Why don't people go to the GP? A scoping review exploring rural and coastal and hard-to-reach communities who are not accessing Primary Care services, with strategies for relationship building and targeted outreach

Amy Zile, Norfolk Initiative for Coastal and Rural Health Inequalities (NICHE). July 2025

Contents

Introduction to this review

This review has two main aims:

- Exploring the existing understanding on hard-to-reach, and/or deprived communities in the health system, the barriers that exist for these groups to access primary care services, and how these barriers can be addressed.
- Documenting the strategies that have been found beneficial and/or recommended on how community health workers could outreach or re-establish relationships with these communities.

Method

A scoping review is used here to summarise the literature regarding communities who do not access Primary Care services, where this information can potentially be utilised to inform policy on improving healthcare provision and outreach, particularly in rural and coastal areas. The methods for the review are guided by Joanna Briggs Institute (Peters et al., 2020), including the reporting used PRISMA-ScR (Tricco et al., 2018). This review followed standard scoping review methodology and adhered to the PRISMA guidelines for reporting scoping reviews. Academic databases (MEDLINE, EBSCO, and CINAHL), relevant government, third sector and NHS websites were searched, with supplemental searching through Google and Google Scholar. Relevant terms around primary care (such as 'GP' 'general practitioner' 'doctor') and rural, coastal and hard to reach groups (such as 'deprived or disadvantaged' 'rural' 'inequality' guided the search.

The full search strategy and methodological detail is included in Supplementary Material 1.

Following identification of relevant papers, the findings and recommendations have been synthesised. For ease of reading and to acknowledge the nuances within findings, the review presents the following:

- Understanding on why people (in general) may not engage with primary care services
- Understanding on why specific groups (e.g. rural and coastal communities, migrants and asylum seekers) may not engage with primary care services
- Community specific strategies to enhance engagement
- A summary of strategies that will help people (in general) to engage
- The role of outreach
- Strategies for successful outreach

Existing understanding on why people may not engage with primary care services

The pressures on the NHS and primary care are well noted, with estimates for waiting times for a routine GP appointment ranging from same day to over three weeks; whilst around 50% of patients are seen within the first 48 hours, this does not appear to be the perception of the general public (NHS Digital, 2024). The UK government plans to tackle hospital backlogs through the Plan to Change (2025) in tandem with the Elective Reform Plan from NHS England (Gov.uk, 2025). Data from the General Practice Survey suggests that around a quarter of patients don't book appointments as they cannot book in advance, instead having to call at surgery opening time, and a third listed the reason as they couldn't get an appointment on the day. This data found around 12% of patients who contact the GP are not offered an appointment (Paddison, 2023).

The NHS and General Practice survey data is reflected in the academic literature. When exploring why patients present to the emergency department instead of going to the GP, the often-opaque appointment systems can make it hard for patients (and staff) to navigate access to appointments. Lack of pre-booking or availability of appointments can lead patients to access emergency care (MacKchan et al., 2017).

When considering the Norfolk and Suffolk context, the role of rural and coastal living, and deprivation are important to consider, around if, and how people engage with primary care services. Areas such as Great Yarmouth score highly on the employment deprivation domain of the Indexes of Deprivation (2019) and within the top 25 most deprived LSOAs (Lower Layer Super Output Areas) in 2019 (IoD) and both Great Yarmouth and Lowestoft amongst the 10% most deprived neighbourhoods in the UK (Gov, 2019).

Coastal areas have suffered within the UK and Ireland across recent decades, as industries such as fishing and shipping facilities have declined, while alternatives to the seasonal jobs in tourism have not been well-developed. Furthermore, there is reduced educational attainment typically, and limited employment opportunities which have resulted in younger age groups migrating to more densely populated urban areas (Asthana & Gibson, 2022). In addition to greater social and economic disparities, the demographic shift in coastal areas has resulted in an ageing population who are more likely to present with healthcare needs (Whitty et al., 2024).

The UK Chief Medical Officer's annual report in 2021 highlighted pronounced health disparities in coastal regions, showing that there is a greater burden of mental health conditions in coastal areas in the UK, which have largely been attributed to impacts from greater deprivation, age profiles, and patterns of migration (Whitty, 2021).

In help-seeking, structural challenges have been identified specific to coastal regions. This includes poor accessibility due to limited public transport and isolation, fragmented support from widely dispersed services, restricted service availability with few alternatives, and lack of trained professionals (Preece & Lištiaková, 2021; Thirkle et al., 2025).

