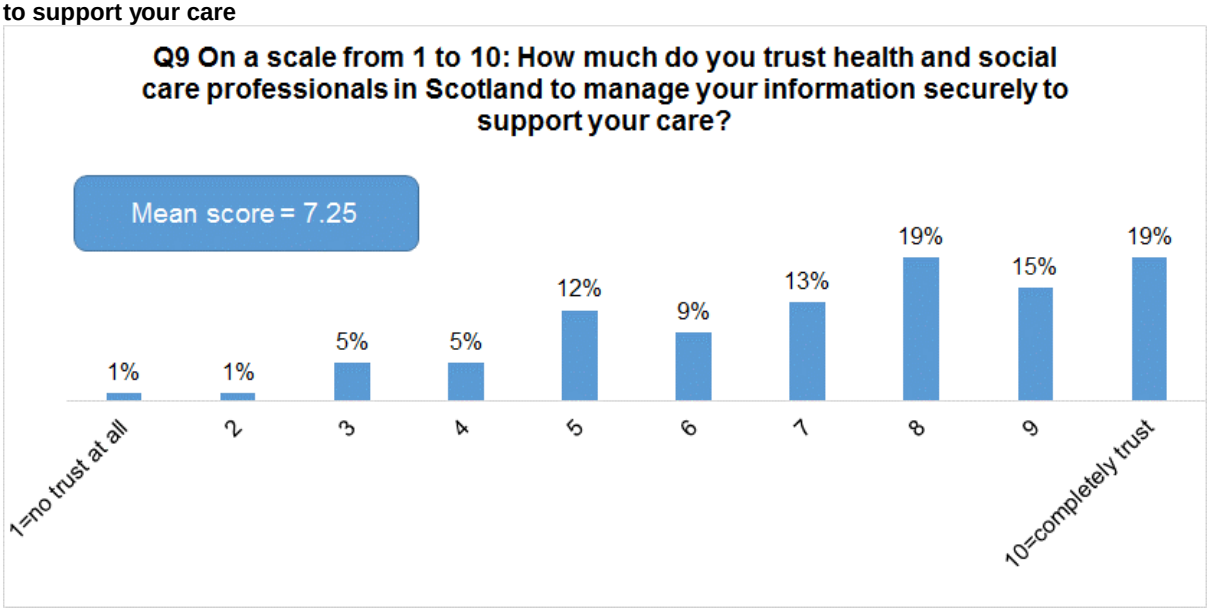
The following comments were provided by Panel members who *disagreed or were unsure* whether professionals should be able to share medical information with other health and social care professionals who are involved in their care, in order to support their ongoing healthcare:



## Trust in health and social care professionals in Scotland to manage health information securely

All Panel members were asked to rate on a scale of 1 to 10 "how much do you trust health and social care professionals in Scotland to manage your information securely to support your care" (where 1 was no trust at all and 10 was complete trust). Nineteen per cent gave a score of 10, i.e. said they completely trusted health and social care professionals in this respect, compared to just 1% who said they had no trust at all. The mean score for this question was 7.25, meaning that Panel members largely trust health and social care professionals to manage their information securely to support their care.

**Figure 14: Trust in health and social care professionals in Scotland to manage your information securely to support your care**




Base: Unweighted, n=481; Weighted, n=482

A total of 319 respondents provided further details regarding their response to this question. The open-ended responses were coded into common themes for analysis purposes and are listed in the following table. Positive comments were generally where Panel members believed health professionals and care providers to be trustworthy professionals (18%), that they do a good job, online security seems solid and that they have confidence in them (12%) and where they have no reason to think otherwise (7%). On the other hand, more negative comments were in relation to past experience of cyber attacks and a lack of confidence in data being kept secure (33%) and that all systems are subject to the risk of hacking, no system is 100% secure and that human error is always possible (20%).

**Figure 15: Reasons given for opinions on how much Panel members trust health and social care professionals in Scotland to manage their information securely to support their care (open-ended response themes)**

| **Q9 On a scale from 1 to 10: How much do you trust health and social care professionals in Scotland to manage your information securely to support your care? Please tell us why you feel this way.** | |
|---|---|
| **Base: Unweighted, n=319; Weighted, n=321** | **%** |
| Mistakes have been made in the past/ my own experience/ lack of confidence in data being kept secure | 33% |
| All systems are subject to the risk of hacking/ cyber attacks/ systems are never 100% secure/ human error always possible | 20% |
| They are trustworthy professionals | 18% |
| They do an excellent job/ online security seems solid/ I have confidence in them | 12% |
| Not sure/ have no experience | 12% |
| I have no reason to think otherwise | 7% |
| All staff require full training in data security | 3% |
| Other | 3% |

Some examples of the comments provided by Panel members who gave positive comments about their trust in health and social care providers in Scotland to manage their information securely to support their care are shown below:

## Q9 How much do you trust health and social care professionals in Scotland to manage your information securely to support your care? Positive comments

So far we have had no issues with our care and are happy with all our support.

Not sure how it would work, but I'm sure sites would be secure.

I have had generally good experiences in the past.

It's part of their job and I'd hope there would be considerable safeguards.

I would hope all healthcare professionals should have high standards.

They are regulated and monitored. In my opinion if there are any problems this can be picked up.

They have helped me out a few times.

Personal experience has proved this to be correct.

Because they deal with that many people. They aren't going to have a vendetta against any person – they are there to help.

I'd like to think that all personal information would be stored safely and encrypted when passed on.

I trust the individuals, they are professionals but less sure for technology safeguards.

Because I haven't had anyone divulge anything about me but technology isn't always reliable but I do generally trust the professionals.

They are a trusted expertise.

Because it is their normal practice to treat information as confidential, they ask me if they can share my records with their doctors.

You never really know who knows what, but you always get the help in the end.

Have complete trust in Scottish Government to do best for citizens of Scotland, in turn professionals in NHS to do best by those that use services.

The following comments were provided by Panel members who gave negative comments about their trust in health and social care providers in Scotland to manage their information securely to support their care:

# Chapter 4: Use of information: Research and development

## Introduction

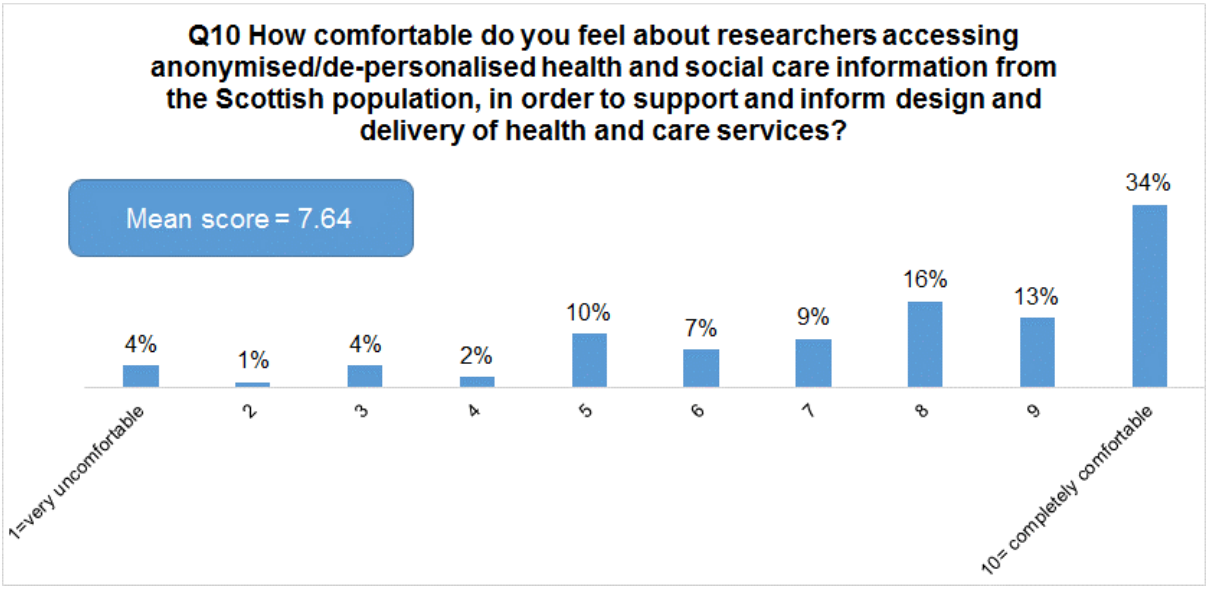
NHS National Services Scotland shares de-personalised or anonymised information about you within NHSScotland to assist in the provision and improvement of NHS services and the health of the public. When they do this, they make sure that the information that identifies you as a person and the information about your health are kept separate or are made anonymous, removing any details which could identify you as an individual. Health condition and treatment information which could identify you is not used for research purposes unless you have explicitly consented to this. Such data and information from the Scottish population can help to highlight where improvements could be made, or identify where resources could be targeted, for example, research into vaccinations, prevalence of different conditions, time intervals between seeing a GP and diagnosis/treatment, etc.

This set of questions was designed to understand Panel members' views on the use of health information for research.

## Access to anonymised/de-personalised health and social care information from the Scottish population

On a scale of 1 to 10, respondents were asked to rate how comfortable they felt about researchers accessing anonymised or de-personalised health and social care information from the Scottish population, in order to support and inform design and delivery of health and care services (where 1 was very uncomfortable and 10 was very comfortable). Over a third of panel members (34%) said they felt completely comfortable in this respect (i.e. gave a score of 10 out of 10), compared to just 4% who said they felt very uncomfortable (i.e. gave a score of 1 out of 10). The mean score for this question was 7.64, meaning that Panel members are largely comfortable with researchers accessing anonymised health and social care information.

**Figure 16: How comfortable Panel members feel about researchers accessing anonymised health and social care information from the Scottish population, in order to support and inform design and delivery of health and care services**

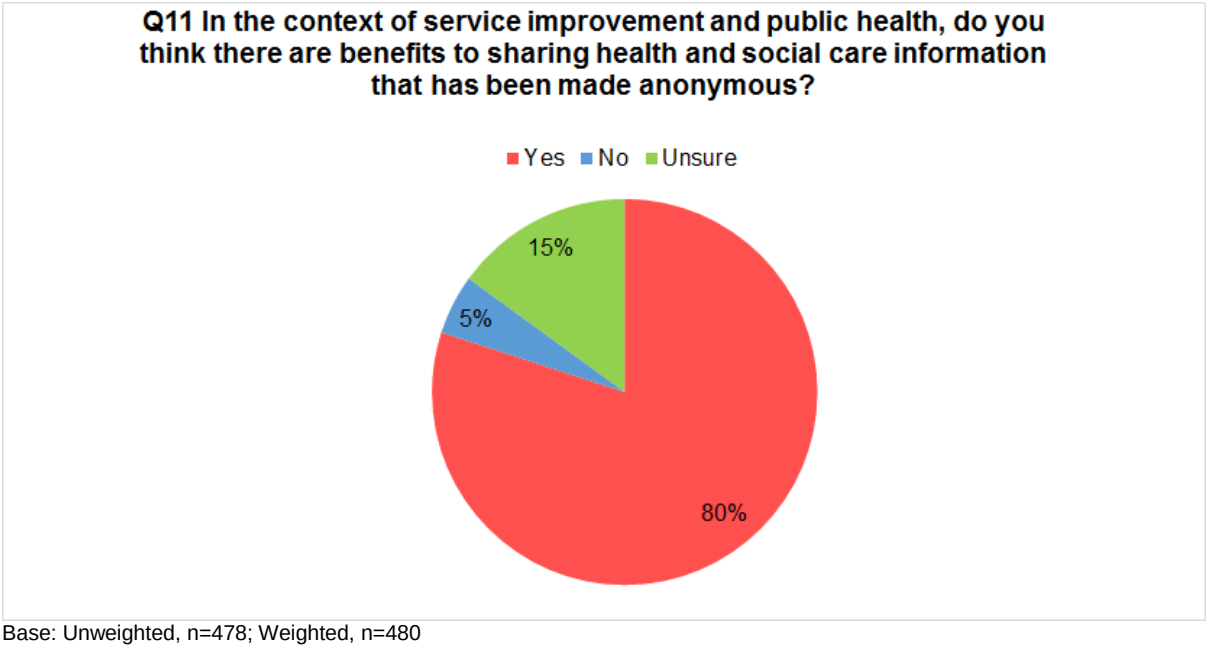



Base: Unweighted, n=479; Weighted, n=480

## Benefits to sharing anonymised health and social care information

Eight in ten Panel members (80%) agreed that in the context of service improvement and public health, there were benefits to sharing health and social care information that has been made anonymous. On the other hand, 5% disagreed with this statement and 15% were unsure.

**Figure 17: Benefits to sharing anonymised health and social care information in the context of service improvement and public health**



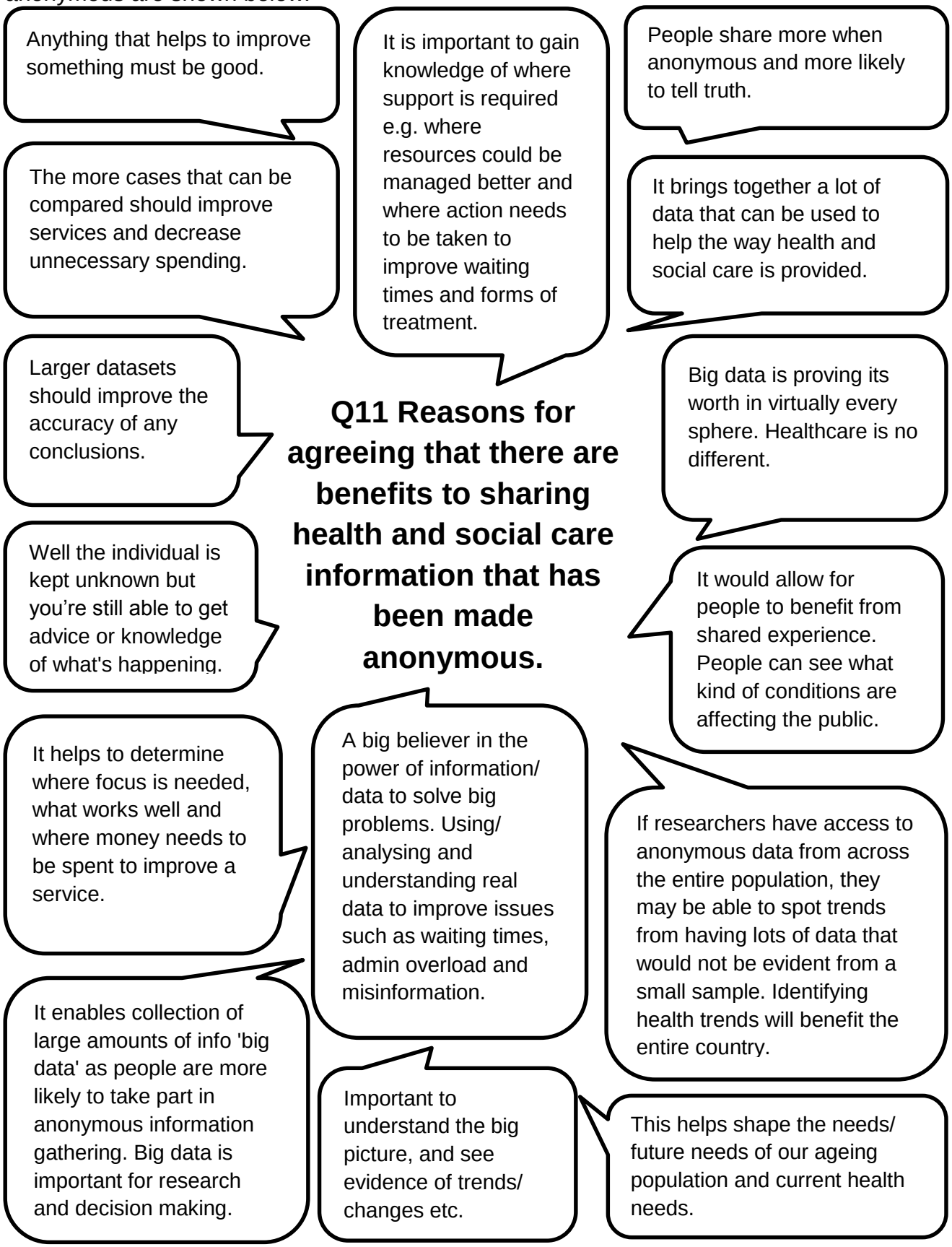

Base: Unweighted, n=478; Weighted, n=480

A total of 343 respondents provided further details regarding their response to this question. The open-ended responses were coded into common themes for analysis purposes and are listed below. Where Panel members provided positive comments these were largely where Panel members believed that all information sharing was useful and can improve services or treatment (59%) and that it is useful in identifying trends, problems and solutions (23%). On the other hand, more negative comments regarding access to anonymised or depersonalised health and social care information from the Scottish population were generally where Panel members had concerns about how data will be used and confidentiality concerns (19%).

