

• An Anatomy of GP Referral Decisions

A QUALITATIVE STUDY OF GPs' VIEWS ON THEIR ROLE
IN SUPPORTING PATIENT CHOICE

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King's **Fund**

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Contents

About the authors	v
Summary	vii
1 Introduction and background	1
Pilots and early implementers of Choose and Book	1
Literature on patient choice	2
The context for this study	3
2 Aims and objectives	5
3 Methods	7
Telephone interviews	7
Focus groups	8
Analysis	9
Ethics approval	9
4 Key findings from telephone interviews	11
Overview of participants	11
Key themes	11
5 Key findings from focus groups	15
Overview of participants	16
GP views on choice and influences on their referral behaviour	17
Early experiences of Choose and Book and choice at point of referral	27
The information needed to support choice	32
The impact of patient characteristics on equity in choice	41
6 Discussion	45
Limitations of the study	45
Application of key findings for the development of choice	46
Further research	53
Appendix 1: Question schedule for telephone interviews	55
Appendix 2: Focus group topic guide	57
Appendix 3: Key findings from telephone interviews	59
Appendix 4: Practice profile information for focus group participants	65
References	71
Linked publications	73

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Summary

This report presents a qualitative study of general practitioners' (GPs') views about their role in supporting patient choice. It explores how GPs advise patients on the choices available to them and the information that GPs draw on to enable patients to make choices.

The study

AIMS

This study aims to explore GPs' views about the introduction of choice at the point of referral, in particular, focusing on:

- GPs' views on choice and influences on their referral behaviour
- early experiences of Choose and Book and choice at point of referral
- the information needed to support choice
- the impact of patient characteristics on equity in choice.

METHODS

The study used a combination of telephone interviews and focus groups. The interviews and focus groups were guided by a topic schedule covering the four themes above. The interviews and focus group discussions were taped and transcribed, and then analysed by thematic content analysis.

KEY FINDINGS

There was broad support for extending patient choice, but GPs identified several constraints that could affect patients' ability to choose between different providers.

GPS' VIEWS ON CHOICE AND INFLUENCES ON THEIR REFERRAL BEHAVIOUR

- Choice is not new and is about more than simply offering choice of provider.
- GPs vary considerably in the extent to which they actively support patient choice.
- Most GPs make choices on the patient's behalf (with or without Choose and Book) unless the patient expresses a preference. They will typically only try to override patient preferences in order to steer them towards excellent providers or away from providers about whom they have concerns.
- Very few GPs had used Choose and Book to actively engage patients in discussions about choice of provider.

- Four factors influence the degree to which GPs support patient choice: the availability and quality of formal and informal information about services; GPs' views of their professional role; patient preferences; and local PCT policies that may restrict choice.
- Patients and GPs seek overlapping but different characteristics when choosing a hospital. GPs' advice to patients typically balances soft information about clinical quality with patient preferences or published data about waiting times and convenience of access.
- When making choices about care for themselves or a relative, GPs often seek out informal information about different services to inform their personal decisions, with a particular emphasis on clinical quality.

EARLY EXPERIENCES OF CHOOSE AND BOOK AND CHOICE AT THE POINT OF REFERRAL

- Arrangements for the use of Choose and Book varied: in some places GPs made full online referrals, in others, secretaries or receptionists helped patients to complete a referral and in others patients made choices without help.
- The referral management centre opened by one primary care trust (PCT) was seen to restrict choice.
- Early experiences of Choose and Book have raised particular concerns about not being able to refer to a named consultant and about choices that are excluded by the PCT but highly desired by patients.
- In terms of their role in supporting choice, GPs broadly fell into three groups – enthusiasts, sceptics and paternalists.
- Views differed on the value of developing support services, such as choice advisers or health advisory centres, to support patient choice.

THE INFORMATION NEEDED TO SUPPORT CHOICE

- There was no consensus about the type of information GPs wanted to support patient choice or about how it should be presented.
- Most GPs distrusted official sources of information (waiting list data, and so on). They considered this sort of formal information to be manipulated to meet targets and subject to political 'spin', and some also had methodological reservations.
- The distrust of formal information was countered by a preference for soft, informal sources of information.
- GPs recognised that in reality both formal and informal information was incomplete and unreliable. They took a pragmatic approach to combining the two in making referral decisions.
- There was no overwhelming preference for any particular way of presenting information, suggesting that ideally it should be possible to view data sets on providers in different ways according to GPs' preferences.
- Most GPs felt that information on clinical aspects of care was the most important category, with waiting times the second most important.

THE IMPACT OF PATIENT CHARACTERISTICS ON EQUITY IN CHOICE

- For all GPs, the single most important equity issue was access and the constraints of geography and transport. This was felt most acutely by GPs in rural areas, but was present even for GPs in inner cities whose populations were deprived or elderly.
- Many GPs do not see choice as an equity issue because they do not see it as providing benefit for patients.
- GPs saw practical difficulties in involving some groups of patients in discussions on choice but there was only limited support for spending extra resources to enable these patients to make choices.
- Choice advisers and choice support centres were proposed as a way of helping people with difficulty in obtaining information and/or making choices but many GPs were worried about the potential costs involved.

Discussion

This study lays open the ‘anatomy’ of GPs’ decision-making about choice at the point of referral. It describes the complex interplay between formal and informal information, GP and patient preferences, the organisation of Choose and Book in GP practices and PCTs’ approaches to implementing choice. The study explores the underlying assumption in current policy that more and better information will support better choices and decision-making. In reality, there is a significant body of evidence that describes the constraints on such rational decision-making and the limits to the influence of factual information.

GPs’ perceptions about the quality and reliability of published NHS data sets (referred to as ‘formal information’) influence the way in which they incorporate this data into their decisions.

The following recommendations must be seen as emerging from a small-scale study of how GPs report they will behave in the future. They reflect early GP responses to choice and Choose and Book that may change as GPs’ experience grows. They propose ways to encourage GPs to advise patients on the clinical characteristics of services while allowing for the possibility of using alternative arrangements to advise patients on non-clinical aspects of care (if GPs do not wish to take on this role). The need for PCT policies that support choice is also reflected in the recommendations.

Recommendations for policy and practice to enhance GP support for choice

GP INVOLVEMENT IN CHOICE

- Work to engage GPs in supporting patient choice should emphasise and provide evidence for the extent to which patients value GP advice.
- GPs’ informal knowledge about local services should be recognised as a legitimate influence on patient choice until more valid and reliable outcome data is available.

IMPLEMENTATION OF CHOOSE AND BOOK

- Guidance on the development of Choose and Book should emphasise:
 - a central role for GPs in advising on clinical care
 - the domains of knowledge and competence required by non-clinical choice advisers and bookers.
- Where referral management centres exist, there should be an explicit policy about the range of advice that can appropriately be provided and the way it is imparted to ensure that it complements advice from the GP or other referring clinicians.
- Choose and Book systems should include the option to refer to a named consultant as a default setting that is only removed as a result of a specific local decision.
- PCT rules for developing a choice menu should allow clinical departments in local hospitals to be included even if they have long waiting lists.
- Further research should be undertaken to understand how non-clinical advice to support choice is mixed with informal clinical information and what impact this has on patient preferences.

INFORMATION TO SUPPORT CHOICE

- Performance data about different providers should be available in multiple formats with the option for online information users to manipulate the data into the format of their choice. (For example, see the Quality Compass system (National Committee for Quality Assurance 2006). This is a comprehensive database that includes results on HEDIS (Health Plan Employer Data and Information Set), a US dataset measuring clinical performance.)
- As data sets are developed, they should be piloted to test both their clarity and credibility before they are widely disseminated.
- Data on MRSA rates, post-operative infections, readmission to hospital and on the sub-specialties of consultants could usefully be developed in consultation with GPs to ensure their confidence in the data.

EQUITY

- Future guidance on implementing choice should encourage providers to develop and improve transport to their facilities.
- The costs and benefits of introducing choice advisers or choice support centres aimed particularly at those individuals for whom choice is difficult should be evaluated.

1

Introduction and background

The Labour 2001 manifesto promised ‘to give patients more choice’ (The Labour Party 2005). The extension of choice in health care is seen as a way of meeting patient expectations, improving efficiency, reducing waiting lists and strengthening local accountability. Choice is not a new phenomenon in the NHS. Patients could choose which hospital they wanted to go to until the 1990s, and the right to choose between GPs has always existed in theory – albeit limited by underprovision in many areas. Nevertheless, extending patient choice is one of several levers in the government’s programme to modernise the NHS as it strives to create a more personalised, responsive and efficient health service.

Several recent surveys reveal the extent of professional and public knowledge about choice. For example, a 2004 study by Nottingham University reported that 65 per cent of GPs supported the extension of patient choice but that only 22 per cent offered choice most or all of the time (Taylor *et al* 2004). The National Audit Office undertook two surveys of GPs’ knowledge and attitudes in relation to choice and Choose and Book in 2004 and 2005. The proportion of GPs who knew something about Choose and Book increased from 50 per cent in 2004 to 76 per cent in 2005. However, the majority of GPs reported that they felt the consultation process for Choose and Book was inadequate (93 per cent in 2005), and just under half felt that their practice had the capacity to implement it (Doctors.net 2005).