This provides some insight into the pressures on the NHS services, and the specific rural and coastal stressors on health systems, to contextualise the remainder of the review, which will explore specific communities and barriers to engagement.

Existing understanding on why those residing in rural or coastal areas may not engage with primary care services

Turnball et al (2008) examined the effects of distance, rurality and deprivation on the use of GP out-of-hours services in a six-month period, assessing variations in service use for almost 35,000 patients. It was found that geographical barriers were a key determinant of access to out-of-hours services, highlighting potential risk for patients living in more rural areas (or further away from the GP practice) then needing to rely on out-of-hours care.

The urban and rural/coastal access appraisal should also consider availability of appointments – if you know you can see a doctor in the morning, you are less likely to rely on out-of-hours consulting such as NHS 111 or presenting to A&E (Farmer et al., 2005; Campbell et al., 2006). There is evidence that as health decreases, ability to safely drive decreases in tandem (George & Aveyard, 2020), and as such the challenges of transport can be compounded for rural patients.

There is evidence that rural patients often consult less frequently than urban patients (Farmer et al., 2005), however it is unclear whether this reflects better health or unmet health needs. In-depth interviews conducted with 62 adults across England suggest that concerns about wasting the time of GPs, and patient awareness of the pressure GPs are under (Cromme, 2016), may indicate that fewer consultations reflect unmet health needs. Patients anticipated waiting times or perceived lack of available appointments influenced patients neglecting to seek help – particularly for ambiguous symptoms (Campbell et al., 2006).

Examining the rural perspective, Farmer et al (2005) found that rural patients experienced (and wanted) a closer, more personal relationship with their GP. GPs were traditionally thought to be part of the community, whereas in urban settings, patients may 'shop around' for care and exhibited a more detached attitude. Rural patients often rely on established relationships with healthcare staff, which has been found to lead to delayed consultation (Campbell et al., 2006). Previous experiences of being perceived as a hypochondriac, or fears the GP feels they are ‘crying wolf’, prevent patients from returning to the GP, even if they are experiencing serious symptoms (Cromme, 2016).

Existing understanding on ethnic and cultural factors which affect people’s engagement with primary care services

In England, there are documented health inequalities between ethnic minority patients and white patients, with the Covid-19 pandemic exacerbating this between 2020 and 2022 (Public Health England, 2020). Ethnic minority communities report worse overall health and limited access to equitable care (Heaslip et al., 2022). Structural inequality and racism can reinforce these health inequalities, from the impact of racism and discrimination on health itself, to the stresses that housing, money, policing, employment and the criminal justice system can also place on health and health outcomes. Understanding the experiences and needs of these groups is important for any consideration of engagement or lack thereof.

Research from the Norfolk Community Foundation’s (2022) work with Gypsy, Roma, Traveller, Refugee and forced migrant communities found that GPs within Norfolk and Waveney were sometimes viewed with mistrust, with individuals feeling dismissed or confused. Previous research into the Gypsy Traveller community found that primary care services often underutilised the efforts of local, trusted, voluntary groups in service delivery and targeting health outcomes (Dar et al., 2013).

Patients may have limited understanding of how healthcare systems work and be unfamiliar with job titles (Norfolk Community Foundation, 2022). This can compound existing difficulties in booking appointments (Cromme, 2016), especially if English is limited or not a first language. When patients do try to engage with the GP, they often had to request interpreters themselves, which could make booking appointments challenging, with patients preferring family and friends as informal support with interpretation (Hieke et al., 2025). Provided interpreters can often miss the contextual information surrounding the appointment, with a participant from the Healthwatch Norfolk (2022) being assigned a young male translator for a cervical screening, making both uncomfortable.

In addition to cultural beliefs about illness, individuals from ‘hard to reach’ groups felt that medicalised responses (such as being prescribed medication or completing questionnaires), did not meet their needs, weakening their trust in the GP process and leading some to rely on crisis services or third-sector support rather than seeing a GP (Bristow et al., 2011). GP’s may overlook the importance of traditional medicine within cultures, and research with the South Asian community found that rather than go to the GP, they would rely on traditional medicine given by elders in the community (Sidhu et al., 2016).

The preconceived ideas that GPs have about cultural norms can also be a factor in not accessing primary care. In their exploration, Ali, Atkin and Neal (2006) found that South Asian patients felt that their GP's provided less information and listened less attentively than they did to their white counterparts.

Existing understanding on barriers to engagement with primary care services within the migrant and asylum seeker community

In addition to the explored health inequalities for ethnic minorities, the experiences of migrant and asylum seeker communities should also be explored. Whilst there is clear overlap in some of the challenges, migrants and asylum seekers may experience additional challenges in accessing care.

