

Research paper

Expanding choice options for older patients in relation to practice-based commissioning: a qualitative study of older patients in a small GP surgery

Norman A Weir MSc MCMI

Practice Manager, Carshalton Fields Surgery, Carshalton, Surrey, UK

Mehul A Kotecha PhD

Research Fellow, Faculty of Health and Social Care, London South Bank University, London, UK

Kusum L Goel MBBS DRCOG

General Practitioner, Carshalton Fields Surgery, Carshalton, Surrey, UK

ABSTRACT

Background Patient empowerment and equality of access are central to the development of practice-based commissioning (PBC). The mechanism that is being used to facilitate this development is the Choose and Book system for referral to secondary care. However, there is little evidence that the older patient (aged 75 years and over) wants the responsibility of making personal healthcare choices. Furthermore, the Choose and Book system may be inappropriate for this age group.

Objective To explore with older patients the value of choice and the appropriate ways in which it can be expressed.

Method Six focus groups were undertaken ($n = 6$ participants for each group). Four of these focus groups were conducted with older clients (two with male clients and two with female clients) and two were conducted with carers. Participants were selected from the practice patient database using a purposive sampling process.

Results The study findings revolved around the following issues: 'relevance of choice', 'barriers to choice' and 'mechanisms facilitating choice'. The

key findings indicated that there was a greater interest in choice than was anticipated in the older age group. There was a unanimous agreement that choice should be made in partnership with a general practitioner (GP) acting as an advisor. While up-to-date and appropriately presented information was seen as very important, more time was needed for it to be absorbed and for a 'comfortable' decision to be made.

Conclusions The need for choice was fuelled by perceived variability in hospital service provision. The immediacy of decision making imposed by the Choose and Book system could impair independent choice options, and the time needed to overcome this could create its own problems for GPs' consultation schedules. While good information tools are needed to aid the choice process, they may not impact on patient satisfaction or anxiety levels. The creation of a voluntary patient support service may provide an ideal way forward.

Keywords: barriers, choice, elderly, information, relevance

How this fits in with quality in primary care

What do we know?

In general practice, patient choice of secondary health care is important; with Choose and Book being one of the main means by which it is made available. However, the level of interest in exercising healthcare choice by older patients may not be significant, and the engagement of this group in choice through Choose and Book may be inappropriate. While the older patient population is rapidly expanding, there is a paucity of information about their healthcare preferences.

What does this paper add?

The level of interest in healthcare choice among older people is greater than anticipated. The Choose and Book system introduces immediacy in decision making that is uncomfortable for the older person. The older person prefers to make healthcare choices for themselves based on the advice of the general practitioner. While good information is necessary for patients to make healthcare decisions, it does not necessarily add to their satisfaction or reduce their levels of anxiety. The development of a voluntary patient support service may provide a 'best fit' solution to helping the older patient make healthcare choices.

Introduction

The NHS *National Service Framework for Older People* states that 91% of the 75 and over age group are satisfied with their general practitioners (GPs) and the inpatient/outpatient care arranged for them.¹ While this age group is more prone to emergency hospital admission (where there is little patient choice) there is still a significant level of elective care activity. This is the context in which patient choice is being vigorously promoted,² with, in the vanguard, the Department of Health electronic Choose and Book system which advises healthcare staff and patients about the availability and location of acute elective treatment.³ There is a paucity of literature examining whether current choice mechanisms (including Choose and Book) are either appropriate for or desired by the older patient.

The study reported in this article had two aims: first to involve a representative group of service users, aged 75 years and over, in assessing the value of choice and the appropriate ways in which it can be expressed; and second to identify the additional support needed for Choose and Book to be more acceptable to older people.

Methodology

The setting for the study was a small general practice on the London/North Surrey borders. This is an area that has one of the largest elderly person populations in Greater London.⁴ The area also has a variety of healthcare provider options, including a selection of modern and well-equipped local NHS trusts, general practitioner with special interest (GPSI) clinics and a GP-led minor surgery centre.