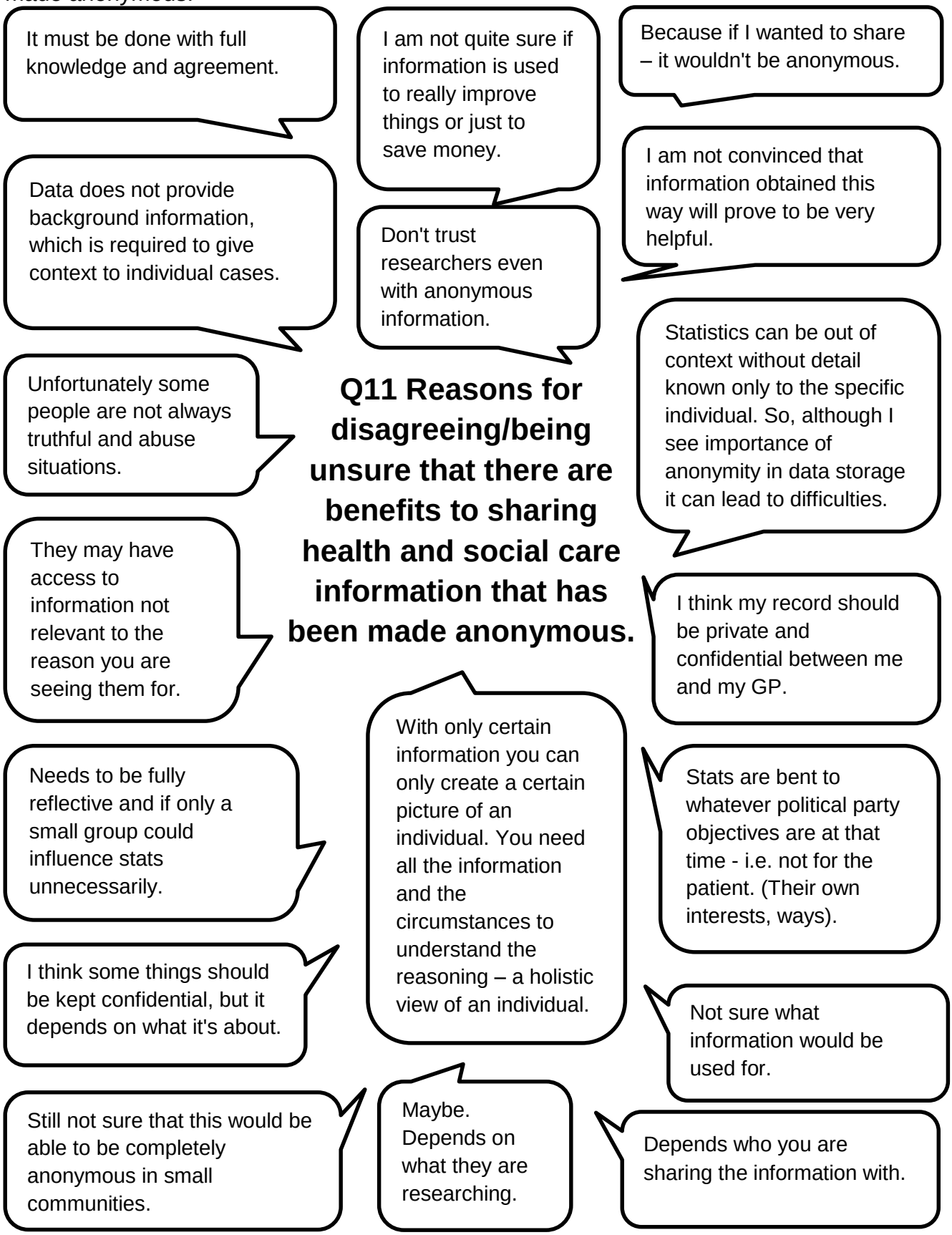
**Figure 18: Reasons given for opinions on the benefits to sharing anonymised health and social care information in the context of service improvement and public health (open-ended response themes)**

| **Q11 In the context of service improvement and public health, do you think there are benefits to sharing health and social care information that has been made anonymous? Please tell us why you feel this way?** | |
|---|---|
| **Base: Unweighted, n=343; Weighted, n=351** | **%** |
| All information sharing is useful/ can improve services and care/ treatment | 59% |
| Useful in identifying trends/ the big picture/ for planning purposes/ identifying problems and solutions | 23% |
| Would need strict guidelines how data will be used/ assurances that confidentiality/ that data is anonymous | 19% |
| Not sure how this would help/ no benefits in doing this/ not helpful | 8% |
| Larger datasets improve the accuracy of any conclusions | 4% |
| People are more likely to share information/ be honest if anonymous | 1% |
| Other | 2% |

Some examples of the comments provided by Panel members who agreed there are benefits to sharing health and social care information that has been made anonymous are shown below:



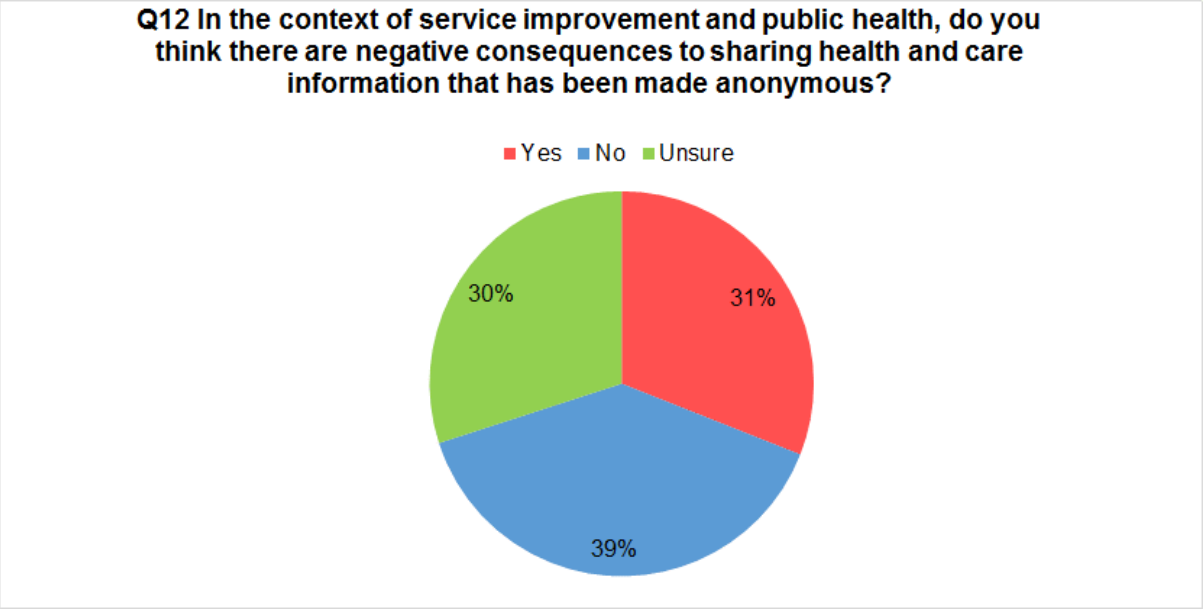
The following comments were made by Panel members who disagreed or were unsure of the benefits to sharing health and social care information that has been made anonymous:



## Negative consequences to sharing anonymised health and social care information

Subsequently, Panel members were asked if they felt there were any negative consequences to sharing health and care information that has been made anonymous. Over 3 in 10 Panel members (31%) answered 'yes' to this question, 39% said no and the remaining 30% were unsure.

**Figure 19: Negative consequences to sharing anonymised health and social care information in the context of service improvement and public health**



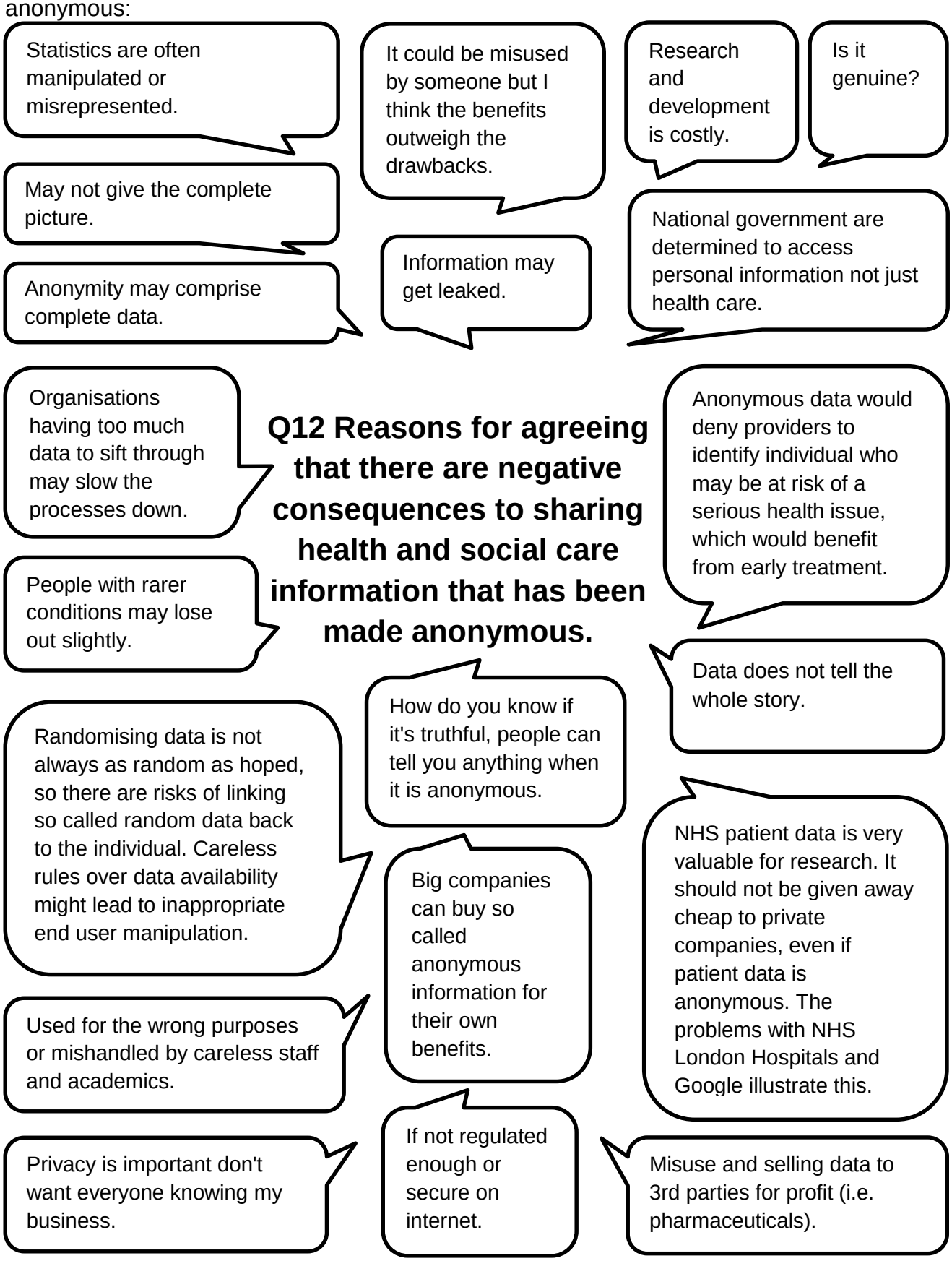

Base: Unweighted, n=471; Weighted, n=470

Following on from this, respondents were asked to provide their reasons for their answer to this question. A total of 368 respondents provided further details and the open-ended responses were coded into common themes for analysis purposes and are listed below. Just under 3 in 10 responses were where Panel members expressed concerns about data security and confidentiality (29%), 17% said that sharing anonymous data could lead to misinterpretation of data and may not give the full picture. On the other hand, 22% of respondents felt that the sharing of anonymous data was a positive thing and could not think of any negative consequences.