Inconsistent policies and confusion among healthcare providers can be a barrier to access (Nicholson et al., 2011). Navigating the inconsistent policies and confusion from the healthcare providers compounds the confusion of the patients who are not familiar with the primary care model (O'Donnell et al., 2007). Research with Eastern European migrants, and Ukrainian refugees have suggested tension between structural differences between countries, and patients perceived lack of autonomy in decision making within the NHS when compared to other countries (Madden et al., 2017; O'Reilly et al., 2025).

Language differences and unfamiliarity with medical terminology (Nicholson et al., 2011) also affect engagement. Interviews with 'hard to reach' groups found that language barriers compounded difficulties in understanding the complexity of the NHS, with individuals struggling with rigid treatment pathways and appointment systems (Bristow et al., 2011).

Experiences of discrimination and stigma weaken peoples trust in GPs (Bristow et al., 2011), and instances of discrimination are often not reported due to the hostile environment that the UK is perceived to have towards asylum seekers (O'Donnell et al., 2007). The impact of feeling unwelcome or experiencing discrimination or racism has an impact on health itself, as well as access to primary care – a potentially vicious cycle.

Despite asylum seekers having legal rights to interpreters, interpreter services may not be used appropriately (Nicholson et al., 2011; Power and Baxter, 2025). Where interpreters are available, the quality can vary. The interpreter-speaker role is also not a power-free relationship, with concerns around confidentiality, missing dialect nuances or turns of phrase, and the parameters of the interpreter role. Often, patients need an interpreter to translate and advocate, but the interaction may stop at translate (O'Donnell et al., 2006). Issues with interpretation is a common thread across ethnic and cultural minorities, asylum seekers and refugees, and those with limited English proficiency.

Strategies for improving engagement with primary care services for ethnic and cultural minorities, migrants and asylum seekers:

Language services are a clinical necessity (Nicholson et al., 2011), and access to quality interpreting services should be recognised as a patient safety issue (Hieke et al., 2005), not a recommendation or extra. When interpreters are provided, continuity with the same interpreter is preferred (Bhatia and Wallace, 2007), with consideration of the type of appointment needed also (Healthwatch Norfolk, 2022).

Language services can be supported by a simplification of NHS terminology and care pathways, with more visual materials, translated materials that are printed out and in community locations, and co-creation of appropriate materials with the communities they are aimed at. Translation of health information (O'Donnell et al., 2007) both in printed and online form is a clinical necessity for patient informed care.

Supporting GPs with funding, training and tools such as telephone interpretation will reduce the risk of communication barriers compromising patient safety or care. Provision of adequate and accessible translation of materials and appointments is in line with the guidance set out in 'Guidance for Commissioners: Interpreting and Translation Services in Primary Care' (NHS England, 2018).

Understanding and embedding trauma-informed care, cultural competence and anti-discrimination practice can reduce dropout from care and build trust (Nicholson et al., 2011). Assumptions about ethnicity and cultural norms may not align with patients' real preferences or backgrounds. Cultural competence training is a solid foundation, but the importance of patient centred care means that primary care professionals should not rely on preconceived ideas and beliefs about cultures.

GP practices working in partnership with groups such as faith-based organisations can help asylum seekers access healthcare, housing, food, legal advice and other support that can narrow health inequalities (Nicholson et al., 2011). GPs collaborating with community organisations can also aid individuals with both social and clinical needs (Bristow et al., 2011).

Telephone outreach has been explored to improve uptake of NHS Health Checks in deprived localities and with minority ethnic groups (Stone et al., 2020). In this study, it was found that telephone outreach workers can reduce administrative burden, increase engagement and build confidence, but only if this is supported by meaningful practice level integration and support.

Utilising community outreach and the registration process (when individuals try to register with a GP) to raise awareness of interpreting services – including clarification of professional and informal support entitlement is important (Hieke et al., 2025) – but these services must then be appropriately available after registration.

Existing understanding on barriers to engagement with primary care services within the homeless population or those who engage in street sex work

Homelessness is associated with drastically reduced life expectancy, complex chronic conditions and barriers to primary care access (Heaslip et al., 2022). While GP practices with homeless services are becoming more common, there are limited mobile homeless health teams outside of major urban areas, with a survey of 900 homelessness projects finding that over half had no link with a primary health care service (Crane et al., 2018).