Focus groups were utilised for this study for a number of reasons. They were seen to be an efficient way of collecting data from a number of participants at the same time,^{5,6} a way of empowering participants by providing them with a forum to express their views, and a means of providing them with an opportunity to be stimulated by the views of others in the group.⁶ The interactional nature of focus groups was also seen to facilitate a richer and deeper understanding of the issues at hand.⁷

Six focus groups were conducted, with each group consisting of six participants. Two focus groups were conducted with male participants, and two with female participants all of whom were aged 75 years and over. Each focus group was made gender specific (i.e. homogenous with regards to this characteristic) because, on balance, it was felt that it would be more appealing for participants to meet with others with whom they shared similar characteristics than for them to meet with individuals that they may have seen as being different in some way.⁸ There were two further groups comprising carers of elderly patients unable to attend themselves. The groups were invited to consider the definition of choice in health care, the reality of, and the extent to which choice was important to them, together with their preferred methods of choosing healthcare providers.

Members of the groups were selected using a purposive sampling process that took account of age and gender. The selection process involved identifying those aged 75 years and over on the practice patient database and then separating out those the GP considered unsuitable for inclusion due to physical or mental infirmity. From the resulting list of exclusions, those with carers were identified and these, together with those patients considered suitable for inclusion, formed the sample from which participants were chosen. The participants were then contacted by letter

with follow-up telephone calls to ascertain willingness and availability to take part.

On average the focus groups lasted for an hour and a half. They were held in the early afternoons on six consecutive Fridays. The groups were facilitated by a practice manager (who was also the lead researcher) and an observer. The overall process was under the supervision of the senior GP partner to whom the practice manager reported on progress made. The discussion at the groups was tape-recorded with supplementary flip chart and handwritten notes.

Analysis was based on the Framework Analysis approach,⁹ which is a useful method for analysing qualitative data. Initial results were listed for each group using Excel. The lists were analysed by the key issues: 'relevance of choice to the age group', 'barriers that were found in making a choice' and 'mechanisms that were needed to overcome these barriers'. The findings from the six groups were then consolidated into a composite list from which the main messages were extracted and inter-relationships identified. Patient confidentiality was maintained at all times and participation/contribution anonymised.

Results

The main findings that emerged from the analysis are described under three key themes.

Relevance

Choice was very relevant to the participants. For them, the importance of healthcare choice was measured in terms of being able to access the best treatment as soon as possible. An oft repeated comment was that:

'... choice is important particularly when good specialist care is needed'.

Focus group participants invariably chose 'good clinical outcome' (i.e. the achievement of the result desired by the patient from the treatment received) as being the main priority, and speed of access as a second preference. Locality always came either third or fourth in the list of priorities. An almost unanimous view was that:

'... both personal experience and the reputation of the hospital was vital in reaching a satisfying choice'.

There was also an underlying desire to see standards of excellence achieved in the local provider which would make choice less of an issue.

The need for GP advice was repeatedly underlined. The statement made by one participant that 'the GP knows what is best for you in your situation and

condition' was a representative view. Against this background, the participants envisaged choices being made in partnership with the GP, where the GP advised and the patient chose. In the first focus group, there was some discussion as to the factors that could motivate the GP to give referral advice (e.g. personal preference, primary care trust (PCT) advice etc). The following comment made by an 80-year-old participant summarised a view often repeated in all of the groups:

'Whilst advice by the GP is very important, I have to make the final decision.'

The participants also felt that patient peer-group feedback was important in making a choice – either from friends and personal contacts or from independent agencies (such as Age Concern). During a discussion on how patients differentiated between one hospital and another one participant observed that:

'... the reputation of the hospital cannot be ignored, bad experiences always influence choice ...'.

Another added that:

'... it is important that we know which one is the best one'.

Barriers

One key barrier perceived by the participants was the risk of making the wrong choice through lack of information. 'No information – no choice' was an oft repeated phrase in all the focus groups. Furthermore, one participant, speaking about the level at which information was imparted observed that:

'... older people can be regarded as stupid because they may be hard of hearing or need longer to process information and this means that their experience and intelligence are undervalued'.

This view was applauded by the other participants and echoed in other groups.