A survey conducted by the social research company MORI in the Midlands in 2003 showed limited public awareness about choice in the NHS, with only 8 per cent of respondents claiming to know about it and only 5 per cent saying that they would travel beyond their local hospital for an appointment (MORI 2003). A second survey by MORI in 2005 found 37 per cent of people had some awareness of choice (MORI 2005). A King’s Fund study conducted in summer 2005 explored public expectations about choice and the support people wanted to enable them to make choices in health and health care (Rosen *et al* 2005). Among other things, the study reported that people rely heavily on GPs to help them understand available information about different services and to advise them on how to interpret it. More generally in relation to choice, there is a body of work showing that many, but not all, patients value involvement and autonomy in clinical decisions with support from their GPs (Coulter 2002).

Pilots and early implementers of Choose and Book

The introduction of choice at the point of referral has depended upon several parallel developments. First, the development and implementation of an IT system – Choose and Book – to support airline-style booking of elective appointments. Second, installation of the IT system into GP practices – often linked to upgrading GPs’ computers. Third,

a computer interface between hospitals and GP practice Choose and Book systems to populate the appointment slots. Fourth, the engagement of GPs in supporting patient choice.

A series of pilot projects were run from 2004 to test the implementation of choice and Choose and Book. Evaluations of the pilot sites revealed slow uptake by GPs (National Audit Office 2005). Exploration of the reasons for this revealed that many had become disengaged when the technology and new systems did not meet expectations. Concerns about the impact of electronic booking and choice on the length of consultations were also raised, although practices tended to find their own solutions to this problem, for example, by giving the patient information or a form to complete outside the consultation (MacKenny 2006).

PROGRESS TO DATE

By the start of 2006, Choose and Book has been rolled out across most of the country. The system was installed into nearly every GP practice during 2005 and went live across the country on 1 January 2006. In addition, a series of NHS and independent treatment centres have been established to increase surgical capacity, and patient choice has become a reality for NHS patients.

A survey by the medical polling organisation MIDEX reported that in January 2006, only 8 per cent of GPs were making full use of electronic booking (MIDEX UK 2005). Technical problems continue to prevent many GPs from making online bookings. The majority of GPs expect to start using the system during 2006 but only 25 per cent had made a booking by February 2006. Recognising the delays in introducing Choose and Book, the 2006/7 NHS operating guidance set a target of 90 per cent of bookings to be made electronically by March 2007 (Department of Health 2006).

Achieving this target remains a significant challenge, and much effort will be required to refine Choose and Book software to develop the choice menus commissioned by PCTs and to engage GPs in supporting patient choice.

Literature on patient choice

It is beyond the scope of this report to review the existing literature on the factors influencing choices by patients and doctors. However, given the underlying assumption of current policy that better information will support better choices, it is worth noting relevant literature from academics and patient organisations. This highlights the importance of shared choices between doctor and patient about diagnostic and treatment options and the need to think of choice in a wider sense than simply choosing between providers (for example, see *The Autonomous Patient* (Coulter 2002) and *17 Million Reasons* (The Partnership on Long Term Conditions 2005). Literature from psychology, economics and other areas describes the limits to our ability to process information to support decision-making, and studies by health service researchers have described the numerous personal and contextual factors in addition to information that shape both patient and doctor decisions.

The context for this study

At the end of 2005, when this study was conducted, choice in general practice was largely synonymous with Choose and Book and the difficulties with its implementation. Initiatives to engage GPs in the wider implementation of choice and to encourage them to advise patients about alternative providers at the point of referral were rare, and overall experience of electronic booking was limited (Carvel 2006). To combat these delays, some PCTs have developed paper-based systems to support choice but these interim solutions have been far from ideal.

It was against this background that this study was conducted. Using a combination of telephone interviews and focus groups, it examines GPs' views on: patient choice; the information they would like to support choice; and how they will become involved in supporting patient choice.

2

Aims and objectives

The aims and objectives of this study were to explore: GPs' views about the introduction of choice at the point of referral; their early experiences of choice and the introduction of Choose and Book software; their attitudes towards offering patients choice in the future, with particular reference to their views on the impact of patient characteristics on equity in choice; and their views and expectations about the information needed to support choice.

Six main questions were identified with the Department of Health for exploration in the study.

1. How far is current referral practice shaped by existing relationships and knowledge of providers, and how much by objective information on quality?
2. Are GPs proactive (that is, initiating advice) or reactive (responding to requests for advice) when advising patients about referral choice and do they steer patients in a positive or negative way?
3. In the new choice environment, what kind of quality information and other information do GPs want in order to support the advice they give to patients?
4. What are GPs' preferences in terms of the content, style and presentation and scoring or ranking mechanisms for information on quality?
5. How sensitive are they to information, at what threshold would they change their advice and do they have a preference about how they would like this information to be presented?
6. Do patient characteristics affect the extent of GPs' involvement in choice, and how can choice be delivered equally to all groups?

3

Methods

Data was collected through a combination of six telephone interviews and six focus groups, using a topic guide covering:

- views about choice at the point of referral
- early experiences of Choose and Book
- the information needed to advise patients about choice
- the impact of patient characteristics on equity in choice.

The telephone interviews were conducted first to test the relevance and appropriateness of the topic guide and to obtain preliminary data about the kind of information that GPs wanted to support patient choice. Data from the telephone interviews was then used to refine the topic guide for the focus groups (*see* appendices 1 and 2 for topic guides, pp 55–58).

Telephone interviews

SELECTION CRITERIA

Telephone interviewees were selected on the basis of their location (urban or rural) and whether their PCTs were early adopters or pilot sites for choice projects. Strategic health authorities' Choose and Book leads were contacted to identify PCTs and practices that were making good progress with implementing Choose and Book. National reporting data was used to identify PCTs with high reported numbers of electronic referrals. The GP lead for Choose and Book in these areas was contacted and asked to participate in an interview or to nominate another GP who had been involved in patient choice.

In addition, early reports and evaluations of Choose and Book pilots were used to identify GPs who had been involved, including those in central London PCTs where GPs had access to multiple hospitals located in their own and adjacent PCTs. The selection strategy aimed to ensure that interviewees described their recent experience of choice rather than providing negative or speculative comments from a position of no active involvement (for example, 'I have tried X and I don't like it because...' rather than 'I don't know' or 'I haven't tried it yet'). The location of interviewees and characteristics of their host PCTs are summarised in Table 1 (*see* overleaf).

Interviews lasted between 40 and 80 minutes. They were digitally recorded and transcribed. Interviewees were assured that their comments would not be personally attributed in any report of the study.

TABLE 1: CHARACTERISTICS OF PCTS SELECTED FOR TELEPHONE INTERVIEWS

PCT	Characteristics
Suffolk West PCT	Rural/market town, involved in an early ‘choice at point of referral’ pilot study
Westminster PCT	London, Choose and Book early adopter
Haringey PCT	London, choice early adopter, Dr Foster pilot
Somerset Coast PCT	Rural, choice early adopter, using clinical referral centre
Colchester PCT	Rural/market town, Choose and Book early adopter
Central Cheshire PCT	Urban, Choose and Book early adopter

Focus groups

Informed by findings from the phone interviews, minor modifications were made to the question schedule for the focus groups. This included additional questions about how GPs build up their knowledge about services; questions about referring to a named consultant versus a specialty; and a more detailed discussion of the methods of presenting information to patients, based on visual aids provided to aid discussion (see pp 36–39).

SELECTION CRITERIA

In contrast with telephone interviews, focus group participants were selected to be representative of typical GPs rather than for their early engagement with choice. Groups were held in six PCTs selected to ensure each location included at least two of the following criteria:

- urban with diverse population and multiple provider sites accessible across neighbouring PCTs
- rural or town settings with a single local provider
- confirmed by a strategic health authority’s Choose and Book lead to include practices supporting choice and making electronic referrals
- experience of Choose and Book ranging from none to ongoing use.

The focus groups were conducted in Westminster, Croydon, Ashford, Yeovil, Crewe and Dudley. GPs were recruited by telephone after receiving an initial letter about the study. Telephone recruitment was conducted by the researchers in one site. Because of the time-consuming nature of this process, IPSOSS-MORI (the social research agency) was commissioned to recruit GPs in five sites. GPs were offered a payment of £100 to participate in the groups.

CONDUCT OF FOCUS GROUPS

Each focus group lasted between 80 and 100 minutes. Focus groups were scheduled in the early evening in order to maximise attendance given the demands of GPs’ working lives. The discussion was recorded and transcribed and participants were guaranteed anonymity in all reports from the study.