It has been found that rough sleepers have the lowest GP registration rates compared to those in shelters or the hidden homeless (Elwell-Sutton et al., 2017). Street-sex workers carry a high burden of unmet health needs and social inequality, with street-sex workers carrying the highest burden of morbidity among the sex-work community (Jeal and Salisbury, 2007).

The role of institutional trust is key, with longitudinal research suggesting that homeless individuals who have been refused GP registration were less likely to access A&E, or call an ambulance, suggesting a complex relationship between aspects of the NHS systems (Elwell-Sutton et al., 2017).

The environment of the GP surgery can be a barrier to access even if the homeless individual or street-sex worker is registered. Fear of stigma for being homeless of doing sex work, limited access to telephones to call for appointments or receive callbacks and having to explain symptoms or situations to the reception in front of people are all barriers (Potter et al., 2022; Bristow et al., 2011). An enabling environment can include things like warm and supportive waiting areas, integration of (or clear signposting to) other health and social care services, and welcoming, non-judgemental staff (Hirst and Cuthill, 2011).

Strategies for improving engagement with primary care services for homeless individuals and those who engage in street sex work

Practices should ensure that staff are trained to register patients without the need for a fixed address. Kaushal et al (2022) point to the ‘My Right to Access Healthcare’ cards developed by Transformation Partners in Health and Care. Practices should accurately record homelessness using a standard code, supporting service planning and delivery that accounts for the needs of this population and ensures continuity of care and resource allocation.

Due to the interplay of health stressors on homeless individuals or those involved in sex-work, adequate training for GPs around third sector services, community groups and referral pathways can aid in supporting these individuals' overall health, not only their presenting issue. For sex-workers, particularly street-sex-workers, ensuring certainty of access to female staff (or male, if the patient is a male worker), understanding the impact of trauma around sex and gender is beneficial.

Strategies that will help all communities engage better with Primary Care services

Inclusion

- Practices should consider the language used, such as using 'contact person' or trusted contact instead of next of kin (Heaslip et al., 2022).
- Simplification of terminology, visual aids or photographs, translation
- Promotion of presentation to Primary Care services, allowing individuals to feel they are a candidate for care
- Printed information in relevant languages and reading levels at community accessible locations
- Alternative booking methods than telephone or internet to address the digital poverty experienced by communities, or technological literacy levels

Access

- Flexible appointment systems (Hirst and Cuthill, 2021)
- Call-stacking telephone systems can reduce frustration and hang-up, rather than individuals being met with the busy tone (Ford et al., 2019)
- Upskilling of receptionists around transport considerations allows receptionists to make bookings based on bus schedules, and feel empowered to discuss patient transport modes, and promote community transport where available (Ford et al., 2019)
- Partnerships with local taxi firms can support 'priority hour' appointment slots for patients who are relying on taxis for transportation (Ford et al., 2019)
- Improving physical access such as automatic doors and provision of adjustable couches is a beneficial change to local primary care services (Cawston et al., 2007)
- The ability to access a quiet and private space to wait for any appointment may also aid feelings of security among those who are homeless or engaging in street-sex-work (Potter et al., 2022; Bristow et al., 2011).
- George and Aveyard (2020) explored a buddying initiative to help individuals access primary care services more effectively, with volunteers providing support

such as: booking and attending appointments, assistance with transport, memory aids (diaries, reminders) and support within the GP appointments. These provided benefits; patients reported improved confidence, autonomy and increased adherence to healthcare appointments.

Strategies to effective outreach

Targeted, clear outreach: to ensure that outreach is effective, identify the specific communities or groups the primary care service is wanting to build relationships with, as can be seen through this review, certain groups have their own needs.

Consider achievable targets and measurable goals: the pressures on the health service mean that 'blue sky thinking' will not yield results, setting metrics with measurable outcomes such as 'engaging with X members of Y community 4 times a year' is a clearly measurable and adjustable goal.

Education and belonging: communities may not have knowledge of what outreach work is, what a workshop is, or that their voices are deserving to be heard, so consider ways that primary care services can make communities feel like they have a voice and know how to use their insights.

Collaborative delivery: primary care partnership with third-sector or community organisations is essential for building trust and engagement.

Flexibility and accessibility: primary care services being brought directly to the community in familiar environments (community venues, churches, drop-ins, other services) reduces barriers such as securing an appointment, or fears around stigma presenting to a GP practice.

Accessibility of messaging: consider use of traditional media, social media, in-person events, posted materials and posters to initiate contact with the community – what would be most appropriate and accessible to them?

Awareness of opportunities for engagement: capitalising on appropriate times for engagement and intervention is crucial, especially if individuals are willing to seek help.