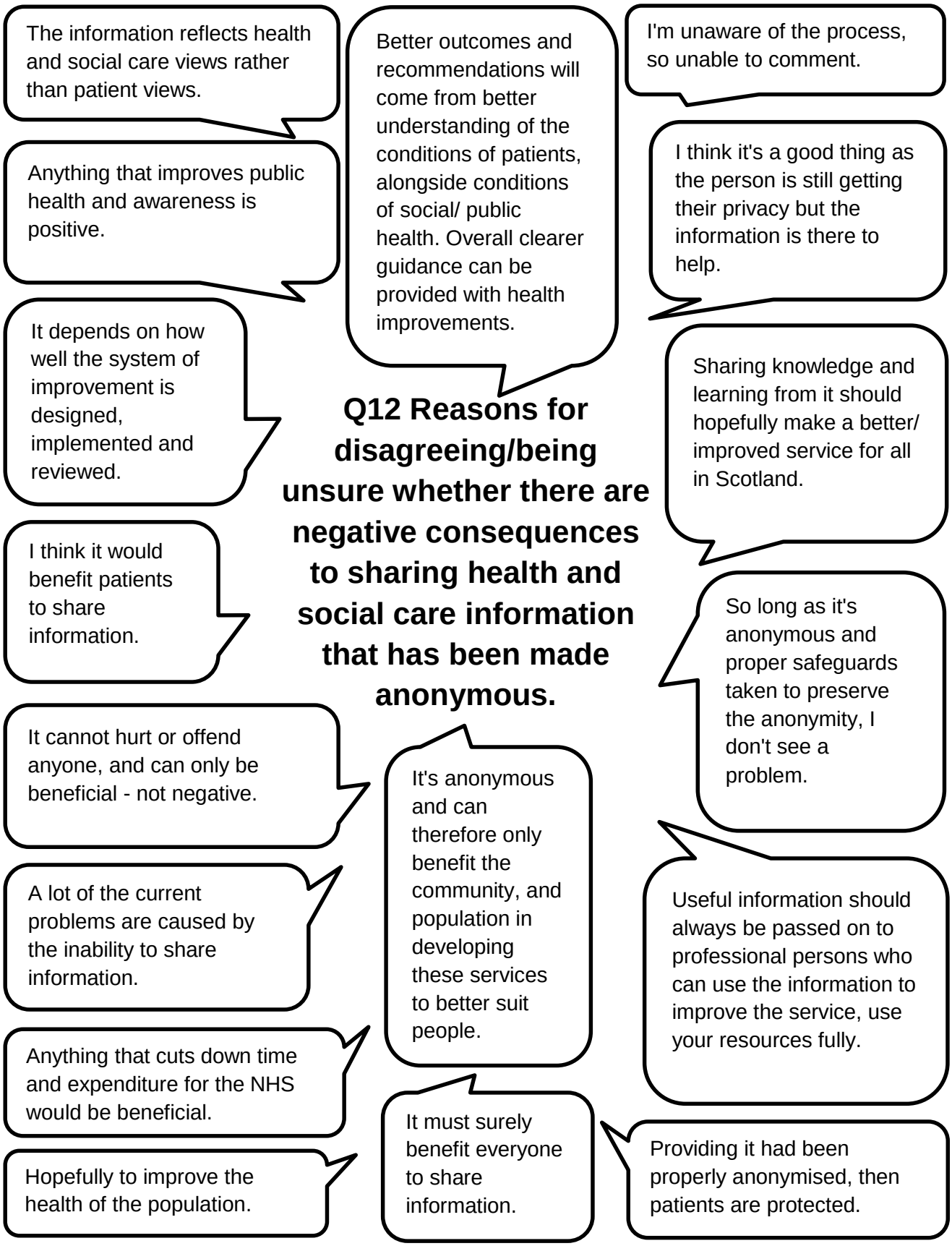
**Figure 20: Reasons given for opinions on the negative consequences to sharing anonymised health and social care information in the context of service improvement and public health (open-ended response themes)**

| **Q12 In the context of service improvement and public health, do you think there are negative consequences to sharing health and care information that has been made anonymous? Please tell us why you feel this way.** | |
|---|---|
| **Base: Unweighted, n=268; Weighted, n=275** | **%** |
| As long as data is secure/ assurances of confidentiality | 29% |
| No, think it is a positive thing/ will be of benefit/ can't think of anything negative | 22% |
| Misinterpretation of data/ may not give full picture | 17% |
| Don't know/ not had enough experience to answer | 16% |
| Depends how accurate the data is/ is it checked? | 11% |
| Misuse and selling data to third parties e.g. pharmaceutical companies/ insurance companies/ depends who wants the data | 5% |
| Other | 4% |

Some examples of the comments provided by Panel members who agreed there are negative consequences to sharing health and care information that has been made anonymous:



Those who answered no or don't know to this question provided the following comments for feeling this way:



# Chapter 5: Community health and care services

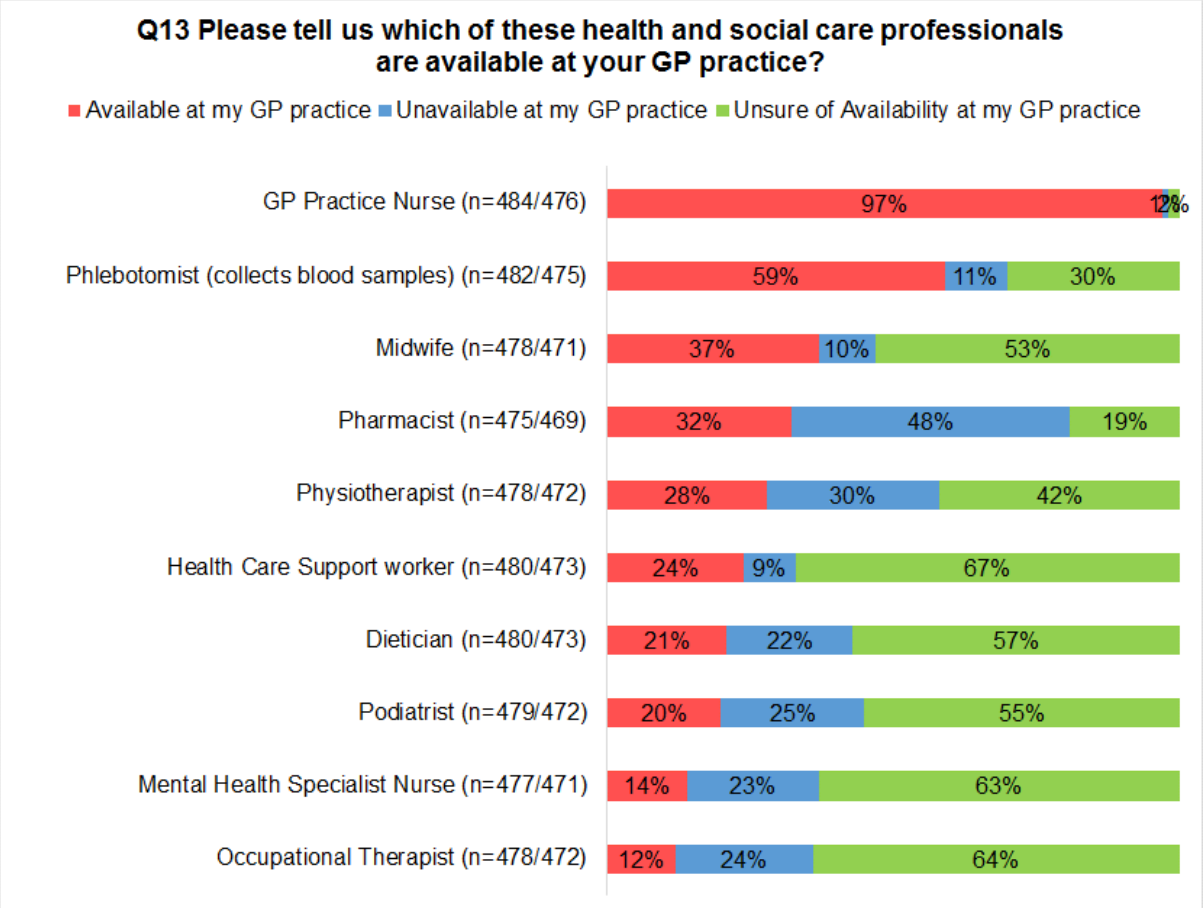
## Introduction

The Scottish Government's vision is that by 2020 everyone will be able to live longer healthier lives at home or in a homely setting. As part of this vision, they aim to strengthen the multi-disciplinary workforce across community health and care services. Doctors will be expected to be involved in providing care for patients with more complex needs, meaning other healthcare professionals will take on new roles to help support patients where it is appropriate for them to do so. Panel members were asked for their opinions on accessing healthcare professionals other than doctors.

## Awareness of health and social care professionals available at GP practice

In terms of awareness of the various health and social care professionals which may be available at GP practices, the vast majority of Panel members (97%) said that GP Practice Nurses were available at their practice. Just under 6 in 10 Panel members (59%) said Phlebotomists were available at their GP practice and 37% said that Midwives were available. Services which had the highest proportions stating they were not available at their GP practice included Pharmacists (48%) and Physiotherapists (30%). Panel members were most likely to be unaware of the availability of Health Care Support Workers (67%), Occupational Therapists (64%) and Mental Health Specialist Nurses (63%).

**Figure 21: Availability of health and social care professionals available at GP practices**

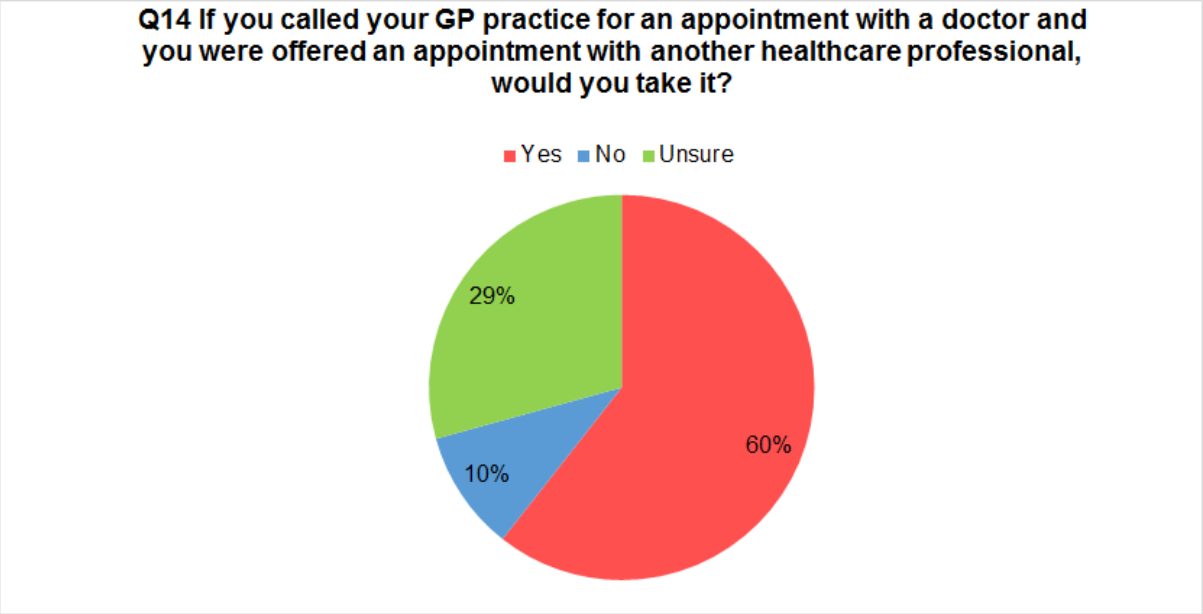



NB The first base figure provided in the chart above is the unweighted base, and this is followed by the weighted base.

## Willingness to take an appointment with another healthcare professional other than a doctor

Six in ten Panel members (60%) agreed that they would take an appointment with another healthcare professional if they were offered this when phoning their GP practice for an appointment with a doctor. Only 1 in 10 Panel members (10%) said they would not take the appointment and 29% were unsure.

**Figure 22: Willingness to take an appointment with another healthcare professional other than a doctor**



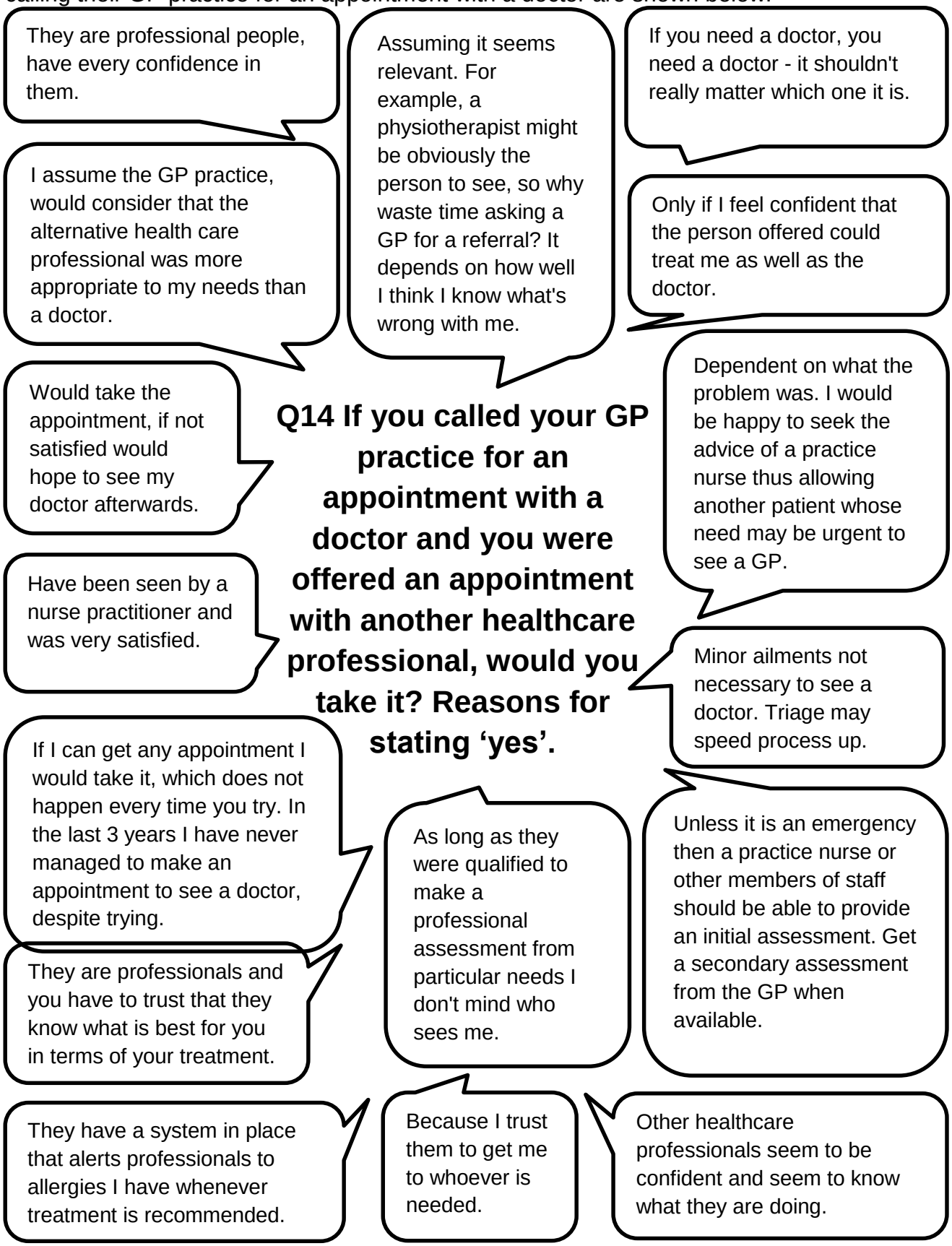

Base: Unweighted, n=480; Weighted, n=481

A total of 368 Panel members provided reasons for their response to this question. Their responses have been coded into common themes and are listed in the table below. Just under 4 in 10 respondents (38%) said that how willing they would be to take another appointment with a healthcare professional other than a doctor would depend on their situation or reasons for requiring an appointment and 18% said it would depend on which healthcare provider they would be seeing and their qualifications. On the other hand, 26% of comments were made by Panel members who said they wouldn't have a problem with this.