At the start of each group, participants were asked to complete a short form about their practice, their referral habits and the extent to which they did or did not use Choose and Book. They were asked to talk about:

- their views on enhancing choice in the NHS
- current referral practice and influences on referral decisions
- early experiences of Choose and Book
- the kind of information they wanted to support patient choice and their preferences as to how the information is presented
- how patient characteristics might affect equity in choice.

We developed four 'mock-up' summary information sheets. They were designed to demonstrate different ways of presenting data to compare performance in three hypothetical hospitals.

Analysis

Interviews and focus group discussions were taped and transcribed and thematic content analysis was undertaken. Transcripts were reviewed by all three researchers and data coded into categories relating to:

- general views about choice
- influences on patient referrals
- experience with Choose and Book
- information needed to support choice
- the impact of patient characteristics on equity in choice.

Coding frames were compared and used to develop a single list of key themes and illustrative quotes. Following this, all transcripts were searched for confirming and non-confirming data. From this the final analysis was developed and reviewed by all three researchers. Because of the nature of the focus group methodology, it is not appropriate to report data in quantitative terms but we have used terms such as 'a few', 'many' and 'most' throughout the report in order to illustrate the frequency of different responses.

Ethics approval

The study protocol was sent to North Central London ethics committee to assess whether or not ethics approval was required. In view of the fact that there was no patient involvement, the requirement for ethics approval was waived.

4

Key findings from telephone interviews

A brief description of participants and summary of key themes is presented here. The themes were explored in more detail in the focus groups, with the findings presented in section 5. To avoid repetition, interview data is presented in Appendix 3 (see pp 59–63).

Overview of participants

The GPs participating in phone interviews were from PCTs that hosted early pilots of Choose and Book or choice at point of referral. All were able to choose between more than one provider of elective care, although the number of alternative providers and the transport links between them varied between sites. In London (Haringey and Westminster), the GPs interviewed had a wide choice of providers with regular transport links between them. The Suffolk practice served a partly rural population with a local hospital and alternative providers up to 60 miles away. The others were in towns with a single local hospital and other providers in surrounding towns and cities. Overall, the GPs interviewed estimated that they made 10–20 referrals per week, although the lowest estimate range was 5–10.

Key themes

The following issues were raised during the interviews.

GPS' VIEWS ON CHOICE AND THE INFLUENCES ON THEIR REFERRAL BEHAVIOUR

- There was general support for the principle of choice, with mixed views about whether this would add anything new for patients. Some said that they had always offered choice, others saw Choose and Book as an opportunity to beat waiting lists and respond to patient preferences. One felt that choice was not wanted by his patients and was a waste of time.
- There was a strong feeling among GPs from towns with a single district general hospital that the difficulties of travelling to distant providers would limit the extent to which patients would choose any hospital other than the local one.
- Maintaining a good local hospital was seen as essential for patients who do not want to exercise choice.
- There was willingness to respond to patients' requests to go to a particular hospital, with only two GPs describing themselves as more proactive about offering choice.
- It was felt that decisions about where to refer patients were shaped by a mixture of published data about hospital performance and informal information about services obtained through many other sources.

- When GPs were looking for a doctor for themselves or a relative, their priorities varied between the shortest wait, convenience of access, and reputation and outcomes of the clinician, with the majority pursuing clinical quality.

EARLY EXPERIENCES OF CHOOSE AND BOOK AND CHOICE AT THE POINT OF REFERRAL

- Some GPs described positive experiences of using Choose and Book but there were more reports of frustration at technological problems.
- There was enthusiasm for a system that would enable them to avoid referrals to units with long waits.
- There was unwillingness to use the paper-based alternative referral systems.
- There were different arrangements within practices to enable patients to book appointments.
- There was frustration among some GPs at not being able to refer to a named consultant using Choose and Book.
- There was frustration if a local provider was not included in the choice menu and if PCT policies – such as use of a referral management centre – restricted the opportunities to provide choice.

THE INFORMATION NEEDED TO SUPPORT CHOICE

- There was universal agreement that information was essential to support choice.
- Waiting list data was seen as a key source of information – although not necessarily trusted.
- There was no consensus on desired information, but at least one person mentioned each of the following: post-operative infection rates, MRSA infection rates, the sub-specialty interests of each consultant.
- There was widespread scepticism about the quality and reliability of available clinical data.
- There was no consensus about the format in which information should be presented. Some preferred composite scores, others preferred raw data benchmarked against other providers.
- It was generally felt that there was a lack of time to go through large sets of information about different providers with individual patients.

THE IMPACT OF PATIENT CHARACTERISTICS ON EQUITY IN CHOICE

- Inequity associated with travel distances and access to transport was widely acknowledged.
- Concerns were raised that allowing access to good departments within a local hospital by non-local people with their own transport would further disrupt access for local people who cannot easily choose to go elsewhere.

- Language barriers, ability to understand complex information and personality type were all seen as potential barriers for some people to benefit from choice.
- Some GPs argued that additional resources might be needed to enable selected individuals to benefit from choice.

These themes are explored in more detail in section 5 (see pp 15–43), and the data from which these emerged is presented in Appendix 3 (see pp 59–63).

5

Key findings from focus groups

This section provides further evidence on the key themes identified above. In particular, it adds detail to the findings from the phone interviews described above about: the knowledge base that shapes the advice that GPs give to patients; the opportunities and constraints associated with Choose and Book; and GPs preferences for how information should be presented to support choice.

The widely recognised diversity of GPs and the opinions that they hold was clearly evident in the data. Varied opinions were particularly evident on early experiences of using Choose and Book and their likely approach to supporting patient choice in the future. Areas of greater agreement included the constraints and contradictions associated with current arrangements for patient choice and the difficulty of referring to a named consultant, as well as the problems associated with referring to unknown hospitals and a distrust of data from official NHS sources.

Data from the focus groups has been grouped into four broad themes linked to the research questions defined on p 5. The first theme describes influences on GPs' referral behaviour, including GPs' views about choice, their opinions about what patients want in terms of choice and an exploration of their strategies for advising patients (questions 1 and 2) and for making choices about their own health care. In this section we distinguish between the influence of two key sources of information that we call formal and informal information. Formal information describes any data or information produced by the NHS in hard copy or electronic form describing the characteristics or performance of organisations or services. Informal information describes intelligence acquired from personal contact, clinical experience or word of mouth.

The second section describes emerging arrangements for Choose and Book and for offering patients choice at the point of referral. Participants described their early experiences of Choose and Book, summarising perceived barriers and facilitators to the extension of choice. Although this theme does not relate directly to the research questions, it is included because it was so prominent in the responses of focus group participants. The data provides important insights into how different GPs are engaging with choice and provides context for the subsequent analysis about information needs. The third section addresses research questions 3–5 about the information that GPs want to support choice and their views on how such information should be presented. The fourth theme addresses question 6, presenting GPs' views on the impact of patient characteristics on equity in choice.

Overview of participants

Focus groups were held in Ashford (6 participants), Croydon (7 participants), Westminster (5 participants), Yeovil (4 participants), Crewe (6 participants) and Dudley. Only two of the six GPs who agreed to attend the Dudley focus group actually arrived. The group was not repeated because researchers had reached a point of saturation in their data collection. No new themes were identified in the subsequent (fifth and sixth) groups and no themes were raised by the Dudley GPs that were not also discussed in other groups.

GPs filled in a short questionnaire to obtain details about their practice, their referral habits and the extent of their exposure to Choose and Book.

- They worked between 3 and 12 sessions per week with a mean of 8.2 sessions.
- Out of 29 GPs who responded, 20 classified themselves as medium referrers, 2 as high referrers and 7 as low referrers. Five said they made fewer than 5 referrals per week, 16 between 5 and 10, and 8 more than 10.
- They listed between 1 and 4 providers each as their main referral destinations and 21 out of 25 who replied stated that 80 per cent or more of their patients went to a single provider.
- Nineteen used the EMIS referral system. Other systems used included VISION and synergy.

Nine GPs did not have electronic booking, 13 did and the rest had limited or unspecified access to the system. Among those who stated they did have electronic booking access, 0–100 per cent of referrals were made through the system. Of the 13 GPs with full access to Choose and Book, eight had all their local or usual providers listed on the system (see Appendix 4, pp 65–70).

GP views on choice and influences on their referral behaviour

KEY FINDINGS

- Choice is not new and is about more than simply offering a choice of provider.
- GPs vary considerably in the extent to which they actively support patient choice. Some GPs in inner cities have always offered choice, while those in towns with a single local hospital see choice as irrelevant to most patients.
- Most GPs make choices on the patient's behalf (with or without Choose and Book) unless the patient expresses a preference. They will typically only try to override patient preferences to steer them towards excellent providers or away from providers about whom they have concerns.
- Very few GPs had used Choose and Book to actively engage patients in discussion about choice of provider.
- Four groups of factors influence the ways in which GPs support patient choice: formal and informal information about services; their view of their professional role; patient preferences; and local PCT policies that may restrict choice.
- Patients and GPs seek overlapping but different characteristics when choosing a hospital. GP advice to patients typically balances soft information about clinical quality with patient preferences or published data about waiting times and convenience of access.
- When making choices about care for themselves or a relative, GPs often seek out informal information about different services to inform their personal decisions, with a particular influence on clinical quality.