Relationships: a less clinical, more personable setting allows the breaking down of power dynamics and can make patients feel heard and respected.

Opportunity for other interventions: co-locating outreach services can allow specific groups to meet multiple needs at once, e.g. provision of a GP in a community centre that has showers, and a food bank or hot meal provided means that those individuals who need to see a GP can do so and meet other needs at the same time.

Continual engagement: primary care practices should avoid one-off consultation as a form of outreach, effective outreach establishes meaningful connections and allows people to feel heard, valued, and that the service is committed to them.

Conclusion

The reasons why people do not engage with primary care services are multifaceted and complex, but often revolve around feelings of not being heard or understood. Patient centred care that appreciates the needs of individuals and reduces barriers to engagement is key for increasing engagement with primary care services, reducing missed appointments, or lack of registration with a GP.

Within the context of the UK, primary care services, particularly in rural, coastal and deprived areas may be under financial and staffing pressures, and some of the strategies to improve engagement may not be currently actionable. This review provides a range of considerations for engaging communities, building relationships and sustaining access to healthcare for particular groups, which it is hoped will enable primary care services to work with their resources and local communities to improve access to care for all.

References

Ali, N., Atkin, K., & Neal, R. (2006). The role of culture in the general practice consultation process. *Ethnicity & Health, 11*(4), 389–404. https://doi.org/10.1080/13557850600824190

Asthana, S., & Gibson, A. (2022). Averting a public health crisis in England's coastal communities: A call for public health research and policy. *Journal of Public Health, 44*(3), 642–650. https://doi.org/10.1093/pubmed/fdab427

Bhatia, R., & Wallace, P. (2007). Experiences of refugees and asylum seekers in general practice: A qualitative study. *BMC Family Practice, 8*, 48. https://doi.org/10.1186/1471-2296-8-48

Bristow, K., Edwards, S., Funnell, E., Fisher, L., Gask, L., Dowrick, C., & Graham, C. C. (2011). Help seeking and access to primary care for people from 'hard-to-reach' groups with common mental health problems. *International Journal of Family Medicine, 2011*, 1–10. https://doi.org/10.1155/2011/490634

Campbell, M., McKenzie, J. E., Sowden, A., et al. (2020). Synthesis without meta-analysis (SWiM) in systematic reviews: Reporting guideline. *BMJ, 368*, l6890.

Campbell, N. C., Iversen, L., Farmer, J., Guest, C., & MacDonald, J. (2006). A qualitative study in rural and urban areas on whether—and how—to consult during routine and out-of-hours. *BMC Family Practice, 7*, 26. https://doi.org/10.1186/1471-2296-7-26

Cawston, P. G., Mercer, S. W., & Barbour, R. S. (2007). Involving deprived communities in improving the quality of primary care services: Does participatory action research work? *BMC Health Services Research, 7*, 88. https://doi.org/10.1186/1472-6963-7-88

Centre for Reviews and Dissemination. (2006). *CRD's guidance for undertaking reviews in health care: Systematic review*. University of York.

Crane, M. A., Cetrano, G., Joly, L. M. A., Coward, S., Daly, B. J. M., Ford, C., ... Williams, P. (2018). Mapping of specialist primary health care services in England for people who are homeless: Summary of findings and considerations for health service commissioners and providers. Social Care Workforce Research Unit, King's College London. https://doi.org/10.18742/pub01-091

Cromme, S. K. (2016). Worrying about wasting GP time as a barrier to help-seeking: A community-based, qualitative study. *British Journal of General Practice, 66*(653), e474–e482. https://doi.org/10.3399/bjgp16X685621

Dar, O., Gobin, M., Hogarth, S., Lane, C., & Ramsay, M. (2013). Mapping the Gypsy Traveller community in England: What we know about their health service provision and childhood immunization uptake. *Journal of Public Health, 35*(3), 404–412. https://doi.org/10.1093/pubmed/fdt052

Elwell-Sutton, T., Fok, J., Albanese, F., Mathie, H., & Holland, R. (2017). Factors associated with access to care and healthcare utilization in the homeless population of England. *Journal of Public Health, 39*(1), 26–33. https://doi.org/10.1093/pubmed/fdw008

Farmer, J., Hinds, K., Richards, H., & Godden, D. (2005). Urban versus rural populations' views of health care in Scotland. *Journal of Health Services Research & Policy, 10*(4), 213–219. https://doi.org/10.1258/135581905774414213

Fenton, K., Pawson, E., & de Souza-Thomas, L. (2020). *Beyond the data: Understanding the impact of COVID-19 on BAME groups*. Public Health England.