**Figure 23: Reasons for opinions on willingness to take an appointment with other healthcare professionals other than a doctor (open-ended response themes)**

| **Q14 If you called your GP practice for an appointment with a doctor and you were offered an appointment with another healthcare professional, would you take it? Please tell us why you feel this way.** | |
|---|---|
| **Base: Unweighted, n=386; Weighted, n=372** | **%** |
| It would depend on my situation/ reason for requiring an appointment/ for my symptoms | 38% |
| I wouldn't have a problem with it/ have confidence in other medical professionals | 26% |
| Would depend which healthcare provider/ they would need to be qualified/ trained/ relevant | 18% |
| If I could be seen quicker/ would cut down waiting times | 8% |
| Only prefer/ expect to see my own doctor | 5% |
| If it needed to be escalated to my GP this would be done | 3% |
| You don't always need to see a doctor/ for minor ailments | 2% |
| Other | 3% |

Examples of the comments provided by Panel members who agreed they would take an appointment with another healthcare professional if they were offered this when calling their GP practice for an appointment with a doctor are shown below:



The following statements were made by Panel members who said they were unsure or would not take an appointment with another healthcare professional if they were offered this when calling their GP practice for an appointment with a doctor:

**Q14 If you called your GP practice for an appointment with a doctor and you were offered an appointment with another healthcare professional, would you take it? Reasons for stating 'no' or 'don't know'.**

Because I feel that my own doctor understands my symptoms/ailments and has treated me for a while.

I would prefer to be seen by a female doctor and if one isn't available I usually call back the following morning.

I like to see my own GP due to building a good relationship and trust.

I would only call my practice if I particularly needed to see a GP. If it was a lower grade problem, I would not bother the doctor's surgery.

A less qualified medical professional may struggle to deal and manage my complex, rare conditions.

Would need to be confident that person triaging call was competent to direct to right member of team.

It would depend on the reason for my call and the healthcare professional I am offered.

This would depend upon the seriousness of my complaint or illness/ service required.

Not unless he or she had access to my medical record.

If I believed I needed a GP I would expect to see one as I rarely go but try to manage my own health.

I've had experience of accepting another healthcare professional and this was terribly unsatisfactory. My condition was wrongly diagnosed and with my condition worsening I then had to have a telephone consultation with my doctor because I was too unwell to go back to the GP practice.

It depends on what the complaint is. Obviously, a podiatrist would be no good for an ulcer! One assumes the substitute would be reasonably aware of the condition which is the cause of the call.

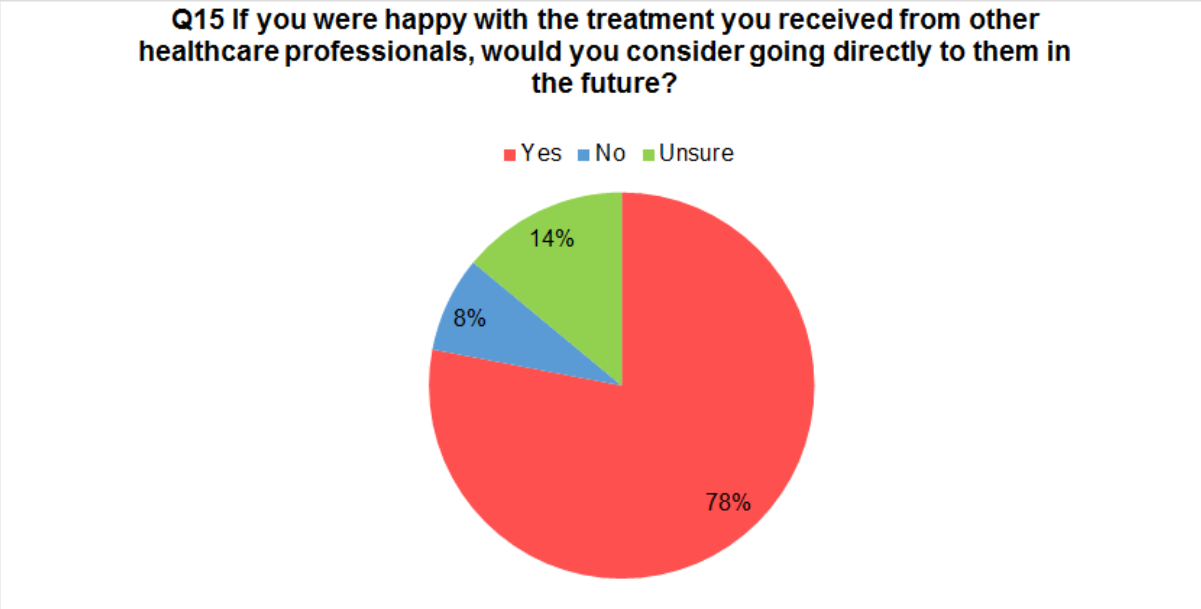
If you were really unwell would the healthcare professional be trusted to properly diagnose your illness?

If it was urgent then I would, if not I would just wait for my GP.

## Willingness to go directly to other healthcare professionals in the future if happy with treatment received

The vast majority of Panel members (78%) said they would consider going directly to other healthcare professionals if they had been happy with the treatment they received. Only 8% said they would not consider going directly to the other healthcare professional and 14% were unsure.

**Figure 24: Willingness to go directly to other healthcare professionals in the future if happy with treatment received**




Base: Unweighted, n=477; Weighted, n=479

A total of 292 Panel members provided reasons for their response to this question. Their responses have been coded into common themes and are listed in the table below. Fifty-three per cent of comments were where Panel members would be happy to go directly to other healthcare professionals if they had confidence in the person in question and felt they could help. A further 11% of comments were where Panel members said they would do this to free up GP time. Eleven per cent said it would depend on the member of staff's qualification and experience, 10% said it would depend on what their problem is, and 10% said they would rather go to their GP.

**Figure 25: Reasons for opinions on willingness to go directly to other healthcare professionals in the future if happy with treatment received. (open-ended response themes)**

| **Q15 If you were happy with the treatment you received from other healthcare professionals, would you consider going directly to them in the future? Please tell us why you feel this way?** | |
|---|---|
| **Base: Unweighted, n=292; Weighted, n=290** | **%** |
| If I have confidence in the healthcare professional/ think they could help/ was happy with them | 53% |
| To free up GP time | 11% |
| As long as they are experienced/ qualified/ relevant | 11% |
| Depends on what the problem is | 10% |
| I would rather go to my GP/ only if GP was unavailable | 10% |
| If could be seen quicker | 9% |
| Other | 4% |

Some of the comments provided by Panel members who were in agreement that they would go directly to other healthcare professionals in the future if they were happy with the treatment they received are shown below:

**Q15 If you were happy with the treatment you received from other healthcare professionals, would you consider going directly to them in the future? If yes, why do you feel this way?**

If more suitable to visit someone else and ease pressure on GP's, then I would do so.

Knowing that a particular person did a wonderful job makes you feel calmer and trusting - rather that than be unsure and potentially get someone who is crap.

If I was comfortable with them, then I might.

I have usually been impressed by the care and advice given, they are often willing to make a GP appointment when necessary.

If I have confidence in the person I am dealing with, would have no hesitation with direct contact.

Happy with using their healthcare professionals, e.g. GP practice nurse for blood tests, injections (vaccinations), dieting advice and blood pressure monitoring.

To free doctors time, to allow me to get treatment quicker.

Because I'd know I could go straight to a podiatrist, for example without waiting for a doctor's appointment.

If they provide specific treatment (specialised), then as experts they should be the right people to see the patient.

If they have the relevant knowledge and skills, then I'd happily take an appointment with them.

If the other healthcare professional is a specialist and gives good treatment, why wouldn't I go directly to them instead of wasting the G.P or someone else's time? The pharmacist at the pharmacy is usually pretty slick in advising the best medication for certain ailments, and I have used her several times before without going to the GP. If she can't help or thinks I should go to the GP, she says so.

Because if they gave me the care needed I would go directly to them, so as not to take up the doctor's time for patients who need it more.

Doctors are clearly overworked, in short supply and it's hard to get an appointment.

If they are qualified and provide satisfactory treatment then I wouldn't see a problem.

Doctors are always in a rush. Nurses have a lot more time.

On the other hand, the following comments were made where respondents said they were unsure or would not consider going directly to healthcare professionals in the future even where they had received a satisfactory service in the past from healthcare professionals:

**Q15 If you were happy with the treatment you received from other healthcare professionals, would you consider going directly to them in the future? If no/don't know, why do you feel this way?**

The healthcare professional might not be a GP.

I've seen my doctor for years - through a lot of serious illness and have developed a good bond, I feel confident with him.

Too inexperienced doctor or not caring/listening at all.

Again this would have to be considered on an appointment by appointment basis and the reason(s) for seeking an appointment.

I would probably prefer to see my doctor, but wouldn't mind seeing someone else if this wasn't possible.

I'd prefer to contact a doctor first because then I can be directed more accordingly.

I prefer to have everything directed through the GP.

It is not for me to diagnose my own complaint and seek treatment from an alternative!

Not directly, if possible I would want to see my GP. This of course depends on waiting time for an appointment with GP, which can be frustrating.

I don't know who will be available when I contact surgery. I trust them to provide me with a satisfactory professional.

I know when I need to see a doctor and don't abuse the system like so many folk do.

I would need to evaluate the quality of such care to make an educated opinion.

You build a relationship with your GP. Plus they get to know you, and if saw you once would know all your issues again.

Your own doctor should know you better.

You couldn't judge on one instance.

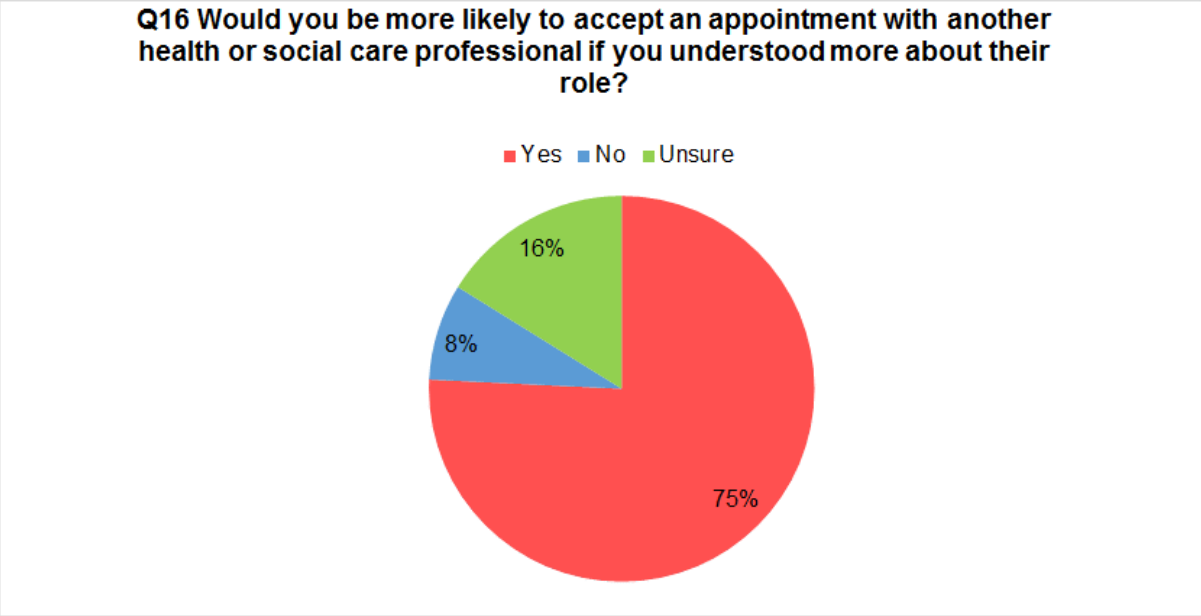
Like confidentiality with doctors etc.

Yes and no because it doesn't necessarily mean other professionals won't be as satisfactory.

## Likelihood of accepting an appointment with another health or social care professional if understood more about their role

Three quarters of Panel members (75%) said they would be more likely to accept an appointment with another health or social care professional if they understood more about their role, 8% said they would not be more likely to do this and 16% were unsure.

**Figure 26: Likelihood of accepting an appointment with another health or social care professional if understood more about the role**




Base: Unweighted, n=472; Weighted, n=473

Respondents who answered no to this question were asked why they felt this way. A total of 29 respondents provided comments to this question and their responses have been coded into common themes and listed in the table below. Of those that responded, 29% said they would only want to see their own GP or a qualified doctor, 25% said they would only be happy if member of staff was professional/qualified and 20% said they would prefer not to see a different individual.

**Figure 27: Reasons given for not being more likely to accept an appointment with another health or social care professional if understood more about the role (open-ended response themes)**

| Q16a Would you be more likely to accept an appointment with another health or social care professional if you understood more about their role? If no, why not | |
|---|---|
| **Base: Unweighted, n=29; Weighted, n=23** | **%** |
| I would only want to see my GP/ doctor | 29% |
| Only if they are professional/ qualified | 25% |
| Would prefer not to see a different individual | 20% |
| Would want to see GP in first instance | 19% |
| Other reasons | 7% |

## Further information that would be useful in affecting decisions to take an appointment with another health and social care professional

The survey included an open-ended question which asked all Panel members what further information would be useful in affecting their decision to take an appointment with other health and social care professionals. A total of 282 respondents provided comments to this question. The main themes generated from these responses were where Panel members felt it would be useful to have an understanding of other health and social care professionals' skills, expertise or experience (43%), an understanding of their role (28%), or about their qualifications or training (19%).

| **Q16 What further information would be useful in affecting your decision to take an appointment with other health and social care professionals?** | |
|---|---|
| **Base: Unweighted, n=282; Weighted, n=290** | **%** |
| An understanding of their skills/ expertise/ experience | 43% |
| An understanding of their role | 28% |
| Their qualification/ training on the job | 19% |
| Waiting time/ accessibility of appointment | 6% |
| Depends on circumstances | 6% |
| Nothing - happy to proceed | 4% |
| Don't know | 12% |
| Other | 2% |

Some of the comments provided by respondents who said other information would be useful in affecting their decision to take an appointment with other health and social care professionals are listed below:

# Chapter 6: Receptionists in GP practices

## Introduction

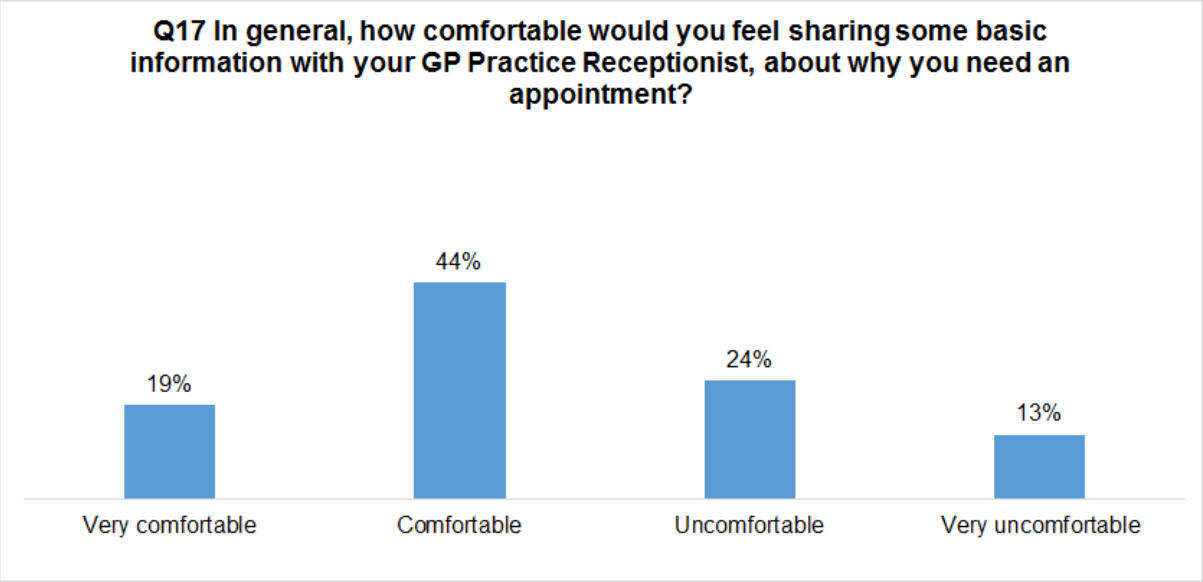
GP practice receptionists have an important role in assisting patients and carers to access the most appropriate source of help, advice or information. In order to do this, receptionists may need to ask people some basic questions about why they want to see a GP.