GENERAL VIEWS ABOUT CHOICE

We first asked GPs their general views on choice. We emphasised that we were interested in the principle of choice rather than the practicalities of using Choose and Book. Many supported more choice, although they had a number of reservations, which are described further below. Few saw choice as something new, with older GPs in particular reflecting on the pre-1990 NHS when they could refer freely to any provider. Some inner London GPs had always enabled their patients to choose between accessible local hospitals:

There is always that choice because I happen to be lucky enough to work in an area where I have four major teaching hospitals around me. I don't know what happens to people who work in the country and have one hospital available to them.

(Westminster)

GPs from towns and rural areas with only one local hospital and variable transport links to other providers were adamant that most patients do not want to travel to distant hospitals. Implicit in their comments was the fact that inner city living would make choice

more meaningful but the quote from a London GP illustrates that this is not always the case.

If you've got five hospitals within walking distance of you, great, but the bus that goes from outside this surgery goes to [Hospital X], it doesn't go to any other hospital.

(Crewe)

I practice in Yeovil. There is a district hospital in Yeovil. People want to go to Yeovil. There will be some younger, more mobile [patients] that will want to go where it's quicker but 90 per cent of them will want to go here so offering choice is laughable.

(Yeovil)

The thing is, our patients are so close to [Hospital A], the majority of them... so if I suggest to someone that they try to go to [Hospital B], they look at you as if you are completely mad. And they won't go to [Hospital C], that's too far.

(Westminster)

For these doctors, preserving access to a reliable and high-quality local hospital for patients who do not want to, or cannot, make choices was seen as more important than facilitating choice.

The danger of this... take for example the colcoscopy locally, it's the only colcoscopy service in the local area which is hitting the recommended target times, so what's going to happen with choice? ... There's places like [A] and [B] where the GP's going to say 'where would you like to go? You can wait here to go to Macclesfield, your local hospital, or I see Crewe have got one in four weeks' time and they think 'oh yes I could take the four by four down there'... so those slots will get filled by inappropriate people. My patients will still only want to go to Leyton, they will have a longer waiting time.

(Crewe)

A similar point was raised by a GP from an inner London area whose practice was very close to a teaching hospital:

I just want to know that my local hospital is adequate because that's where everybody wants to go. They don't need a choice of everything, they just want to know that their local hospital is good.

(Westminster)

Other views included the idea that choice is not only about which elective provider to use, it is also about whether to refer at all and what treatment and investigations to have. A minority felt that choice could provide GPs with a lever to improve services. Some said that a choice of a first outpatient appointment should be followed by choice of where to go if an operation or procedure is subsequently required. Current choice arrangements were widely seen as irrelevant to those with long-term conditions.

The GPs varied in the extent to which they currently offer patients choice. Many simply opt for the provider with the shortest waiting list or the local hospital so long as they know that service to be good and reliable. London GPs were more likely to have patients requesting a particular provider but others also faced such requests and would typically accommodate them unless they had a specific reason to do otherwise:

I tend to suggest that patients see people with whom I'm personally happy, people who I would let see me and my family. Now there are certain doctors you wouldn't let see

your dog and I am quite blunt about that and patients might say I want to see doctor X and I go (intake of breath) 'I wouldn't really'.

(Dudley)

A few early adopters had enjoyed the experience of using Choose and Book to actively involve patients in decisions about which provider to go to. However, these were a small minority and most – even those who were trying out the new booking system – were less proactive in offering choice.

I haven't got into [it]... we have had Choose and Book for a few weeks and [I'm] trying to get into the mindset of giving people choice, I'm not denying them choice as much as not making them aware that they have a choice. It is a fine distinction but it is one of those things.

(Yeovil)

Yes I would definitely wait for the patient to ask and I would want to have some way out so that I can refer them to the [Choose and Book telephone] number [to make the actual booking].

(Croydon)

WHAT SHAPES GPs' REFERRAL PRACTICE?

Data on this theme reflected the fast-changing choice environment. GPs described a combination of past referral behaviour, their current response to the introduction of Choose and Book and their plans for referring patients in future. The boundaries between these comments were blurred, perhaps reflecting blurring of their own practice in response to patient choice. Nevertheless, we identified four key influences on referral practice and on how GPs offer choice: first, a combination of formal and informal data and information about services; second, the role that GPs opt to take on in relation to supporting choice; third, patient preferences; fourth, the effects of selected PCT policies on the delivery of choice.

Formal and informal knowledge about services

Participants drew on a wide range of information when advising patients on which hospital to attend or making referrals on their behalf. For some, published data (referred to here as 'formal information') on waiting lists was the most important influence on referrals, but many worried about the quality of this data. Among those who had started to use Choose and Book, some actively sought out published information about different providers and passed this on to patients although very few thought it an appropriate part of their role to discuss this data with patients. The concerns expressed by many GPs about the quality of published data are explored further on pages 32–34.

I provide the information. I give them a choice. Depending on what I am trying to do for the patient, I give them a choice at every stage. I give what I hope is relatively unbiased information about the two or three choices I have given – this is the distance, there is good parking there, or there isn't good parking there. They may not need the parking but if you have a car it is important.

(Westminster)

In addition to published data sources, participants described drawing on a variety of informal information sources. Examples included patient feedback after hospital

attendance; experience of having to manage clinical complications of surgical procedures; educational meetings; conversations with patients who work at the local hospitals; interaction with the individual clinicians through letters, phone calls and/or socially and knowledge about convenience and speed of access to local providers.

I think it is useful with a new consultant, and you have had a patient see that new consultant [who] has come back and we ask them, 'what was he like?' 'Oh he was fine' or 'he didn't seem to have much time'. That can influence things. Also the quality of the[ir] letters.

(Yeovil)

One interviewee said that his practice made a point of inviting each new consultant at the local hospital to a practice meeting within six months of them taking up post. Another explained how clinical experience adds to his informal knowledge for surgical and medical patients:

Say an orthopaedic surgeon [tells us that he] specialises in feet and knees and doesn't like anything else, so you mentally record that that's the person to deal with any new problems with knees or feet and you wouldn't refer to them for a back problem. Also obviously over the years you get to know the ones where there have been problems and who you wouldn't want to see.

(Crewe)

Well, the surgeons are fairly straightforward. You know the problems following surgery. The physicians... then you're getting it directly from the patient on how, sometimes, unhelpful their consultations were with a particular specialist.

(Ashford)

Patients also provided informal information to GPs by virtue of the fact that many work in local hospitals and talk about their experiences there. Others have experienced care there themselves, and some develop views about a local hospital based on experiences of family and friends. As one phone interviewee stated:

...people live in places for a long time and they know about the local hospitals.

(Yeovil)

A proportion of focus group participants had trained locally and knew many local consultants from their time at the hospital. For others, getting to know the consultants required more effort, and younger GPs and those who were new in an area said that they knew little about the local consultants. One GP who was well established in his practice had no obvious relationship with local consultants:

I never worked at our local hospital... so I've had to build up a knowledge of these people... actively seek out opportunities to meet them. I go to more than my fair share of educational events just to meet [them] really, and you... do actively look at what people are saying, what your colleagues are saying.

(Crewe)

I hardly know any of the consultants at [Hospital X] and I hardly ever talk to any of them and I've been here 21 years... Even if I talk to them on the phone and I want an urgent appointment I mean I think if they met me they wouldn't know who I am.

(Croydon)

The data suggests that GPs have a sort of ‘mental filing cabinet’ of informal information or soft intelligence about local consultants, and about the departments they work in that they draw on when making referrals. The ways in which they blend formal and informal information vary between GPs and in different situations. It is nebulous and hard to pin down, as evidenced by the comment:

I wouldn't like to commit to paper why I choose, I wouldn't like to stand in a court of law and say I wouldn't send someone there.

(Crewe)

If their informal information suggests that a particular consultant or department is perfectly good or if they know nothing about it, they may refer to the person or place (if multiple local providers exist) with the shortest waiting list or to the place identified by a patient as most convenient.

If, however, their informal information points either to a problem with a particular provider or to the excellence of a particular consultant or department, this may override the influence of data on waiting times or lead them to challenge patient preferences. Thus, one GP explained how he advised patients to prioritise good clinical outcomes over localness and ease of travel as the following dialogue illustrates:

They [patients] are interested in outcomes and often they will ask ‘what’s his track record?’ They are also interested in geography and visiting times because with a lot, particularly joint replacements, I tend to refer out of district and my patients are very parochial and a bit unwilling to travel.

(Yeovil)

Q: And you refer out of district because you feel the outcomes are better?

(Facilitator)

Yes.

(Yeovil)

Q: And do you tell patients that?

(Facilitator)

Yes, I do, yes.

(Yeovil)

Q: Then you have a discussion with them about things like geography?

(Facilitator)

That's right, yes.