Ford, J. A., Jones, A. P., Wong, G., Barton, G., Clark, A., Sims, E., Swart, A. M., & Steel, N. (2019). Improving primary care access in context and theory (I-ACT trial): A theory-informed randomised cluster feasibility trial using a realist perspective. *Trials, 20*(1), 193. https://doi.org/10.1186/s13063-019-3299-2

George, T., & Aveyard, H. (2020). Improving access to primary care services for those on low income: Voluntary advocacy. *British Journal of Community Nursing, 25*(4), 162–166. https://doi.org/10.12968/bjcn.2020.25.4.162

Healthwatch Norfolk (2022). *Language Barriers & Access to Care in Norfolk*. Healthwatch Norfolk: Wymondham

Heaslip, V., Holland, S., Thompson, R., Tauringana, M., & Glendening, N. (2022). Addressing health inequity in the UK: People who are homeless, from ethnic minority groups or LGBTQ+ communities. *Practice Nursing, 33*(3), 1–6. https://doi.org/10.12968/pnur.2022.33.3.106

Hieke, G., Black, G. B., Yargawa, J., Vindrola-Padros, C., Gill, P., Islam, L., Williams, E. D., Braun, S., & Whitaker, K. L. (2025). South Asian patient experiences of professional interpreting service provision in general practice in England: A qualitative interview study. *International Journal for Equity in Health, 24*, 104. https://doi.org/10.1186/s12939-025-02137-z

Hirst, V., & Cuthill, F. (2021). Benefits of GP care in outreach settings for people experiencing homelessness: A qualitative study. *British Journal of General Practice, 71*(709), e245–e252. https://doi.org/10.3399/BJGP.2020.1024

Jeal, N., & Salisbury, C. (2007). Health needs and service use of parlour-based prostitutes compared with street-based prostitutes: A cross-sectional survey. *BJOG, 114*(7), 875–881. https://doi.org/10.1111/j.1471-0528.2007.01379.x

Jordan, H., Roderick, P., Martin, D., & Barnett, S. (2004). Distance, rurality and the need for care: Access to health services in South West England. *International Journal of Health Geographics, 3*, 21. https://doi.org/10.1186/1476-072X-3-21

Kaushal, R., Jagpal, P., Khanal, S., Vohra, N., Lowrie, R., Johal, J., Jenkins, D., Saunders, K., & Paudyal, V. (2021). Representation of persons experiencing homelessness and coding of homelessness in general practices: Descriptive evaluation using healthcare utilisation data. *BJGP Open, 5*(4), bjgpopen20X101148. https://doi.org/10.3399/bjgpopen20X101148

MacKichan, F., Brangan, E., Wye, L., Checkland, K., Lasserson, D., Huntley, A., Morris, R., Tammes, P., Salisbury, C., & Purdy, S. (2017). Why do patients seek primary medical care in emergency departments? An ethnographic exploration of access to general practice. *BMJ Open, 7*(4), e013816. https://doi.org/10.1136/bmjopen-2016-013816

Madden, H., Harris, J., Blickem, C., Harrison, R., & Timpson, H. (2017). “Always paracetamol, they give them paracetamol for everything”: A qualitative study examining Eastern European migrants’ experiences of the UK health services. *BMC Health Services Research, 17*, 604. https://doi.org/10.1186/s12913-017-2530-0

Ministry of Housing, Communities and Local Government. (2019). *The English Indices of Deprivation 2019 (IoD2019)*. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Moher, D., Shamseer, L., Clarke, M., et al. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic Reviews, 4*(1), 1.

NHS. (2023, April). *Appointments in general practice*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/april-2023

Nicholson, B. D., Reid, C., & Albuerne, C. (2011). Primary care for asylum seekers. *InnovAiT, 5*(2), 112–121. https://doi.org/10.1093/innovait/inr141

O'Donnell, C. A., Higgins, M., Chauhan, R., & Mullen, K. (2007). "They think we're OK and we know we're not": A qualitative study of asylum seekers' access, knowledge and views to health care in the UK. *BMC Health Services Research, 7*, 75. https://doi.org/10.1186/1472-6963-7-75

O'Reilly, N., Smithwick, E., Murphy, E., & Jennings, A. A. (2025). The challenges experienced by Ukrainian refugees accessing general practice: A descriptive cross-sectional study. *Family Practice*. Advance online publication. https://doi.org/10.1093/fampra/cmae013

Page, M. J., McKenzie, J. E., Bossuyt, P. M., et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ, 372*, n71.