Panel members were asked for their opinions on how comfortable they would feel sharing basic information with their GP practice receptionist about why they need an appointment.

## Sharing basic information with GP practice receptionist about reasons for appointment

Over 6 in 10 Panel members (63%) said they would feel very comfortable (19%) or comfortable (44%) sharing some basic information with their GP Practice Receptionist about why they need an appointment. On the other hand, 37% said they would feel uncomfortable (24%) or very uncomfortable (13%) in doing this.

**Figure 28: How comfortable Panel members feel sharing basic information with GP Practice Receptionist about reasons for appointment**



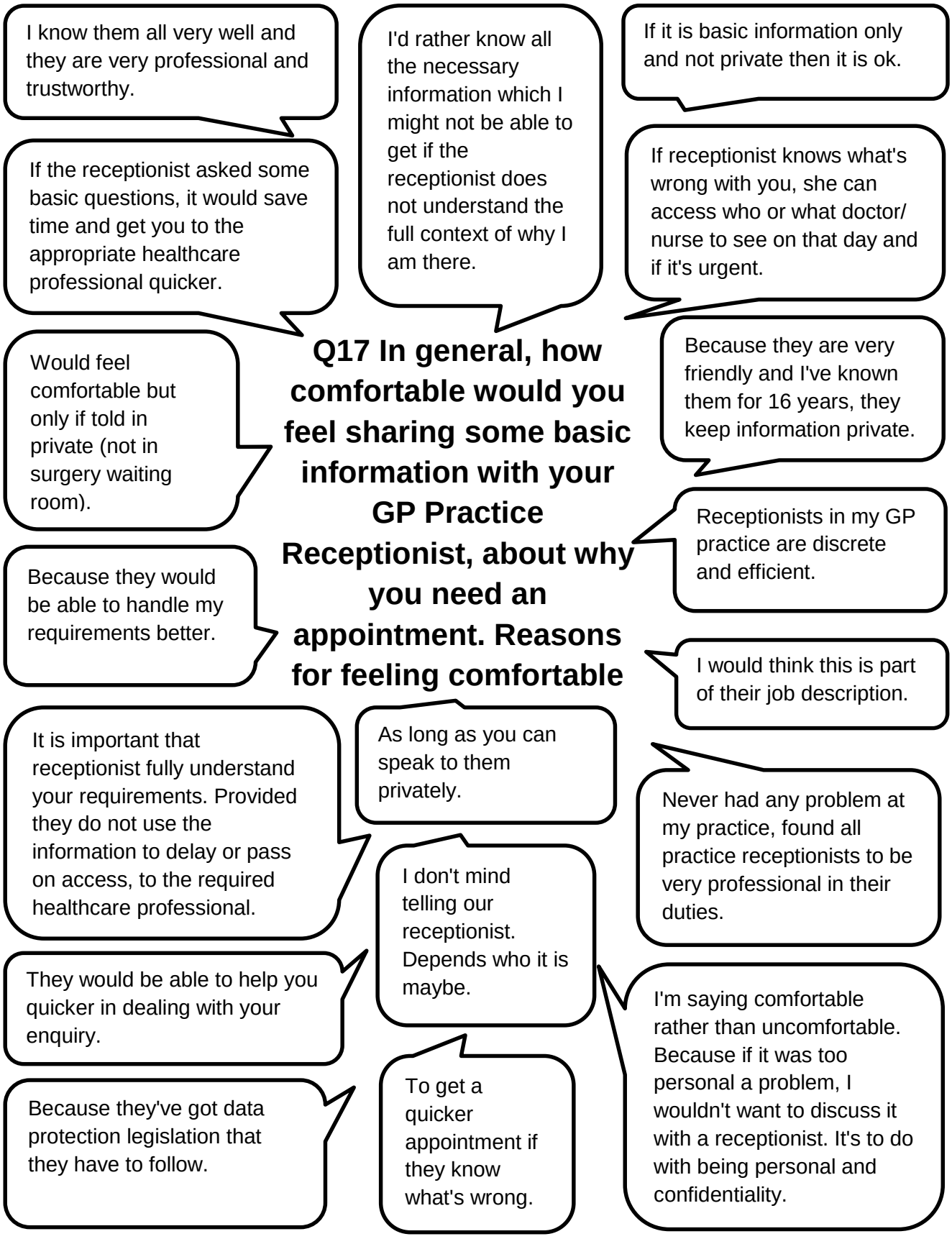

Base: Unweighted, n=472; Weighted, n=475

All respondents were asked to provide the reasons for their answer. Where respondents were comfortable in speaking to the receptionist about why they needed an appointment, this tended to be where Panel members believed that receptionists can help them get an appointment or direct them to appropriate health professionals (29%) and where they trust the receptionists at their local practice and consider them to be helpful and friendly (14%). On the other hand, reasons for feeling uncomfortable were where Panel members would not want to discuss anything personal (20%), where they felt receptionists were not medically trained (13%) or where they had concerns about confidentiality or the receptionist gossiping (12%).

**Figure 29: Reasons given for feeling comfortable/ uncomfortable sharing basic information with GP Practice Receptionist about reasons for appointment (open-ended response themes)**

| **Q17 In general, how comfortable would you feel sharing some basic information with your GP Practice Receptionist, about why you need an appointment? Please tell us why you feel this way?** | |
|---|---|
| **Base: Unweighted, n=382; Weighted, n=378** | **%** |
| Can help you get an appointment/ save time/ direct you to appropriate health professionals | 29% |
| Would not want to discuss anything personal | 20% |
| I trust the receptionists at my practice/ they are helpful/ friendly | 14% |
| They are not medically trained | 13% |
| Concerns about confidentiality/ receptionist gossiping | 12% |
| Would need to be in private/ not in front of other patients | 12% |
| Receptionists can be rude/ insensitive/ unhelpful | 12% |
| Depends on circumstances | 2% |
| Other | 1% |

Examples of the comments provided by Panel members who said they would feel comfortable speaking to a GP Receptionist about why they needed an appointment are shown below:



The following comments were made by Panel members who said they would feel uncomfortable speaking to a GP Receptionist about why they needed an appointment.

**Q17 In general, how comfortable would you feel sharing some basic information with your GP Practice Receptionist, about why you need an appointment. Reasons for feeling uncomfortable**

I am wary of that they would talk about me and if I could trust them.

Depending on the issue involved e.g. I think I have chest infection, is ok but anything more personal or intimate I would not feel comfortable with.

It could be personal or embarrassing.

I am a very private person.

The receptionist is being used as a triage and this is totally inappropriate. They have no skills to evaluate medical need. This should be done by trained professionals.

Receptionists are way too nosey and ask private questions in front of other patients.

Sometimes such things are too personal. Health professionals have to commit to confidentiality. Not sure if receptionists are required to do the same.

Confidentiality, lack of training and open plan counters where there is no privacy.

My answer has veered between comfortable and uncomfortable. When I consider experience with different receptionist/ practices. Receptionists need to be able to reassure the patient, that this is in their best interest and not just to protect the doctor. Receptionist customer care/training is vital. Also important to feel confident that information shared is private - not open to full waiting room.

It would depend on reason to see my GP. Also if feel personally that receptionists, do not require to know why you wish to see GP. They are not medically qualified.

They are at a reception desk and you know when you call, there could be people standing waiting.

It's none of their business. This happens at my practice at present and it can be humiliating, if they are talking to you about private matters on the phone in front of a queue of patients.

Consider it private and don't want to broadcast illness to waiting patients.

Gossip in a small town.

The receptionist at my practice is downright rude. Also it's in front of other people.

# Chapter 7: Local optician services

## Introduction

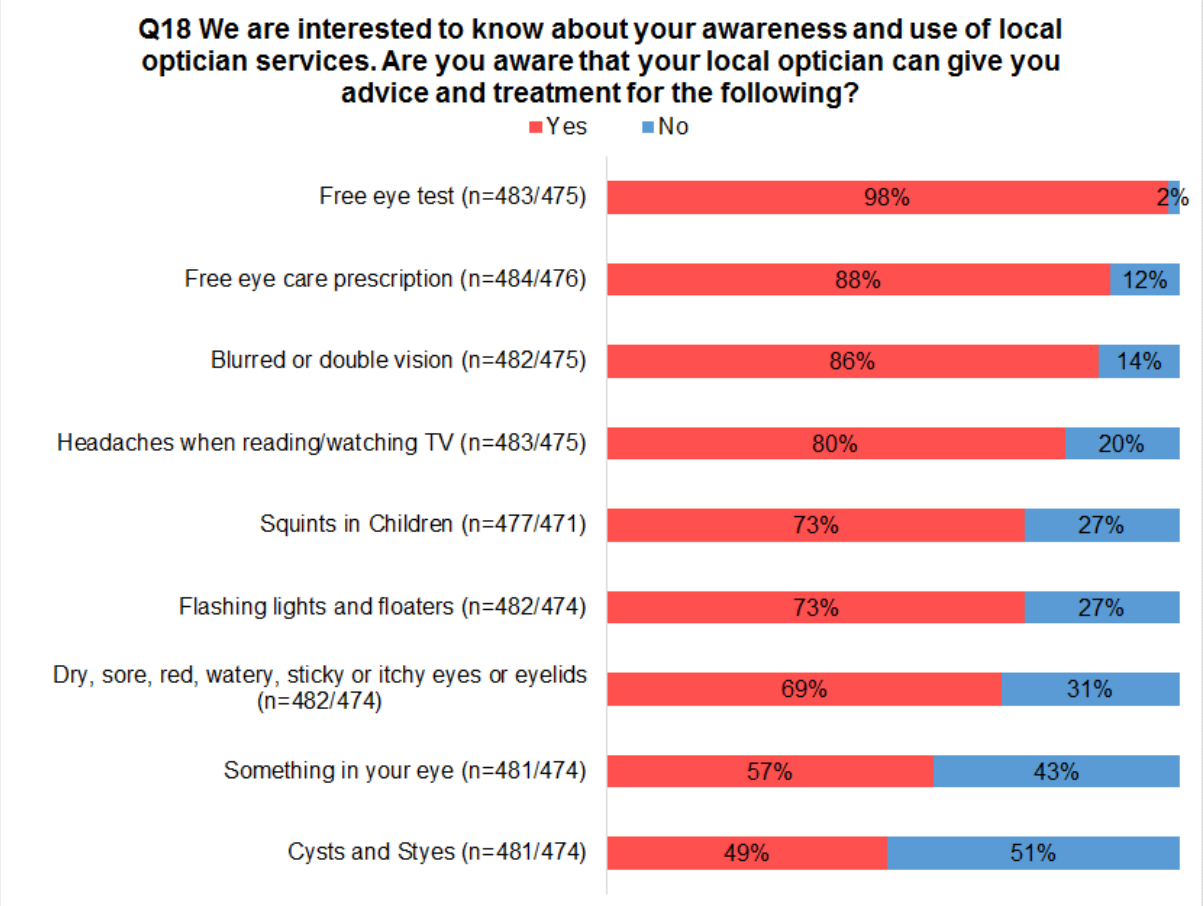
This section of the questionnaire aimed to understand awareness levels and use of the various local optician services available in Scotland.

## Awareness of optician services

Firstly, in terms of awareness of local optician services in Scotland, Panel members were most likely to be aware that their local optician can give them advice and treatment on; free eye tests (98%), free eye care prescriptions (88%), blurred or double vision (86%) and headaches when reading or watching television (80%).

On the other hand, respondents were least likely to be aware that their local optician can offer advice and treatment for cysts and styes (49% aware) and if they had something in their eye (57% aware).

**Figure 30: Awareness of various local optician services available in Scotland**

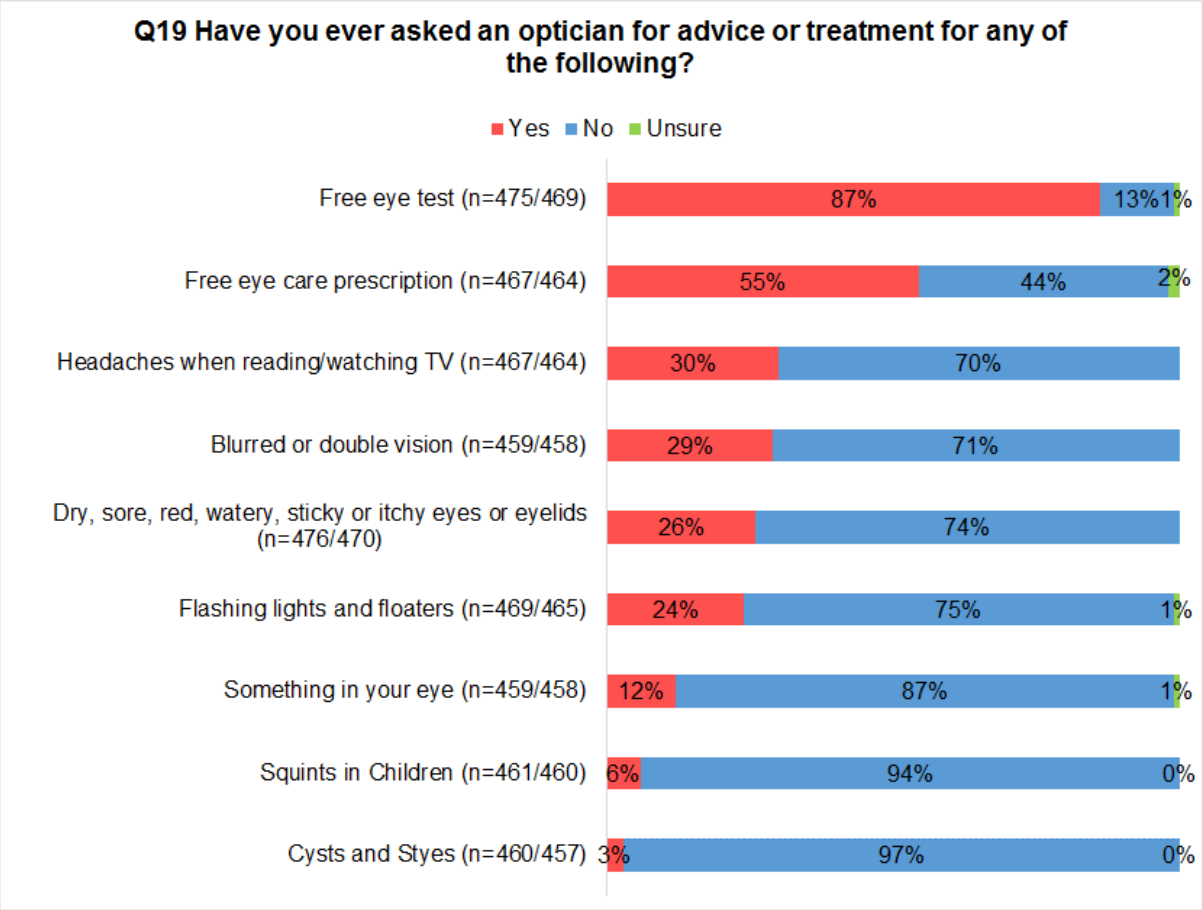



NB The first base figure provided in the chart above is the unweighted base, and this is followed by the weighted base.