(Yeovil)

In order to explore these issues further we asked GPs how they choose between providers for themselves or a close relative. Some stated that they would behave exactly as they would for their patients and/or rely on their own GP's choice of referral or on a local consultant's choice of tertiary centre.

I do it that you would do to others what you would do to yourself. I take a card out of my mental file box and if it's me or my family I will pick the name that I would have referred my patients to and I will refer my patients to that name, you know.

(Crewe)

A few said they would simply go to the place with the shortest wait. But the majority attached more importance to good clinical outcomes and reputation and actively searched for additional informal information. This included asking both GP and specialist colleagues who they would recommend and phoning specialists of the relevant sub-specialty. A few also mentioned investigating whether information is available on clinical outcomes but nobody gave an example of having found such information.

As a clinician I'd obviously go for the best clinician.

(Croydon)

Basically it would be someone I've known for years, who I may well have trained with and who I respected and who had a breadth of knowledge.

(Dudley)

My father needed a CABG pretty urgently so I rang up my consultant cardiologist and I asked him 'if you had a problem who would you go to?' and he goes 'I would go to this surgeon' so that's the way I did it.

(Croydon)

The 'word of mouth' approach to finding out about different specialists was supplemented in some cases by web-based information. This might be from official sites or from what one GP called an 'electronic super grapevine'.

I would ask at Doctors.Net UK actually. That is what I would do. Are you familiar with Doctors.net? [Dr X] and I are both aficionados and if I had a question of that nature I would post it on there and say what do you chaps reckon? That is all it is, a big electronic super grapevine.

(Yeovil)

The comments of one GP illustrated other inconsistencies in GP behaviour. As a doctor, he could go some way towards overcoming the absence of robust, reliable information about the performance of individual clinicians. When referring patients, he made generic referrals to a department rather than to a named consultant on the grounds that the informal intelligence he has about individual consultants is unreliable and not evidence-based. But when his wife was considering an operation, he drew on additional information to inform her decision.

I know some of the consultants... by their reputation. Then again, it's all hearsay, it's all anecdotal. And I might get a feel after seven or eight years as a principal in general practice that certain clinicians or surgeons are better than others. But again, that's taken years to build up, years of hearsay. But what's the evidence behind it?

And later the same GP stated:

...My wife is at the moment hassling me to get laser corrective surgery, and I haven't got a clue, I wouldn't know who to refer to... I've contacted a couple of local ophthalmologists. I've been to a couple of clinical meetings. I've tapped up some of the people who make the laser equipment and they've given me the top guys in the country. I'll look at all their websites but I'm none the wiser as to which one I'm going to go to.

(Location not given to preserve anonymity)

Although he claimed to be ‘none the wiser’, he had used informal information to identify a shortlist of highly regarded surgeons but lacked any formal method to choose between them.

GP ROLES IN SUPPORTING CHOICE

Describing their role in supporting patient choice, GPs fell into three broad groups that we have called choice enthusiasts, choice sceptics and choice paternalists. Differences between the GPs in these groups tended to reflect their degree of involvement with Choose and Book and their enthusiasm for current choice policy and, to some extent, differences in their views about the roles of GPs.

Choice enthusiasts

For a significant minority, the choice agenda, and more specifically Choose and Book, fitted very well with their view of their professional role as facilitators of patient choice. GPs in this group were happy to engage with the patient in discussing both clinical and non-clinical aspects of choosing a provider. They also wanted to be able to complete the electronic booking so that the patient left the consultation with an appointment.

A lot of patients delegate that responsibility to the GP but increasingly more patients want to be involved in that decision, they want to be empowered with information. My experience is slightly different in that I’m all for this. I would like to be able to complete the whole episode in one consultation; I realise that that probably isn’t going to be feasible in the near future because the systems are just not fast enough to do that but I would like to be able to complete the process.

(Dudley)

Choice sceptics

These GPs were not sceptical about the benefits of choice but about the appropriateness of GP involvement in decisions. They were adamant that they had no business advising patients about the non-clinical aspects of different providers and some were even worried that advice on clinical aspects of care by different providers could be problematic, with medico-legal consequences.

It needs to be ‘Here are the options. These are the ones I wouldn’t touch with a bargepole... These are the three you’re left with, do your research, I can’t be responsible for this. I’ll do a referral for you, but again the buck stops with you, in a way.’

(Ashford)

Choice paternalists

The third group could be termed choice paternalists – GPs who felt that their role was to make choices for their patients but without necessarily involving them. Some were worried that current efforts to involve patients in choice would undermine their role as GPs.

I see myself as doing that, I’m the patient’s adviser in the big wide world out there, and yes in certain consultations I’m able to diagnose their depression and beat it for them and in some consultations I’m there to advise them go to that surgeon and not that surgeon, you know.

(Crewe)

My consulting methods will be very directive in terms of I would say to the patient 'you have a choice but if I was you, if I was in your situation, I would go here' and I would say to them 'go for it'.

(Croydon)

I'm the paternalistic one, I'd like them to have the best. I'd help them to make the choice that I think is best for them... I agree that there are some people who have got problems that might make somewhere else [other than local hospital] more suitable for them... And I'd say to the patient 'I'm sending you to see Mr X because I think he's the best of the lot at the moment'... I mean perhaps that is paternalistic, but that's the way that I've been doing it for the last 20 years.

(Ashford)

PATIENT PREFERENCES ABOUT PLACE OF REFERRAL

Participants described different ways in which patient preferences influence their current referral practice. At present many patients simply ask their GP to decide where to refer but others express preferences that vary according to local circumstances and may be different from the priorities pursued by the GP. The two most frequently mentioned influences on patient preferences were waiting time and convenience of access. Also evident, but less frequently mentioned, were patients who want to see 'the best doctor' and preferences based on a particularly good or bad personal experience (see phone interview quote by Dr B, London, pp 59–60).

Everyone has different aspirations, so for some people it might be ease of access, public transport and parking, for other people it might be 'I want the best top-quality surgeon who's going to do the best job', for other people it might be 'I want a hospital that's clean'.

(Croydon)

No, I don't even know where some of them [providers available through Choose and Book] are. Didn't mean a thing. She was after the quickest and if she wants the quickest she can have the quickest.

(Yeovil)

GPs from rural areas with a single conveniently accessible provider emphasised that, for most patients, access and transport were the dominant issues that shape preferences. In other areas, some GPs described combining information on waiting times, access and clinical factors when advising patients, but most saw their key role as making judgements about, and advising on, clinical quality. Non-clinical influences on patient preferences were seen as important but not their primary concern, and many argued that patients should research and assess those categories of information themselves.

It's a waste or a complete waste of or a misuse of a trained, qualified, experienced general practitioner to actually do the research into all these different hospitals and then help guide the patient to make their choice.

(Crewe)

And an interchange in the Yeovil focus group illustrated the same idea:

Q: So we have talked about: access, hospital facilities, good translation services, whether patients are copied in on the letters and involved in decisions, admission

rates and waiting times. Those sorts of areas, are they areas where it is important for you to have information about... when you go into a discussion about choice?

(Facilitator)

No, waste of my time doing this.

(GP A, Yeovil)

The patient is coming in to talk about having an operation.

(GP B, Yeovil)

Q: So clinical outcomes are the most important thing?

(Facilitator)

There is no point sending them to the Ritz if they haven't got the clinical outcomes.

(GP C, Yeovil)

We haven't got the luxury of the time you would need to do it properly.

(GP D, Yeovil)

The interplay between advice from GPs – based on their knowledge of the clinical reputation of different hospitals – and patient preferences is illustrated in another exchange between GPs in the Yeovil focus group:

Yes, I ask people where they want to go. For example, rheumatology, you can refer, I can refer them to the local service in Yeovil, if you really want I will be happy to refer you to the consultant that I see at Musgrove [in Taunton] or we can refer you to the local specialist centre at Bath and by and large most of our patients choose to go to Bath.

(GP A, Yeovil)

I think one of the issues is that yours are obviously prepared to travel quite a way. I think if I said to one or two of my patients, particularly in rheumatology which we have not got a very good service locally at the moment in terms of capacity, I think if I said to people 'you can go to Bath', I think a lot of them would say 'well how am I going to get there?' Transport would be an issue.

(GP B, Yeovil)

Transport is no longer under our control any more.

(GP C, Yeovil)

There is a bus that runs from Yeovil to right outside the rheumatology hospital in Bath.

(GP A, Yeovil)

But it doesn't run from [Town X where the GP practised]!

(GP B, Yeovil)

So their choice is different.

(GP A, Yeovil)

The above interchange illustrates well how patient choices may be based on a mixture of non-clinical information (for example, about transport) and GP advice about good providers.

CONSTRAINTS ON CHOICE ARISING FROM CONFLICTING POLICIES

GPs from Yeovil PCT described the influence of a local policy to introduce a referral management centre through which all specialist referrals had to pass. The general view was that this system restricted choice and undermined any advice the GP may provide about different providers. This had implications for the way GPs offer choice to patients and provide advice to support choice:

All of our referrals are being routed through a referral management centre whether we want them to or not and the ones that are doable at the [independent sector treatment centre] are being done there regardless or not of whether the patient wants to go. There is no choice for the patient in that case.