Paddison, C. (2023, June). How long are patients waiting for a GP appointment in England? *Nuffield Trust* [Blog post].

Potter, L. C., Horwood, J., & Feder, G. (2022). Access to healthcare for street sex workers in the UK: Perspectives and best practice guidance from a national cross-sectional survey of frontline workers. *BMC Health Services Research, 22*, 178. https://doi.org/10.1186/s12913-022-07583-5

Power, M., & Baxter, L. (2025). "I think they are actually a bit racist in not giving us everything that we need in terms of medication": Racialised governance and asylum seeker access to healthcare in England. *Social Science & Medicine, 365*, 116223. https://doi.org/10.1016/j.socscimed.2024.116223

Preece, D., & Lištiaková, I. L. (2021). "There Isn't Really Anything around Here ...": Autism, education and the experience of families living in rural coastal England. *Education Sciences, 11*(8). https://doi.org/10.3390/EDUCSCI11080397

Prime Minister's Office. (n.d.). PM sets out plan to end waiting-list backlogs through millions more appointments. *GOV.UK*. Retrieved June 3, 2025, from https://www.gov.uk/government/news/pm-sets-out-plan-to-end-waiting-list-backlogs-through-millions-more-appointments

Stone, T. J., Brangan, E., Chappell, A., Harrison, V., & Horwood, J. (2020). Telephone outreach by community workers to improve uptake of NHS Health Checks in more deprived localities and minority ethnic groups: A qualitative investigation of implementation. *Journal of Public Health, 42*(2), e198–e206. https://doi.org/10.1093/pubmed/fdz063

Thirkle, S. A., Adams, E. A., Harland, J., John, D. A., Kaner, E., & Ramsay, S. E. (2025). 'The lights are on, and the doors are always open': A qualitative study to understand challenges underlying the need for emergency care in people experiencing homelessness in rural and coastal North East England. *BMJ Public Health, 3*(1), e001468. https://doi.org/10.1136/BMJPH-2024-001468

Turnbull, J., Martin, D., Lattimer, V., Pope, C., & Culliford, D. (2008). Does distance matter? Geographical variation in GP out-of-hours service use: An observational study. *British Journal of General Practice, 58*(552), 471–477. https://doi.org/10.3399/bjgp08X319422

Supplementary Material 1: Full Methodology

Methods

Scoping reviews aim to improve the understanding of a body of literature and to inform practice in the field (Munn et al., 2018). A scoping review is used here to summarise the literature regarding communities who do not access Primary Care services, where this information can potentially be utilised to inform policy on improving healthcare provision and outreach, particularly in rural and coastal areas. The methods for the review are guided by Joanna Briggs Institute (Peters et al., 2020), including the reporting used PRISMA-ScR (Tricco et al., 2018).

Participants

This review included studies on individuals who do not access Primary Care services within the UK particularly within rural and coastal areas. The aim is to capture studies examining barriers to access, groups that may not access services, and strategies for outreach or relationship building with these communities and individuals. As the review aimed to understand research that can potentially impact UK policy and inform future research, thus included any type of evidence set within a UK context.

Search strategy

This scoping review included a diverse range of study types that examine and report on access to Primary Care services, particularly within rural and coastal areas, and links to health inequalities. These included quantitative studies; mixed-method and qualitative studies that explored the experiences of people in rural and coastal communities in relation to their health care; and grey literature, such as reports and policy documents that provide relevant data and insight but are not formally published in academic journals. For feasibility reasons, only studies written in the English language were included. The search terms were set up utilising MeSH and truncation to capture all available evidence. The following databases were searched for relevant published studies: MEDLINE, EBSCO, and CINAHL. Grey literature was searched using platforms such as Google Scholar, OpenGrey, and ProQuest – Dissertations, up to page 50 of search results in line with Haddaway et al. (2015) recommendations Further searches were conducted on the reference list and citations of studies that satisfies the inclusion criteria. Included studies will have a full text available in English.

Isolating relevant studies and sources

Titles and abstracts were initially used to identify relevant papers for inclusion. Following the search, all identified citations were collated and uploaded into Rayyan Systematic Review software to remove duplicates. The reviewer then screened the titles and abstracts of all citations for inclusion. The full texts of the selected papers were then read to determine if they met the inclusion criteria. The reasons for excluding full texts from the review were documented. See Table 1 for Inclusion and Exclusion Criteria. The PRISMA flowchart will be utilised in presenting the outcome of the screening.