## Use of optician services

As a follow up to the previous question, Panel members were provided with the same list of optician services and asked whether they had ever asked an optician for advice or treatment regarding any of these. Use of these services was highest regarding free eye tests (87%) and free eye care prescriptions (55%). On the other hand, very few respondents had asked an optician for advice or treatment regarding cysts and styes (3%), squints in children (6%) or if they had something in their eye (12%).

**Figure 31: Use of various local optician services available in Scotland**




NB The first base figure provided in the chart above is the unweighted base, and this is followed by the weighted base.

# Chapter 8: Next steps

This report will be published and shared widely, but this is only the first step in our improvement process. The sponsors of each set of questions will be asked how they intend to use the feedback to make improvements to health and social care services. The Scottish Health Council will then offer support to services to make improvement plans including how improvement can be described and measured. A further report will then be produced by the Our Voice Project Team to share how the feedback from the Our Voice Citizens' Panel has been considered and led to improvements to Scottish health and social care services. These findings will be shared with Panel members and will be shared more widely with health and social care organisations and professionals.

The information below is an example of how Panel members' responses are being used. From this, it is evident that the views and experiences provided by Panel members are welcomed and are being considered by policy makers and others involved in delivering health and social care services in Scotland.

**Impact from 1st Panel survey**

### Social Care Support

Amongst other information on social care support the panel highlighted that 59% of people get social care information from their GP. This was publicised amongst social care practitioners as most of the effort on ensuring people get accurate information about social care options is put out through other channels. This will help ensure information is better targeted in future.

### Pharmacy service and use of medicines

The findings from this section demonstrated that there is work to be done on raising awareness of distinct pharmacists' skills; support for long term conditions; and support for minor conditions. The findings provided insight on how improvements could be made to pharmacy services and service information. Currently an action plan is being developed with the Royal Pharmaceutical Society and key stakeholders in pharmacy provision to develop improvements.

### Improving Oral Health

The Panel results to the oral health questions in the first Panel survey have been used by the Scottish Government to help inform an Oral Health Improvement Plan which is due to be published in early 2018. The Panel results were incorporated into the consultation on oral health which showed that there was a need to provide better information on what the NHS provides in the way of dentistry services.

## Ongoing impact of the Panel findings

In addition to influencing work of question commissioners, the findings from Panel surveys to date have influenced the work of other health-related services, plans and policies.

### Health Literacy Action Plan

Panel results have shown that there is a need to work better with people who have specific health needs in terms of their health literacy. The results influenced some of the Health Literacy Action Plan which was published by the Scottish Government in November 2017. A link to the report is provided below with a specific mention of the Citizens' Panel on page 18.

Making it Easier - a health literacy action plan for Scotland 2017-2025

## Appendix 1: Questionnaire

# Welcome to Our Voice Citizens' Panel

Welcome again to the Our Voice Citizens' Panel survey.

As a member of the panel, you are part of a group of volunteers who provide public opinions on a range of health and social care issues - helping inform service improvement in Scotland. When taken together, the views panel members provide can reflect the views of the Scottish population.

Linked to this survey is a summary of the key findings from the second Our Voice Citizens' Panel survey. In the second survey, we asked you questions around your relationship with health and social care professionals, and we also asked you some questions about loneliness and the things that you consider to be good and bad with health and social care services locally.

**This is the third Our Voice Citizens' Panel survey on Health and Social Care.** In this survey, we will ask you questions about:

- the use of Digital Technologies for healthcare improvement
- using and sharing personal health and social care information
- accessing healthcare professionals other than doctors

In addition to these questions, we would also like to ask you a few personal background questions - to make sure our information remains up to date and representative of the Scottish population at large.

As usual, there are no wrong answers to these questions. Please do not use Google to find answers. We are interested in your own experiences and opinions on these issues and how they apply to you.

We are very grateful to you for taking the time to complete this survey. Sharing your views will help us gain a better picture of the opinions of the Scottish public on issues of health and social care.

Data Protection

The information you provide will be used only for the purposes listed above and the Scottish Health Council will comply with its duties and obligations under the Data Protection Act 1998. The views you express in this questionnaire will remain anonymous, and no personal data that identifies you will be published or shared with third parties.

**If you would like to complete future surveys online, please provide your email address:**

# Digital Health and Care

**The Scottish Government is developing a new Digital Health and Social Care Strategy for the next five years, which is summarised in the draft vision statement below:**

*As a citizen of Scotland, I have access to the digital information, tools and services I need to help maintain and improve my health and wellbeing. I expect my health and social care information to be captured electronically, integrated and shared securely to assist service staff and carers that need to see it, and that digital technology and data will be used appropriately and innovatively to help plan and improve services, enable research and economic development, and ultimately improve outcomes for everyone.*

We would like to hear your views about the use of digital information and digital health and care technologies. This will help the Scottish Government to understand whether the above draft vision is right, and will inform further discussion during the development of the digital health and social care strategy.

A link to the integrated Digital Health and Social Care Strategy 2017-22 will be provided at the end of this survey.

**1. Do you use any of the following digital communication/information devices? (please select all that apply)**

- ☐ **Desktop or laptop computer**
- ☐ **Wearable technology (e.g. smart watch, Fitbit)**
- ☐ Mobile phone or smart phone
- ☐ Other, please state:
- ☐ Tablet (iPad or android)

What are your reasons for using these devices?

**2. Do you use any of the following digital communication tools?**

| | Yes, rarely (three times a month or less) | Yes, occasionally (at least once a week, but less than daily) | Yes, regularly (at least once a day) | No, never |
|---|---|---|---|---|
| Social media | ☐ | ☐ | ☐ | ☐ |
| Internet (e.g. for shopping, banking, finding information, managing wellbeing, etc) | ☐ | ☐ | ☐ | ☐ |
| Web based communication (e.g. Skype) | ☐ | ☐ | ☐ | ☐ |
| Apps (e.g. banking, shopping, health, etc) | ☐ | ☐ | ☐ | ☐ |
| Email | ☐ | ☐ | ☐ | ☐ |

Other, please state:

**3. On a scale from 1 to 10: How confident do you feel in using digital communication technology (e.g., the Internet, social media, using tablets, smart phones)?**

**(1 = not at all confident, 10 = very confident)**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**4. Do you think there are any benefits to using digital communication tools and technologies to access health and social care services?**

☐ Yes ☐ No

If Yes, please list these benefits:

**5. Do you think there are any disadvantages or difficulties in using digital communication tools and technologies to access health and social care services?**

☐ Yes ☐ No

If Yes, please list these difficulties or disadvantages:

**6. Do you feel it would be useful to share health and wellbeing information from your devices/apps with your health professionals or care providers?**

☐ Yes ☐ No ☐ Unsure

Please tell us why you feel this way?

**7. Thinking about your or your family's experience of health and social care services in Scotland, please indicate whether you have used or are aware of the following services:**

| | have used **in last 12 months** | **are aware but** not used **in last 12 months** | not aware |
|---|---|---|---|
| Care Information Scotland (online source of care information) | ☐ | ☐ | ☐ |
| NHS24 (111 service) | ☐ | ☐ | ☐ |
| GP Surgery website for information | ☐ | ☐ | ☐ |
| Online appointment booking at your GP practice | ☐ | ☐ | ☐ |
| Online repeat prescriptions at your GP practice | ☐ | ☐ | ☐ |
| NHS Inform | ☐ | ☐ | ☐ |
| Technology Enabled Care (e.g. personal/home alarm) | ☐ | ☐ | ☐ |
| Health and wellbeing apps | ☐ | ☐ | ☐ |
| Health and wellbeing websites/online support | ☐ | ☐ | ☐ |
| Remote monitoring of long-term condition (e.g. blood pressure monitor) | ☐ | ☐ | ☐ |
| Video access to services (e.g. via Skype for an outpatient appointment) | ☐ | ☐ | ☐ |

Other, please specify:

# Use of Information: Personal

When you register with a GP practice in Scotland, your personal information is passed to NHS National Services Scotland where it is securely held on the Community Health Index (CHI). This information is used to register you, transfer your medical records between GP practices, make payments to GP practices for medical services provided, and to process and issue medical cards, medical exemption certificates and entitlement cards.
We are interested in your views about how this could be developed in the future.

**8. Do you think that professionals should - with the appropriate safeguards - be able to share your medical information with other health and social care professionals who are involved in your care, in order to support your ongoing healthcare?**

☐ Yes ☐ No ☐ Unsure

Please tell us why you feel this way?

**9. On a scale from 1 to 10: How much do you trust health and social care professionals in Scotland to manage your information securely to support your care?**

**(1 = no trust at all, 10 = completely trust)**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please tell us why you feel this way?

# Use of Information: Research Development

NHS National Services Scotland shares information about you within NHS Scotland to assist in the provision and improvement of NHS services and the health of the public. When they do this, they make sure that the information that identifies you as a person and your health information are kept separate or are made anonymous, removing any details which could identify you as an individual. Health condition and treatment information which could identify you is not used for research purposes unless you have consented to this. Such data and information from the Scottish population can help to highlight where improvements could be made, or identify where resources could be targeted, for example, research into vaccinations, prevalence of different conditions, time intervals between seeing a GP and diagnosis/treatment, etc.

We would like to find out more about your views on the use of health information for research**.**

**10. On a scale of 1 to 10:**

**How comfortable do you feel about researchers accessing anonymised/de-personalised health and social care information from the Scottish population, in order to support and inform design and delivery of health and care services?**

**(1= very uncomfortable, 10 = completely comfortable)**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**11. In the context of service improvement and public health, do you think there are benefits to sharing health and social care information that has been made anonymous?**

☐ Yes ☐ No ☐ Unsure

Please tell us why you feel this way?

**12. In the context of service improvement and public health, do you think there are negative consequences to sharing health and care information that has been made anonymous?**

☐ Yes ☐ No ☐ Unsure

Please tell us why you feel this way?

# Community health and care services

The Scottish Government's vision is that by 2020 everyone will be able to live longer healthier lives at home or in a homely setting. As part of this vision, they aim to strengthen the multi-disciplinary workforce across community health and care and GP services. Doctors will be expected to be involved in providing care for more complex patients, meaning other healthcare professionals will take on new roles to help support patients where it is appropriate for them to do so.

We would like to know what you think about accessing healthcare professionals other than doctors.

**13. Please tell us which of these health and social care professionals are available at your GP practice? (please select one option per row)**

| | Available **at my GP practice** | Unavailable **at my GP practice** | Unsure **of Availability at my GP practice** |
|---|---|---|---|
| Physiotherapist | ☐ | ☐ | ☐ |
| Pharmacist | ☐ | ☐ | ☐ |
| GP Practice Nurse | ☐ | ☐ | ☐ |
| Mental Health Specialist Nurse | ☐ | ☐ | ☐ |
| Phlebotomist (collects blood samples) | ☐ | ☐ | ☐ |
| Dietician | ☐ | ☐ | ☐ |
| Midwife | ☐ | ☐ | ☐ |
| Health Care Support worker | ☐ | ☐ | ☐ |
| Occupational Therapist | ☐ | ☐ | ☐ |
| Podiatrist | ☐ | ☐ | ☐ |

☐ Other professionals at your GP practice (please specify):

**14. If you called your GP practice for an appointment with a doctor and you were offered an appointment with another healthcare professional, would you take it?**

☐ Yes ☐ No ☐ Unsure

Please tell us why you feel this way

**15. If you were happy with the treatment you received from other healthcare professionals, would you consider going directly to them in the future?**

☐ Yes ☐ No ☐ Unsure

Please tell us why you feel this way?

**16. Would you be more likely to accept an appointment with another health or social care professional if you understood more about their role?**

☐ Yes ☐ No ☐ Unsure

If No, why not?

**What further information would be useful in affecting your decision to take an appointment with other health and social care professionals?**

# Receptionists in GP practices

GP Practice Receptionists have an important role in assisting patients and carers to access the most appropriate source of help, advice or information. In order to do this, receptionists may need to ask people some basic questions about why they want to see a GP.

**17. In general, how comfortable would you feel sharing some basic information with your GP Practice Receptionist, about why you need an appointment?**

- ☐ Very Comfortable
- ☐ Comfortable
- ☐ Uncomfortable
- ☐ Very Uncomfortable

Please tell us why you feel this way

# Local Optician services

**18. We are interested to know about your awareness and use of local optician services. Are you aware that your local optician can give you advice and treatment for the following? (please tick yes or no for each option below).**

| | Yes | No |
|---|---|---|
| Dry, sore, red, watery, sticky or itchy eyes or eyelids | ☐ | ☐ |
| Squints in Children | ☐ | ☐ |
| Flashing lights and floaters | ☐ | ☐ |
| Headaches when reading/watching TV | ☐ | ☐ |
| Cysts and Styes | ☐ | ☐ |
| Something in your eye | ☐ | ☐ |
| Blurred or double vision | ☐ | ☐ |
| Free eye test | ☐ | ☐ |
| Free eye care prescription | ☐ | ☐ |

**19. Have you ever asked an optician for advice or treatment for any of the following?** (please tick yes, no or unsure for each option below).

| | Yes | No | Unsure |
|---|---|---|---|
| Dry, sore, red, watery, sticky or itchy eyes or eyelids | ☐ | ☐ | ☐ |
| Squints in Children | ☐ | ☐ | ☐ |
| Flashing lights and floaters | ☐ | ☐ | ☐ |
| Headaches when reading/watching TV | ☐ | ☐ | ☐ |
| Cysts and Styes | ☐ | ☐ | ☐ |
| Something in your eye | ☐ | ☐ | ☐ |
| Blurred or double vision | ☐ | ☐ | ☐ |
| Free eye test | ☐ | ☐ | ☐ |
| Free eye care prescription | ☐ | ☐ | ☐ |

# Personal Information Update

We want to make sure that everyone has an equal opportunity to get involved with our work. By completing this section of the form you will help us to understand who we have engaged with and who we have not. We will use the information you provide to compare the profile of people we have involved with that of the Scottish population. All the information you provide is anonymous and no identifiable personal data will be published or shared with any other organisation.