(Yeovil)

Referrals go through a referral management centre now so that where you refer them is irrelevant anyway because there is a chance they may be hived off to somewhere else.

(Yeovil)

Another Yeovil GP pointed out that this had come on top of 15 years in which their freedom to refer beyond the local hospital had been restricted:

The problem of it is that we have had 15 years of not being able to choose so... you are probably not going to know what is going on, what is available to you... So being able to inform your patient becomes more difficult then and it is no good if somebody says to you 'I want to go to so and so' if you don't know anything about it yourself.

(Yeovil)

Several GPs identified potential constraints on patient choice associated with the introduction of GP specialists – either as local PCT policy or as part of practice-based commissioning.

They're really scared about how practice-based commissioning is going to integrate with Choose and Book and from what I gather... for example, when practice-based commissioning comes in we'll be referring say to a GP specialist and it's then up to the GPSI to refer on, to give you the choice, rather than us.

(Croydon)

And referring to wider national policy, a cluster of GPs expressed concerns about the inconsistency between practice-based commissioning policy, with its incentives to keep care 'in house', and the aims of the choice agenda:

I mean I'm interested in moving this towards how practice-based commissioning conflicts with choice... if that's going to take place, you will find that patients actually won't be offered secondary care any more. It'll all be done in primary care because it's cheaper, because we know what we're doing, and because the primary care can do it before they ever get sent to secondary care.

(Ashford)

A third element of choice policy that restricts choice is the exclusion of local services from a PCT choice menu. This is typically because a particular department had long waiting lists. This issue is further described below (see pp 30–31).

Early experiences of Choose and Book and choice at point of referral

KEY FINDINGS

- Arrangements for the use of Choose and Book varied: in some places GPs made full referrals; in others, secretaries or receptionists helped patients to complete a referral; in others patients made choices without help.
- The referral management centre opened by one PCT was seen to restrict choice.
- Practical barriers to making electronic referrals include technical problems with Choose and Book software, time constraints and lack of training.
- Early experiences of Choose and Book have raised particular concerns about not being able to refer to a named consultant and about choices that are excluded by the PCT but highly desired by patients.
- In terms of their role in supporting choice, GPs broadly fell into groups – enthusiasts, sceptics and paternalists.
- Views differed on the value of developing support services, such as choice advisers or health advisory centres, to support patient choice.

Some GPs described how Choose and Book meant they were offering more choice to patients. For others, its introduction had led to a reduction in the choices they were able to offer – for instance, because the most used local provider was not on the system or because they were no longer able to refer to named consultants.

For others still, Choose and Book was being introduced but in such a way that it was not accompanied by an increase in the range of providers. The computer systems were up and running but, because the PCT had not yet agreed a full ‘menu’ of providers for each specialty, only one or two options were available. Then there were practical problems with the introduction of Choose and Book. These included patients being unable to benefit because they did not have a diary in the consultation or because dates were changed by providers after the appointment was made and difficulties in completing the electronic booking within time-limited consultations.

You say to Joe Punter, ‘I’ll get your appointment five weeks on Thursday’ and guess what 60 per cent will say – ‘I haven’t got my diary’.

(Crewe)

I mean I agree, before it stopped working, I actually did do about ten click referrals on the web system and they, my patients loved that, you know. Then they all came back and said the date had been changed – or even cancelled altogether. I’ve done about 15 and for two of those... [a] week later the consultants refused it.

(Crewe)

There were four main ways in which GPs had organised Choose and Book referrals in their practices with a fifth variant organised by PCTs. GPs in the same practice sometimes used the system in different ways.

- **Full booking during a consultation** A small number of GPs had successfully booked appointments during a consultation, working through the software with their patients.
- **Option review with GP, then patient contacts secretary regarding chosen provider** Available providers were discussed and the GP produced a printout of preferred providers. Patients considered and researched options outside the surgery and contacted GP's secretary when they had chosen.
- **Option review with GP, then patient dials helpline to book appointment** As above but patients phoned the hospital of their choice.
- **Receptionist support for Choose and Book** GPs provided a list of available providers to patients, who discussed available information about each provider and made the online booking of their choice with the practice receptionists.
- **Referral sent to a referral management centre** GPs referred patients to a referral management centre covering one or more PCTs, where staff provided patients with support for choice.

BARRIERS TO USING CHOOSE AND BOOK

Participants identified a range of practical constraints on the use of Choose and Book, including technical problems, time limitations, lack of information to support patient choice and limited PCT progress in developing a menu for choice.

Choose and Book enthusiasts continued to use the system despite early technical hitches.

At the moment I use Choose and Book. When we first got it, the system collapsed but we are back on track now. It is a good system provided it works well.

(Westminster)

Others had given up, trying some initial referrals but unwilling to continue in the face of slow computer speeds and having to start a booking again if they made an error. Some found it too disruptive to the flow of their consultations.

Since I've used it my surgery is late by one hour. There are about twenty clicks to go through and if you make a mistake, the computer says you have to go back again to the start.

(Westminster)

For some GPs, Choose and Book was still not really available; either their PCT had not yet fully implemented it or the principal local provider(s) were not on the system.

Yes [it's installed] but we haven't had any training on it.

(Westminster)

The only problem is that the hospital side hasn't got themselves together, they don't supply the information.

(Westminster)

We've got the stuff on the computer but that's as far as we've got. But it's limited because there are not many providers. They're just putting them on.

(Croydon)

This is an issue really because I had one session of about half an hour on Choose and Book and then I went away on holiday. You come back with Choose and Book in front of you and basically the first patient that comes in is going to be an extremely long learning curve, which is probably one of the reasons why, among the others that I've mentioned, I haven't started.

(Yeovil)

RESTRICTIONS IMPOSED BY CHOOSE AND BOOK AND CHOICE AT POINT OF REFERRAL

A number of GPs had been involved in the early implementation of Choose and Book and/or pilot projects to provide choice. Their early experiences affected their views about patient choice in two key ways. First, many resented the loss of their ability to refer to a named consultant. Second, the rules governing PCT selection of 'choice' providers had resulted in a series of problematic exclusions that were not tolerated by patients.

Restrictions on the ability to refer to a named consultant were raised by many GPs. We noted above the division between GPs who typically referred to a particular department and those who referred to a named consultant. For these latter GPs, informal information about individual consultants was an important influence on their referrals. The inability of all but one local Choose and Book system to offer such choices was a source of significant concern and for some GPs it struck at the core of the relationship between GP and specialist. They lost the ability to tailor referrals to suit individual patients or even to avoid particular consultants whom they considered dangerous. They also felt that given their reliance on information about particular consultants, this would be problematic when making referrals to distant hospitals where they could not rely on such relationships.

For me you lose the essence of becoming a GP because part of becoming a GP is building up a relationship with a specific consultant who knows your quality of referrals, who knows that you're a good GP or a bad GP or when to take things more seriously or not seriously and that's fundamental to a GP-consultant relationship and that's going to be lost.

(Croydon)

And let's take gynaecology, for example. Locally, there are four gynaecologists, one of whom has a manner which is very matter of fact, one of whom has a manner which is very much to the other extreme and you could, before Choose and Book, tailor your referrals by personality of the patient, so will she get on with Mr So and So or actually I think she would be far better looked after by Mr So and So. But you can't do that any more, there has been a limitation, a reduction of choice.

(Yeovil)

However, others provided arguments in favour of generic referrals – for instance, a patient referred to a named consultant might end up seeing a junior doctor on the team or a GP just may not know about individual specialists. There was also a feeling that generic referrals resulted in patients being seen more quickly. But even so, the need

occasionally to steer patients away from some consultants or towards others with a relevant sub-specialty was acknowledged.

I'm one of the newer breed of GPs that has always had generic referrals, never known anything different. The relationship between myself and the consultants are almost non-existent, there's not these sort of golfing weekends that they used to do perhaps in the days when you first started.

(Ashford)

It's not a problem at the moment, I pool most of my referrals to [Hospital X] because unlike [Dr Y] I'm actually quite happy with the vast majority of the consultants in the various specialties, so unless it's one of the specialties, which I'm not going to name, or unless it's something where say in orthopaedics if they need a specialist in shoulders, there's only one of the half a dozen, then I will pool them because I think it smoothes out the [waiting list].

(Crewe)

...some of this stuff will change year on year depending on which registrar there is... Even if you've got a named consultant, you could have a different registrar who is going to be doing most of the operations, he's going to have different skills, different attitudes, there's going to be different infection rates.

(Ashford)

This system assumes that GPs know enough about all the consultants and that's not true. You know a few consultants and a few specialties so it becomes difficult for the GP to give choices when you are not in a position to do that yourself. A choice of hospitals seems more reasonable to me.