Another barrier was the uncertainty as to what is available in a rapidly changing NHS scene – a scene that was perceived as being characterised by a lack of finance, withdrawal of hospital services and the closure of wards. There was a widespread concern about the reductions in service provision by local hospitals under threat of closure. One participant observed that 'situations change very quickly in the NHS', and another, commenting on performance league tables, felt that they were 'a snapshot of what was rather than what is'.

While the Choose and Book system was seen as potentially useful there often appeared to be a lack of confidence in the system. Several asked the following question with a note of scepticism:

'Does it really work?'

And another often asked question was:

‘What happens when the computer system crashes?’

Mechanisms

Although choice was seen as important by the participants, Choose and Book was seen as limited in importance and was restricted to elective procedures and not to the life-and-death situations feared by this age group. This frequently repeated view is summarised by one participant, who stated that:

‘... urgent healthcare needs and emergency treatment leaves no room for choice’.

Another repeated observation was that the:

‘... emphasis of Choose and Book appeared to be reducing waiting times rather than satisfying the need for quality of care’.

Most participants also regarded Choose and Book as of limited importance due to their own indifference towards information technology (IT), with the majority preferring information methods with which they were more familiar (the favourite being GP advice supplemented by appropriate literature that they could read in arriving at a decision). Less than one-third of the participants had any experience of using a computer and one person made a representative comment that:

‘... the GP is the expert with both the computer and what it tells him about me. For me to make a decision, I need the information in a form that I can readily get at and understand’.

All the participants thought that the Choose and Book pamphlet would be more influential if it was read and understood by the patient prior to the GP appointment at which a hospital referral is made. As one participant observed:

‘... the leaflet is good ... but it does take time to understand it’.

When presented with the leaflet to read, one participant sighed: ‘oh dear! I haven’t brought my glasses with me’, which provoked a brief discussion on the smallness of the print.

In addition, there was a general view that the written presentation of information was not always the most appropriate (particularly where the writing was complicated, technical and verbose), and alternatives (e.g. pictorial leaflets/videos of hospital services etc) would have been useful. This was particularly the case with carers who wanted their charge to be able to contribute to the choice process. As one carer put it succinctly:

‘... it would be great for those I look after to be able to understand and choose the hospital they are referred to’.

Over-riding messages common to all three issues

Many participants thought that a personal involvement in the process of choice was important. ‘Importance’ was defined in terms of having the personal satisfaction of owning a good healthcare choice decision. Barriers were identified as having access to meaningful information and the time available for patients to explore choice options adequately within the GP surgery. The importance of the mechanisms for facilitating choice was underpinned by the belief that personal choice remained the right of the individual, irrespective of age and physical ability.

Also, participants thought that understandable information about health service options was fundamental to choice. The lack of information was seen as a barrier to choice and much time was spent in exploring innovative information communication methods.

Whilst the participants acknowledged Choose and Book to be a useful mechanism for enabling choice, the contraction of the local healthcare scene and fear that the ‘computer system’ may break down were barriers to it being regarded very seriously.

Although the focus groups varied in terms of age, gender and ethnicity, the responses received from the participants were consistent and the results that are referred to in this article are representative of all six meetings. There were exceptions, however, such as some participants having private healthcare arrangements which, sometimes, introduced an element of the hypothetical into their contribution in that they had little or no experience of the NHS system, which led them to conjecture and hypothesise.

Perhaps one of the most surprising results from the groups was the change in relationship between participants that resulted from spending an hour in one another’s company. The meeting started off with a disparate group of participants and ended with band of newly found friends. Without exception the participants said how much they enjoyed attending the group and appreciated the opportunity of being able to voice their views on what they considered important issues. These experiences of the participants underline the empowering potential of focus groups.⁶

Discussion

Summary of findings

Whilst ‘patient choice’ is a central tenet in healthcare commissioning, there is little evidence to show that the NHS has been able to engage the population in any significant way in its operation.¹⁰ The emergence of

practice-based commissioning was seen as an opportunity to involve the patient in the choice of healthcare provision.¹¹ This study contributes to an understanding of how to engage older members of the practice population in making healthcare choices.