**20. Please tell us about yourself, selecting all that apply. Are you a:**

- ☐ User of health and social care services
- ☐ Carer for someone who uses health and social care services
- ☐ Worker in health or social care services

**21. Which one of the following best describes your gender?**

- ☐ Male
- ☐ Female
- ☐ Prefer not to answer
- ☐ If you describe your gender with another term, please tell us here:

**If you use another term, do you consider yourself to be a trans* person?**

☐ Yes ☐ No ☐ Prefer not to answer

*Trans is an umbrella term to describe people whose gender is not the same as the sex they were assigned at birth.

**22. Which of the following best describes your sexual orientation?**

- ☐ Heterosexual / Straight
- ☐ Prefer not to answer
- ☐ Gay / Lesbian
- If you prefer to use another term, please tell us this below
- ☐ Bi / Bisexual

**23. What is your religion or belief?**

- ☐ None
- ☐ Buddhist
- ☐ Church of Scotland
- ☐ Sikh
- ☐ Roman Catholic
- ☐ Jewish
- ☐ Other Christian
- ☐ Hindu
- ☐ Muslim
- ☐ Prefer not to answer
- ☐ Other religion, please write in below

**24. Do you have a physical or mental health condition or illness lasting or expected to last 12 months or more?**

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Prefer not to answer

**If Yes. Does your condition or illness reduce your ability to carry out day-to-day activities?**

- ☐ Yes, a lot
- ☐ Yes, a little
- ☐ Not at all
- ☐ Prefer not to answer

**Does this condition or illness affect you in any of the following areas?**

- ☐ Vision (e.g. blindness or partial sight)
- ☐ Hearing (e.g. deafness or partial hearing)
- ☐ Mobility (e.g. walking short distances or climbing stairs)
- ☐ Dexterity (e.g. lifting or carrying objects, using a keyboard)
- ☐ Learning or understanding or concentrating
- ☐ Memory
- ☐ Mental health
- ☐ A long term illness (e.g. cancer, HIV, heart disease or epilepsy)
- ☐ Stamina or breathing or fatigue
- ☐ Social or behavioural (e.g. associated with autism, attention deficit disorder or Aspergers' syndrome)
- ☐ None of the above
- ☐ Prefer not to answer
- ☐ Other (Please specify)

# Links

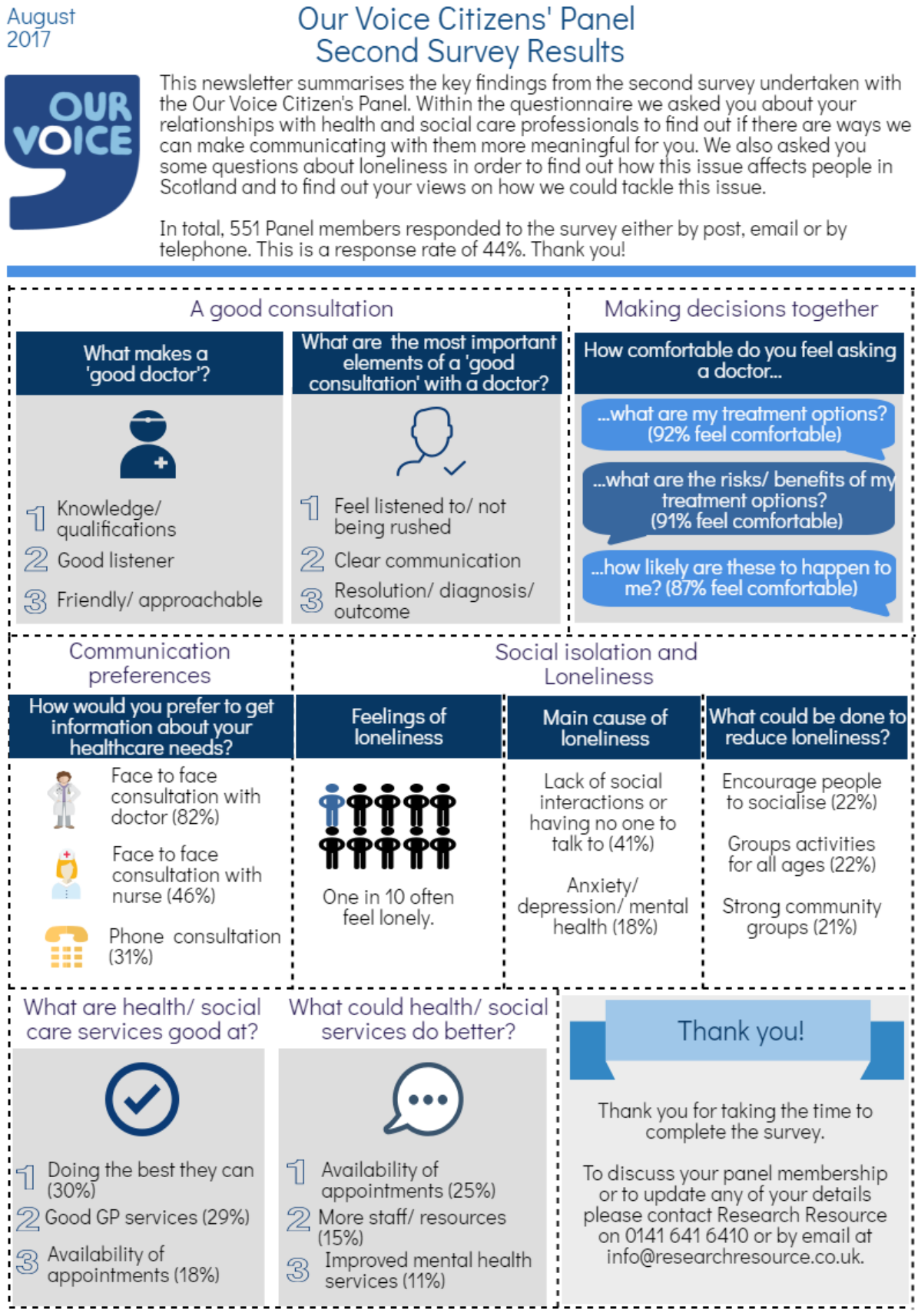
**You can visit www.ehealth.nhs.scot to be kept up to date on digital health and social care developments.**

**You can visit www.ourvoice.scot/citizens-panel to read previous Citizens Panel reports.**

**You have completed this survey!**

**Thank you for taking the time to answer this survey.**

# Appendix 2: Update for Panel members on previous Panel survey



# Appendix 3: Response profile

## Our Voice Citizens' Panel - Third Survey Response Analysis and Profile

**2nd November 2017**

| Date | Activity | Description | Number |
|---|---|---|---|
| **4th September** | First email | Distributed | 975 |
| | | Bounce back | 80 |
| | | Total emails delivered | 895 |
| **8th September** | First postal survey | Number sent to panel members without email addresses | 282 |
| | | Number sent to bounce back Panel members | 80 |
| | | Total number sent | 362 |
| **11th September** | First email reminder | Number sent | 732 |
| | | Number Bounce back | 0 |
| | | Total emails delivered | 732 |
| **15th September** | Additional postal surveys delivered | Number sent to those with email addresses who had not responded | 651 |
| **3rd October** | Final email reminder | Number sent | 659 |
| | | Number Bounce back | 0 |
| | | Total emails delivered | 659 |

| **SURVEY OUTCOMES AS AT 02/11/2017** | |
|---|---|
| Emails sent | 895 |
| Number of email responses | 221[5] |
| **Email response rate** | **25%** |
| | |
| Number of postal sent | 1013 |
| Number of postal returned | 199 |
| **Postal response rate** | **20%** |
| | |
| **Telephone surveys** | **76** |
| | |
| OVERALL RESPONSE RATE | |
| Current response | 496[6] |
| Current number on Panel | 1216[7] |
| **Overall response rate** | **41%** |

[5] Includes 5 partial email responses
[6] 1 respondent removed their ID from the questionnaire
[7] 22 panel members opted out via email and 19 asked to be removed from the Panel through the telephone survey

| | Third Survey | | | | | | Original Panel | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Gender[8]** | **No on Panel** | **Response** | **Response rate** | **% of response** | **Scottish popn.[9]** | **Difference** | **No. on Panel** | **% of Panel** | **Scottish popn.** | **Difference** |
| Male | 386 | 178 | 46% | 36% | 49% | -13% | 414 | 32% | 49% | -17% |
| Female | 825 | 316 | 38% | 64% | 51% | 13% | 877 | 68% | 51% | 17% |
| Prefer not to answer | 5 | 1 | 20% | 0% | | | 5 | 0% | | |
| **Total** | **1216** | **495** | **41%** | **100%** | | | **1296** | **100%** | **100%** | |

| | Third Survey | | | | | | Original Panel | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Physical or mental health condition or illness** | **No on Panel** | **Response** | **Response rate** | **% of response** | **Scottish popn.[10]** | **Difference** | **No. on Panel** | **% of Panel** | **Scottish popn.** | **Difference** |
| Yes | 460 | 223 | 48% | 45% | 40% | 5% | 462 | 36% | 40% | -4% |
| No | 702 | 254 | 36% | 51% | 60% | -9% | 782 | 60% | 60% | 0% |
| Prefer not to say/ Don't know | 54 | 18 | 33% | 4% | | | 50 | 4% | | |
| **Total** | **1216** | **495** | **41%** | **100%** | **100%** | | **1294** | **100%** | **100%** | |

| | Third Survey | | | | | | Original Panel | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Tenure** | **No on Panel** | **Response** | **Response rate** | **% of response** | **Scottish popn.[11]** | **Difference** | **No. on Panel** | **% of Panel** | **Scottish popn.** | **Difference** |
| Own | 735 | 366 | 50% | 75% | 62% | 13% | 787 | 62% | 62% | 0% |
| Rent from Council/ HA | 283 | 68 | 24% | 14% | 24% | -10% | 295 | 23% | 24% | -1% |
| Private Rent | 120 | 38 | 32% | 8% | 14% | -6% | 127 | 10% | 14% | -4% |
| Other | 67 | 18 | 27% | 4% | | 4% | 68 | 5% | | |
| **Total** | **1205** | **490** | **41%** | **100%** | **100%** | | **1277** | **100%** | **100%** | |

[8] Panel members could also describe their gender using any other terms. No Panel members took the opportunity to do so.

[9]National Records Scotland - Population Estimates 2014. Table 1
Retrieved from: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2014/list-of-tables 07/11/2016

[10]Long term conditions. (December 23, 2015). The Scottish Government. Retrieved from http://www.gov.scot/Topics/Health/Services/Long-Term-Conditions 26/10/2016

[11]Scotland's Census 2011. Table DC4427SC - Accommodation type by tenure - Households. (2014). National Records of Scotland, Crown copyright. Retrieved from: http://www.scotlandscensus.gov.uk/ods-anlyser/jsf/tableView/tableView.xhtml 26/10/2016

| | Third survey | | | | | | Original Panel | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Age** | **No on Panel** | **Response** | **Response rate** | **% of response** | **Scottish popn.[12]** | **Difference** | **No. on Panel** | **% of Panel** | **Scottish popn.** | **Difference** |
| 16-24 | 105 | 20 | 19% | 4% | 14% | -10% | 113 | 9% | 14% | -5% |
| 25-44 | 336 | 102 | 30% | 21% | 31% | -10% | 357 | 28% | 31% | -3% |
| 45-64 | 457 | 218 | 48% | 45% | 33% | 12% | 486 | 38% | 33% | 5% |
| 65+ | 302 | 146 | 48% | 30% | 22% | 8% | 330 | 25% | 22% | 3% |
| **Total** | **1200** | **486** | **41%** | **100%** | **100%** | | **1286** | **100%** | **100%** | **0%** |

| | Third survey | | | | | | Original Panel | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Ethnic group** | **No on Panel** | **Response** | **Response rate** | **% of response** | **Scottish popn.[13]** | **Difference** | **No. on Panel** | **% of Panel** | **Scottish popn.** | **Difference** |
| White British/ Irish | 1156 | 469 | 41% | 96% | 96% | 0% | 1240 | 97% | 96% | 1% |
| Other | 43 | 19 | 44% | 4% | 4% | 0% | 43 | 3% | 4% | -1% |
| **Total** | **1199** | **488** | **41%** | **100%** | **100%** | **0%** | **1283** | **100%** | | |

| | Third survey | | | | | | Original Panel | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **SIMD Quintile (2012)** | **No on Panel** | **Response** | **Response rate** | **% of response** | **Scottish popn.** | **Difference** | **No. on Panel** | **% of Panel** | **Target** | **Difference** |
| 1 | 241 | 55 | 23% | 11% | 20% | -9% | 254 | 20% | 20% | 0% |
| 2 | 255 | 94 | 37% | 19% | 20% | -1% | 271 | 21% | 20% | -1% |
| 3 | 236 | 107 | 45% | 22% | 20% | 2% | 248 | 20% | 20% | 0% |
| 4 | 254 | 120 | 47% | 25% | 20% | 5% | 284 | 22% | 20% | -2% |
| 5 | 201 | 109 | 54% | 22% | 20% | 2% | 210 | 17% | 20% | 3% |
| **Total** | **1187** | **485** | **41%** | **100%** | **100%** | **0%** | **1267** | **100%** | **100%** | **0%** |

[12]National Records Scotland - Population Estimates 2014. Table 2.
Retrieved from: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2014/list-of-tables 07/11/2016

[13]Scotland's Census 2011. Table DC2101SC - Ethnic group by sex by age. (2014). National Records of Scotland, Crown copyright. Retrieved from: http://www.scotlandscensus.gov.uk/ods-analyser/jsf/tableView/tableView.xhtml 26/10/2016

| Local authority | | | |
|---|---|---|---|
| | **No on Panel** | **Responses** | **Response rate** |
| Aberdeen City | 44 | 15 | 34% |
| Aberdeenshire | 45 | 17 | 38% |
| Angus | 26 | 12 | 46% |
| Argyll & Bute | 31 | 17 | 55% |
| Clackmannanshire | 8 | 7 | 88% |
| Dumfries & Galloway | 37 | 17 | 46% |
| Dundee City | 29 | 7 | 24% |
| East Ayrshire | 33 | 15 | 45% |
| East Dunbartonshire | 29 | 12 | 41% |
| East Lothian | 21 | 10 | 48% |
| East Renfrewshire | 45 | 11 | 24% |
| Edinburgh, City of | 87 | 42 | 48% |
| Eilean Siar | 21 | 15 | 71% |
| Falkirk | 27 | 13 | 48% |
| Fife | 66 | 18 | 27% |
| Glasgow City | 107 | 39 | 36% |
| Highland | 54 | 21 | 39% |
| Inverclyde | 30 | 8 | 27% |
| Midlothian | 28 | 15 | 54% |
| Moray | 31 | 16 | 52% |
| North Ayrshire | 32 | 12 | 38% |
| North Lanarkshire | 69 | 14 | 20% |
| Orkney Islands | 15 | 6 | 40% |
| Perth & Kinross | 30 | 12 | 40% |
| Renfrewshire | 26 | 11 | 42% |
| Scottish Borders | 32 | 18 | 56% |
| Shetland Islands | 33 | 22 | 67% |
| South Ayrshire | 34 | 15 | 44% |
| South Lanarkshire | 57 | 20 | 35% |
| Stirling | 19 | 11 | 58% |
| West Dunbartonshire | 28 | 12 | 43% |
| West Lothian | 41 | 15 | 37% |
| #N/A | 1 | 0 | 0% |
| **Total** | **1216** | **495** | **41%** |

| NHS Board | | | |
|---|---|---|---|
| | **No on Panel** | **Response** | **Response Rate** |
| Ayrshire & Arran | 99 | 42 | 42% |
| Borders | 32 | 18 | 56% |
| Dumfries & Galloway | 37 | 17 | 46% |
| Fife | 66 | 18 | 27% |
| Forth Valley | 53 | 31 | 58% |
| Grampian | 120 | 48 | 40% |
| Greater Glasgow & Clyde | 278 | 98 | 35% |
| Highland | 85 | 38 | 45% |
| Lanarkshire | 114 | 29 | 25% |
| Lothian | 177 | 82 | 46% |
| Orkney | 15 | 6 | 40% |
| Shetland | 33 | 22 | 67% |
| Tayside | 85 | 31 | 36% |
| Western Isles | 21 | 15 | 71% |
| #N/A | 1 | 0 | 0% |
| **Total** | **1216** | **495** | **41%** |

## Weighting survey data

As can be seen in the analysis of the response profile to this survey, different response rates have been achieved for different groups of respondents. For this survey, we received a greater response from females than males and also from older respondents than younger respondents.