(Westminster)

In general, it seemed that some GPs have close relationships with selected consultants and are very conscious of the quality of the consultants to whom they refer. Others rely on most consultants being of an adequate standard and the fact that they will gradually find out about those providing poor-quality care (see pp 19–20). The latter will send most patients as generic referrals to the local hospital unless they know of a specific reason to do otherwise.

The impact of guidance to PCTs about which providers can and cannot be on their choice menu was also widely mentioned and reported to be having perverse effects. Specialties with a waiting time for a first appointment of more than 13 weeks were not included in the Choose and Book menu.

Because I'm interested, I'm going into this [pilot] for a month, and I've made two referrals where the patients said they wanted a referral but the local [district general] hospital wasn't on the menu. They came back to me, saying that [the local district general] hospital is where they wanted to go... So it was all a bit of a failure from my perspective.

(Ashford)

I use the Choose and Book system to make somebody a dermatology appointment and I could offer her Taunton, which is 40 minutes away by car, but it was an elderly lady

who would go on public transport, two buses, however long it takes. Where were the others? [Hospital B] or [Hospital C], which has a quicker outpatient clinic. There wasn't a [Hospital D] option on Choose and Book. 'But I want to go to Yeovil'. 'Sorry, you can't have that choice, it's not there'.

(Yeovil)

These restrictions had caused two GPs to pull out of local pilot studies of choice and many others to bemoan this significant limitation of current choice policy. None reported having contacted their PCT to request that the rules be applied differently despite the upset it was causing to patients.

VIEWS ON SUPPORT SERVICES FOR CHOICE AT POINT OF REFERRAL

With many GPs concerned about the limited time available to advise patients, a number suggested that some sort of patient support service would be needed. We therefore explored their views on the potential value of some form of 'choice advisers' to support patients in making choices. Reactions ranged from guarded support to horror that the choice agenda may generate a costly bureaucracy, diverting further resources from frontline services.

I think there's probably a place for some kind of health advisory centre in the high street, or in an internet café, wherever it happens to be, you know, that's council led and government funded. And takes a slice out of the NHS budget! But I really do think it's a minority that will be using it, a real minority... So I wouldn't envisage that this should be something that the government should run and waste thousands and thousands of pounds on.

(Ashford)

It's the same with all these things. When you offer them a choice, if you could say 'or would you rather scrap this whole system and have the money put into extra nurses, extra wards or whatever'... Yes, if I can have the choice I might as well have it but if they had realised the expense of other things [you need to support choice]...

(Crewe)

In one sense the 'choice adviser' role was already embodied in the work of the referral management centre set up in Yeovil. But one GP highlighted concerns about whether the system will be seen to act in the best interests of individual patients.

The referral management centre is probably very good at customer service but how are [patients] going to feel about the trust element and so on. Is this person making this referral because it fits in with the strategic objectives of the organisation or is it being made by my local clinician based on his knowledge of the local set-up?

(Yeovil)

Other suggestions about ways to disseminate information to patients were made across all the focus groups. These included interactive websites and telephone advice lines operated through a national call centre. None of the suggestions were mutually exclusive and the overall picture from the focus groups was of a collage of different approaches emerging in different locations – some practice based and others PCT wide.

The information needed to support choice

KEY FINDINGS

- There was no consensus about the type of information GPs wanted to support patient choice or about how it should be presented.
- Most GPs distrusted official sources of information (waiting list data, and so on). They considered this sort of formal information to be subject to political ‘spin’, and some also had methodological reservations.
- The distrust of formal information was countered by a preference for soft, informal sources of information.
- GPs recognised that in reality both formal and informal information was incomplete and unreliable. They took a pragmatic approach to combining the two in making referral decisions.
- There was no overwhelming preference for any particular way of presenting information, suggesting that ideally it should be possible to view data sets on providers in different ways according to GP preference.
- Most GPs felt that information on clinical aspects of care was the single most important category, with waiting times second. They recognised that patients often had different priorities, particularly waiting times and convenience of access, but did not typically feel that discussion of these areas fell within their role.

Whatever GPs’ views on choice, there was universal agreement that choice without information had no meaning. The statement ‘if you have choice it has to be informed choice’ reflects a view expressed in every focus group and by the majority of participants.

When we explored in greater detail what GPs thought about different forms of information, and how they would use it, we identified an important dichotomy. They recognised the importance of key data sets – such as waiting list information – to patients and advocated that they should be available. But many described their distrust of data from official NHS sources and some were reluctant to use the data themselves.

GP VIEWS ON OFFICIAL DATA SOURCES

There were two main reasons why GPs distrusted NHS data. First, they thought NHS institutions that collect and produce the data have vested interests in meeting targets or presenting them in certain ways that could distort their meaning. A smaller number of GPs expressed concerns about the methodological problems associated with data on clinical outcomes.

We first asked for thoughts about the Healthcare Commission star rating system. Although all had heard of it, there was a general lack of knowledge of how it was constituted (for instance, that it is a composite based on many different types of data), combined with a distrust of the system that produced it.

Participants condemned the star ratings as ‘irrelevant’, ‘manipulated’, ‘untrustworthy’ and generally devoid of any useful information about clinical quality. They were aware from media stories that a non-clinical domain such as financial performance could reduce the number of stars allocated to a hospital with an excellent clinical reputation. One GP described his experiences in relation to the collection and reporting of accident and emergency (A&E) data by a particular hospital:

They brought us all the way down from Croydon, six doctors for about two or three weeks just before they made up the [A&E waiting time] numbers so the waiting time would be about five minutes. And after that was looked into they kicked us out and the waiting time was back to three or four hours or six.

(Croydon)

Two other GPs who doubted the validity of existing data, whether from the Department of Health or from local trusts, illustrated how this distrust extended to emerging data to support choice:

My experience in this area is that the newsletter sent out by the trust on a regular basis was... what did we used to call it... was it the comic strip? It bore no relation to reality at all. Now they have populated the directory of information so there is no trust between the GPs and that information.

(Dudley)

Don't believe any of it, they tell you that the parking is this, that and the other... you know, and the access is easy, you know, they told me the access was easy to [Hospital X] and I say 'well you've never been there'.

(Crewe)

A sizeable minority of GPs also spontaneously described methodological reservations, reflecting an awareness of the statistical implication of data on small patient numbers and the importance of adjusting for the effects of case mix. With prompting, many others agreed that they would consider data more reliable if they took into account case mix. This distrust extended to a view that hospital managers might deliberately try to influence case mix to improve figures and there was also a view that it might be more difficult for GPs to interpret data from hospitals with which they were not familiar.

Can I just say, you're talking about the number of surgical procedures in identifying the quality of surgical care, it's so easy to manufacture that sort of data... They showed me that [my local] trust, or [local] department had to come up with so much more because [it was] there in the national average, compared to a gold standard of 99.99 per cent of day surgeries. And we just were shocked and sat there, and somebody was good enough to point out that that hospital has got only a day care centre, it doesn't have an inpatient operation unit!

(Ashford)

Although I'd be worried about the quality of the information and the stats. I can see all that information could be very easy to touch up.

(Yeovil)

For example, it tells us about surgical procedures but some surgical procedures last a few minutes, others last hours where we would expect mortality or morbidity to be higher.

(Westminster)

And how do we know that readmission rates and reinfection rates are a true reflection of the quality because it's dependent on the type of patients they're admitting? Statistics, the raw statistics aren't everything.

(Crewe)

I mean do you know what you're actually measuring? It may be that they're a kind of tertiary referral centre. You know cardiology at [Hospital X] might do much more sophisticated work than the cardiologist at [another hospital]...

(Westminster)

Well I said if you're looking at other hospitals you've no experiences on, it's the same with schools and everything else. There are statistics published which really it's impossible to interpret. You don't know the quality of the patients going in and readmission rates could be related to a lot of variables.

(Crewe)

Pragmatic participants argued that, although the quality of the data is not great, referrals have to be made. Sceptics expressed concern that to actively provide advice to patients on the basis of such methodologically problematic data could result in blame – or even medico-legal action – from patients if their treatment went wrong.

But with choice comes responsibility, and they can't come back to me in the end and say 'oh Doc, you gave me one of those three options, and by the way the one I ended up choosing was rubbish. And thank you very much for that, I'll see you in court!'

(Ashford)

The combination of the informal information described above and sub-optimal official performance data was seen by many GPs to form the best available knowledge base on which to base advice to patients. As one GP summarised, 'It is difficult to find out and that's the honest truth.' And another expressed his reservations as follows:

At the end of the day it's a leap of faith. Because there are so many factors, albeit the Department of Health can write these nice little things about there's car parking, there's this, there's MRSA etc, you're never really going to get a true picture. And whatever your knowledge base, whether it be acquired from your mates or whatever, it's never totally foolproof.

(Ashford)

PRESENTATION OF INFORMATION

We were interested in participants' preferences for the style in which performance information should be disseminated. We showed them four different ways of presenting the same 'exemplar' information for a hypothetical cluster of hospitals. Two of the examples presented raw data in numerical and graphical form and the other two compared each hospital's performance to all the others in the country using colour coding or stars to allocate them to a particular band. Some measures were by consultant and some by hospital. Not surprisingly, given GPs' distrust of hard or formal data from official sources and preference for informal sources, many GPs' initial reaction was scepticism about the validity of the data. We asked them to suspend disbelief about this and concentrate on the different presentational styles.