Table 1: Inclusion and Exclusion criteria

Inclusion:	**Exclusion:**
Studies including individuals who do not access Primary Care services of all age groups in the UK	Studies including participants outside of the UK
Studies investigating key determinants of access to Primary Care services or barriers to access.	Studies involving access to secondary or other forms of health care such as presentations to Accident and Emergency Departments.
Studies investigating the characteristics of communities who do not access Primary Care services.	Studies without full text written in English language

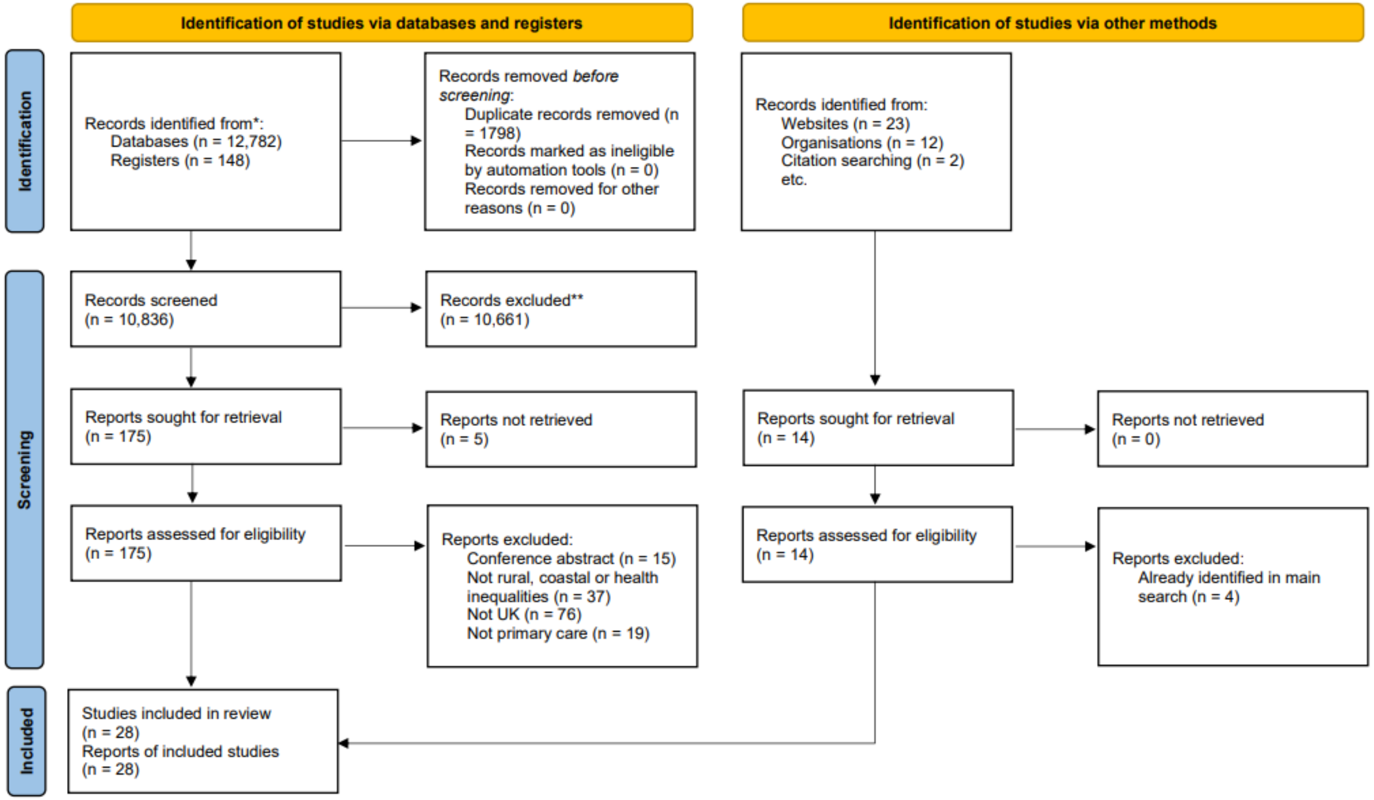
Data extraction

Data was extracted into a data extraction spreadsheet, which included: (i) publication details: author, title, year of study/publication; (ii) study characteristics: study design, aim of study, location of study, sample size, sample demographics, (iii) access to care, services available, service utilization, barriers/facilitators to care, quality of care; (iv) summary of key findings/recommendations.

Study characteristics

10,836 were screened, 175 were assessed and 28 included, as depicted in Figure 1 PRISMA diagram

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources



*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).
**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/