In most surveys it will be the case that some **groups are over-represented** in the raw data and **others under-represented**. These mis-representations are usually dealt with by weighting the data.

The idea behind weighting is that:

- Members of sub-groups that are thought to be over- or under-represented in the survey data are each given a weight
- Over-represented groups are given a weight of less than one
- Under-represented groups are given a weight of greater than one

The weight being calculated in such a way that the weighted frequency of groups matches the population.

All survey estimates are calculated using these weights, so that averages become weighted averages, and percentages become weighted percentages, and so on.

## Appendix 4: Citizens' Panels

Citizens' Panels are used extensively across local authorities in Scotland, however, the Our Voice Citizens' Panel and Local Authority Citizens' Panels are not directly comparable due to different recruitment methods[14]. Although the Our Voice Citizens' Panel is similar to those conducted by local authorities across Scotland, it varies in one significant methodological aspect – that Panel members cannot actively volunteer or petition to 'sign up' to the Our Voice Citizens' Panel. Although a mixed methodology of recruitment practice exists across local authorities, using for example electoral rolls, face-to-face recruitment, issue-based recruitment and, door-to-door recruitment, most local authorities allow Panel members to actively volunteer or 'sign up' rather than be reactively recruited. It is possible that this active interest rather than reactive interest may provide one reason why the Our Voice Citizens' Panel experiences lower completion rates than some local authority Citizens' Panels.

Of the 24 local authorities that had Citizens' Panels in 2013, 43% of participants are recruited as volunteers. Although response rate varies widely across these panels from a high of 82% to a low of 28%, 44% of panels retrieve an average 40-60% response[15]. A review of Citizens' Panels run by local authorities conducted by Rolfe, (2012)[16] noted that the majority of Panels have proportionately fewer younger people than the wider population. The Our Voice Panel, has experienced similar difficulties in recruiting and encouraging response of younger Panel members. More surprisingly, over half of the local authority Panels reported in Rolfe's review also had lower than proportional representation of older people, suggesting that a truly representative Panel is difficult to achieve and sustain.

It is usual to experience attrition of Panel members. Eighty Panel members have actively chosen to remove themselves from the Panel between the first and third survey cycle. It has been argued that citizens are only interested in participating in Panels when their views have a tangible impact on service delivery. To this end, it has been noted that local authority Citizens' Panels have to continually demonstrate the impact that Panel members have on service delivery. Due to the high level and national nature of the Our Voice Citizens' Panel, the process of demonstrating the impact of Panel members' views on local service change and delivery is often slow. It is possible that this has contributed to attrition rates. Some of the Panel members who have requested to be removed from the Panel have fed back that the Panel is not what they thought it was and without the opportunity to provide feedback on their own local health and social care services, they do not wish to participate in the Panel on an ongoing basis.

Discussion is underway to address these challenges, in the meantime, the Our Voice Citizens' Panel remains robust with statistically significant findings at national level.

[14] http://www.improvementservice.org.uk/documents/research/Consultation%20Report%20Aug%2014.pdf
[15] http://www.improvementservice.org.uk/documents/research/Consultation%20Report%20Aug%2014.pdf

[16] **Steve Rolfe. 2012.** More than ticking boxes. An exploration of the representativeness of Citizens Panels in Scotland. *MSc in Applied Social Research. University of Stirling, 2012*

## Appendix 5: Interpreting results

The results of the research are based upon a sample survey therefore all figures quoted are estimates rather than precise percentages. The reader should interpret the data with statistical significance in mind.

All tables have a descriptive and numerical base, showing the population or population subgroup examined in it. While all results have been calculated using weighted data, the bases shown give both the unweighted and weighted counts.

In some tables and charts, differences between subgroups have been noted because they are interesting, however, not all differences are statistically significant. Where the unweighted base on which percentages are calculated is less than 50 or close to 50, they should be treated with caution, as even though these estimates have been published, they are subject to high levels of volatility and have a high degree of uncertainty around them.

All proportions produced in a survey have a degree of error associated with them because they are generated from a sample of the population rather than the population as a whole. Any proportion measured in the survey has an associated confidence interval (within which the 'true' proportion of the whole population is likely to lie), usually expressed as ±x%. It is possible with any survey that the sample achieved produces estimates that are outside this range. The number of times out of 100 surveys when the result achieved would lie within the confidence interval is also quoted; conventionally the level set is 95 out of 100, or 95%. Technically, all results should be quoted in this way. However, it is less cumbersome to simply report the percentage as a single percentage, the convention adopted in this report.

Where sample sizes are small or comparisons are made between subgroups of the sample, the sampling error needs to be taken into account. There are formulae to calculate whether differences are statistically significant (i.e. they are unlikely to have occurred by chance) and the table below provides a simple way to estimate if differences are significant.

| | | **Sub-group Size** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **50** | **75** | **100** | **150** | **200** | **250** | **300** | **400** | **500** | **617** |
| **Sample Estimate (lookup to nearest multiple of 5%)** | **5%** | 6.9% | 5.7% | 4.9% | 4.0% | 3.5% | 3.1% | 2.8% | 2.1% | 2.2% | 1.7 |
| | **10%** | 9.6% | 7.8% | 6.8% | 5.5% | 4.8% | 4.3% | 3.9% | 2.9% | 3.0% | 2.4 |
| | **15%** | 11.4% | 9.3% | 8.0% | 6.6% | 5.7% | 5.1% | 4.6% | 3.5% | 3.6% | 2.8 |
| | **20%** | 12.8% | 10.4% | 9.0% | 7.4% | 6.4% | 5.7% | 5.2% | 3.9% | 4.0% | 3.2 |
| | **25%** | 13.8% | 11.3% | 9.8% | 8.0% | 6.9% | 6.2% | 5.6% | 4.2% | 4.4% | 3.4 |
| | **30%** | 14.6% | 11.9% | 10.3% | 8.4% | 7.3% | 6.5% | 6.0% | 4.5% | 4.6% | 3.6 |
| | **35%** | 15.2% | 12.4% | 10.8% | 8.8% | 7.6% | 6.8% | 6.2% | 4.7% | 4.8% | 3.8 |
| | **40%** | 15.6% | 12.8% | 11.0% | 9.0% | 7.8% | 7.0% | 6.4% | 4.8% | 4.9% | 3.9 |
| | **45%** | 15.9% | 12.9% | 11.2% | 9.2% | 7.9% | 7.1% | 6.5% | 4.9% | 5.0% | 3.9 |
| | **50%** | **15.9%** | **13.0%** | **11.3%** | **9.2%** | **8.0%** | **7.1%** | **6.5%** | **4.9%** | **5.0%** | **4.0%** |
| | **55%** | 15.9% | 12.9% | 11.2% | 9.2% | 7.9% | 7.1% | 6.5% | 4.9% | 5.0% | 3.9 |
| | **60%** | 15.6% | 12.8% | 11.0% | 9.0% | 7.8% | 7.0% | 6.4% | 4.8% | 4.9% | 3.9 |
| | **65%** | 15.2% | 12.4% | 10.8% | 8.8% | 7.6% | 6.8% | 6.2% | 4.7% | 4.8% | 3.8 |
| | **70%** | 14.6% | 11.9% | 10.3% | 8.4% | 7.3% | 6.5% | 6.0% | 4.5% | 4.6% | 3.6 |
| | **75%** | 13.8% | 11.3% | 9.8% | 8.0% | 6.9% | 6.2% | 5.6% | 4.2% | 4.4% | 3.4 |
| | **80%** | 12.8% | 10.4% | 9.0% | 7.4% | 6.4% | 5.7% | 5.2% | 3.4% | 4.0% | 3.2 |
| | **85%** | 11.4% | 9.3% | 8.0% | 6.6% | 5.7% | 5.1% | 4.6% | 3.5% | 3.6% | 2.8 |
| | **90%** | 9.6% | 7.8% | 6.8% | 5.5% | 4.8% | 4.3% | 3.9% | 2.9% | 3.0% | 2.4 |
| | **95%** | 6.9% | 5.7% | 4.9% | 4.0% | 3.5% | 3.1% | 2.8% | 2.1% | 2.2% | 1.7 |

Below is a worked example which explains how to interpret results presented in the gender analysis tables.

The percentage of respondents who felt very comfortable sharing some basic information with their GP Practice Receptionist was 15% for female respondents and 24% for male respondents. At face value, these values seem to differ significantly. However, because this figure is based upon a sample we need to calculate confidence intervals to determine where the true value of the population lies.

Using the statistical significance table above to find the 95% confidence intervals for each value, we can see that for females (with a base of 297) the lower limit of the 95% confidence interval is 10.4% and the upper limit is 19.6%. For males (with a base of 175) the lower limit is 16% and the upper limit is 32%.

Looking at the intervals for the two together we can see that the upper limit for females does overlap with the lower limit for males. This means that the difference observed between these two groups for this variable is not statistically significant and, therefore, should be read with caution.

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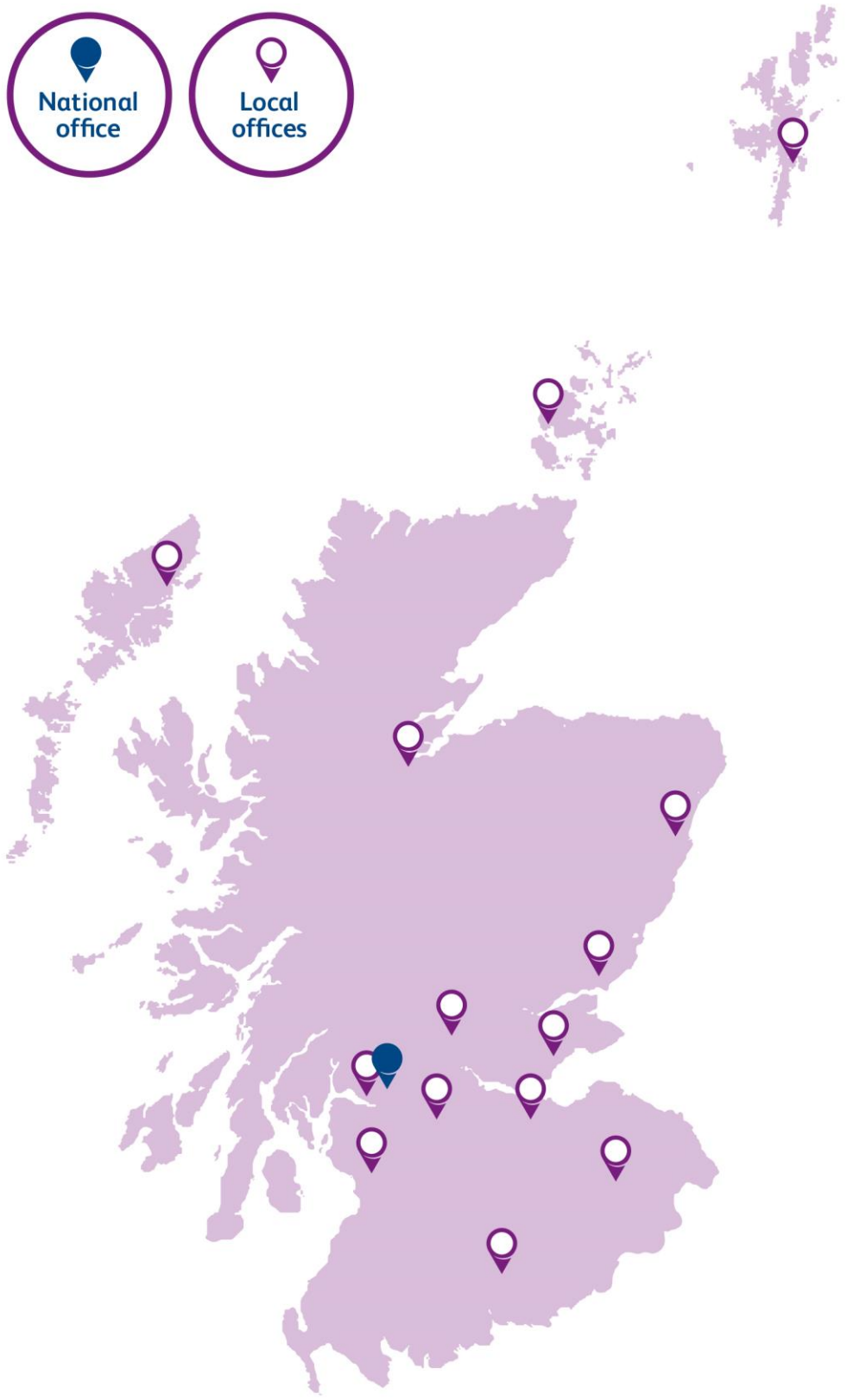
- چھاپے کے بڑے حروف میں
- آڈیو ٹیپ یا سی ڈی کی شکل میں
- بریل میں ، اور
- دیگر زبانوں میں




The Scottish Health Council has a national office in Glasgow and a local office in each NHS Board area. To find details of your nearest local office, visit our website at: www.scottishhealthcouncil.org/contact/local_offices.aspx







**www.scottishhealthcouncil.org**

**Scottish Health Council National Office:** Delta House | 50 West Nile Street | Glasgow | G1 2NP
**Telephone:** 0141 241 6308 **Email:** enquiries@scottishhealthcouncil.org

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