The study demonstrated that there is a much higher level of interest in 'choice' than was previously indicated by the literature search or informal discussion among GPs. This view was moderated by a frequently expressed comment that a good local hospital could make the need for choice less important. This was very much in line with the British Medical Association's observations on choice, based on previous research.¹² While GP advice regarding secondary care referral was valued, it was suspected that drivers (e.g. convenience for the GP, cost of treatment etc) other than the patient's own health needs could inform such advice and that it was important for the patient to make their own informed choice. For the patient to make a choice, information additional to that provided by the GP is needed; existing available patient information literature was thought to be inadequate and needed to be supplemented by other more imaginative means of communication. Care must be taken in interpreting these findings. For example, recent research by O'Connor *et al* indicates that improved information tools do not seem to have an effect on satisfaction with decision making or anxiety,¹³ and a different approach to the problem may be needed.

The time available for patients to make choice is limited to the length of the consultation; some found this time constraint resulted in real choice being impossible and that the 'immediacy' imposed by Choose and Book resulted in rushed decisions rather than considered and informed choices. While this dilemma may have been in the policy framework for Choose and Book, which anticipated that some patients are likely to need additional support in making choices,¹⁴ the provision of the necessary resources to resolve the problem lies beyond the current means of the local health economy. The voluntary Patient Support Service launched in South Yorkshire in 2004 (for mental health patients) may provide a worthwhile model for adoption by general practice.¹⁵ Such a patient support service would allow GPs to refer patients to it for a consultation during which informed volunteers will help them to arrive at a satisfying decision.

Strengths and limitations of the study

The increase in the 75-year-old and over population within the local borough in which the study took place is very significant, with Sutton having one the largest per capita populations in this age range. The study allowed members of this age group to explore for

themselves the strengths and weaknesses of being involved in healthcare choice and the means by which the process of choice could be more risk free. A number of suggestions emerged from the focus groups that may lead to improved patient communications.

By involving older patients with an 'external locus of control' in choosing their own health destiny, it was intended that this would have benefits for the others in the age group. However, the length of time taken for these benefits to emerge may be overtaken by changes in the NHS arising from the current problems in the local NHS health economy.

While the participant recruitment process was successful in achieving a group membership that was ethnically representative of the practice, it was not representative of the ethnicity of the borough overall. In addition, the social and economic status of the area in which the survey was set is considerably higher than in other parts of the borough and as a consequence the results may not be representative; in particular, this may reflect on the higher than expected level of interest in choice.

In his role as project lead/chief investigator, the practice manager sought to ensure that the research programme was consistent with the patient care quality standards of the practice. While his involvement and familiarity with the practice meant that participants were more at ease, there may have been a greater level of freedom of expression amongst the participants if the focus groups had been led by a person not connected to the practice.

The problems being experienced in the local health economy coloured the discussions in the focus groups and may well have also contributed to the high level of interest. Recently produced patient literature on local secondary care provision had been overtaken by cuts in service provision that were driven by the local PCT's financial deficit. As such, there was an often expressed feeling of hopelessness in the face of the huge financial problems being faced by the local healthcare trusts.

What next?

The challenge to primary care of ensuring that the growing population of service users aged 75 years and over has the opportunity to make informed healthcare choices needs to be adopted at the practice or practice-based commissioning consortium level rather than left to increasingly remote PCTs. The value of the Choose and Book system to the older patient demands more time on their part than is currently allowed to assess the options. A review of consultation length with this in mind may be beneficial, although unrealistic with current time pressures on GPs and no remunerative incentives for the additional workload involved. The end aim is to achieve the goal of patient centredness

whereby the concerns and perspectives of this population are more fully understood.¹⁶ To this end, a new generation of multimedia information tools supplemented by a volunteer patient support service would possibly provide the necessary patient-centred focus. The results of the study are of benefit not only to the older patient of today, but to those who achieve that status tomorrow ... to which we all aspire.

ETHICAL APPROVAL

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Norman A Weir, Practice Manager, Carshalton Fields Surgery, 11 Crichton Road, Carshalton, Surrey SM5 3LS, UK. Tel: +44 (0)20 8643 3030; fax: +44 (0)20 8643 1013; email: norman.weir@nhs.net

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