Clearly it is not appropriate with a focus group methodology to quantify the results but it is possible to get an impression of the range and frequency of responses. In addition to comments (reported above) on the Healthcare Commission star ratings, GPs commented on the four other forms of data presentation. No single way of presenting the data emerged as a clear favourite. Different individual GPs and different groups expressed different views. For some the traffic-light-like colour coding system worked well, while it utterly confused others. One asked: 'Does highest quartile for waiting time mean you wait longer or that their performance is good and they see you quickly?' With a response from another GP to think of it like a traffic light – 'green means go. Get on with it'. This confusion is well exemplified by the following interchange that took place in Crewe:

But it's confusing though because cancelled operations by specialty is red and presumably that's good because it's low.

(GP A, Crewe)

No, it's high.

(GP B, Crewe)

Is it? Are they? No red is the lowest quartile.

(GP A, Crewe)

Yes.

(GP B, Crewe)

So they're in the lowest quartile.

(GP A, Crewe)

Lowest quartile of performance.

(GP B, Crewe)

Ah right, okay, right, it doesn't say that.

(GP A, Crewe)

There was also some confusion about elements of the terminology used, such as 'quartiles', and frequent requests for a national average for each measure to be presented as a benchmark for all data. Some expressed a strong preference for seeing absolute numbers but there was only limited awareness of the statistical issues associated with such analyses. Others recognised these problems and stated that they couldn't make any meaningful judgements about who had performed well without some information on the complexity of the cases being measured.

Among GPs who preferred information sources that presented numeric data, preferences were equally divided over tables of numbers versus bar-chart formats. These values were argued by those who like them to be easier to explain to patients and generally more meaningful:

Yes, I think it's much easier this and it's easier to discuss with patients, you know you've got a two per cent chance of something or other, not one star chance.

(Crewe)

For me, if I'm the patient making the choice, this is what I'd want. I'd want precise percentages, numerical values... Because you know, you know precisely where you are with this [readmission rates]...

(Ashford)

The traffic-light system, not many people... was it quartiles you're using there? It's like 'excuse me? I beg your pardon?' No one really deals with that in real terms, I mean everyone knows if they buy a beer for £2.20 they want 80 pence out of their £3.00 in change. I mean, this is just...

(Ashford)

Those who favoured the comparative presentation of data with each hospital assigned to a quartile range felt it was more straightforward to understand. But the two quotes below suggest even this is not straightforward:

You're looking at specific numbers, which can vary from week to week, from month to month, so unless they're updated on a frequent basis I don't feel it's very useful... The star rating is much simpler.

(Croydon)

I would say if you're going to be discussing it with patients I would go for the star rating. For my own personal information I like [the bar chart] with the proviso, as we were saying, that it has to be updated, it can run out of date reasonably quickly.

(Croydon)

These mixed views on presentational preferences reflect what we have already noted – that GPs are a heterogeneous group with heterogeneous views and preferences. Combined with the comments above on methodological concerns about data, these quotes illustrate the problems GP have in deciding which patients should go where.

EXAMPLE A: PRESENTATION OF DATA ON CARDIAC REFERRALS USING TRAFFIC LIGHTS

Organisation	Hospital A	Hospital B	Hospital C
Number of Healthcare Commission stars	★★	★	★★★
Referral information			
Pooled or named consultant referral	Consultant	Pooled	Pooled
Waiting times			
Time from referral to treatment			
Number of surgical procedures performed per year			
Outcome data			
MRSA bacteraemia rates per 1,000 bed days			
Surgical site infection rates by specialty			
Readmission rates by specialty			
Standardised mortality ratio by specialty			
Average length of stay by specialty			
Convenience and efficiency			
Cancelled operations by specialty			
Patient satisfaction by specialty			

Key

- Top quartile
- Inter-quartile range
- Lowest quartile

EXAMPLE B: PRESENTATION OF DATA ON CARDIAC REFERRALS USING STAR RATINGS

Organisation	Hospital A	Hospital B	Hospital C
Number of Healthcare Commission stars	★★	★	★★★
Referral information			
Pooled or named consultant referral	Consultant	Pooled	Pooled
Waiting times	★	★★	★★
Time from referral to treatment	★★★	★	★
Number of surgical procedures performed per year	★★	★★★★	★★
Outcome data			
MRSA bacteraemia rates per 1,000 bed days	★	★★	★★★★
Surgical site infection rates by specialty	★★	★	★★
Readmission rates by specialty	★	★★★★	★
Standardised mortality ratio by specialty	★★★★	★★★★	★★
Average length of stay by specialty	★	★★	★★
Convenience and efficiency			
Cancelled operations by specialty	★	★★	★★★★
Patient satisfaction by specialty	★★★★	★★	★★★★

EXAMPLE C: PRESENTATION OF DATA ON CARDIAC REFERRALS USING NUMERIC VALUES

Organisation	Hospital A	Hospital B	Hospital C
Number of Healthcare Commission stars	★★	★	★★★
Referral information			
Pooled or named consultant referral	Consultant	Pooled	Pooled
Waiting times	8 weeks	6 weeks	7 weeks
Time from referral to treatment	12 weeks	14 weeks	14 weeks
Number of surgical procedures performed per year	370	720	424
Outcome data			
MRSA bacteraemia rates per 1,000 bed days	0.41	0.21	0.16
Surgical site infection rates by specialty	2%	5%	1.8%
Readmission rates by specialty	3.6%	1.3%	4.9%
Standardised mortality ratio by specialty (100 = average)	85	98	101
Average length of stay by specialty	8	7	6
Convenience and efficiency			
Cancelled operations by specialty	1.2%	0.9%	0.49%
Patient satisfaction by specialty	89%	78%	83%

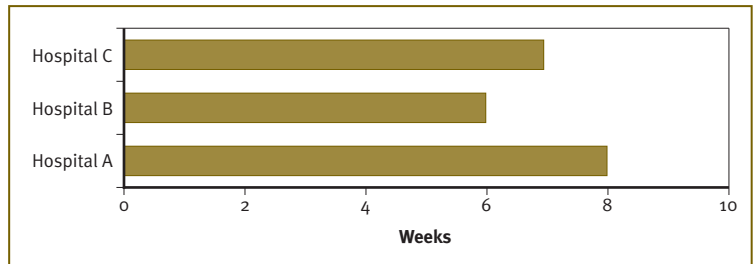
EXAMPLE D: PRESENTATION OF DATA ON CARDIAC REFERRALS USING BAR GRAPHS

Referral information

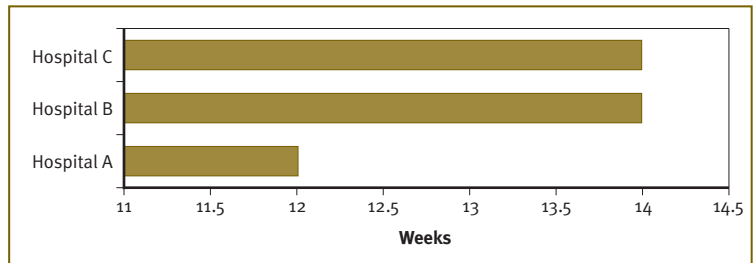
Pooled or named consultant referral

Hospital A: consultant
Hospital B: pooled
Hospital C: pooled

Waiting times

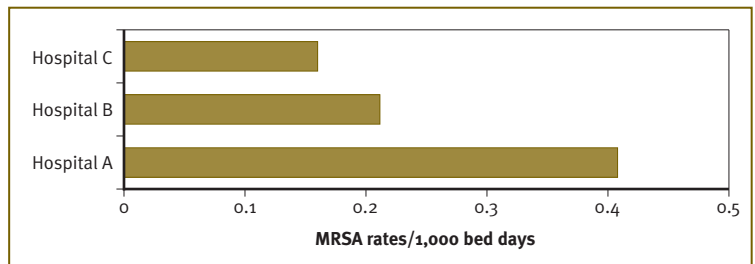


Time from referral to treatment

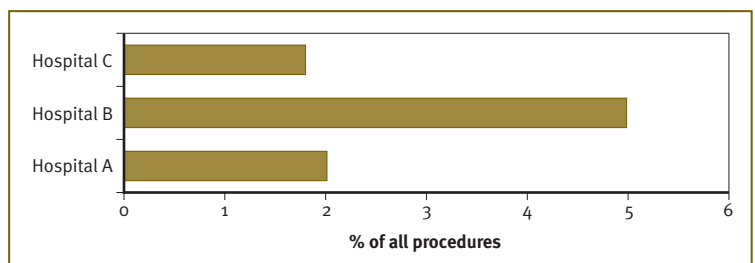


Outcome data

MRSA bacteraemia rates per 1,000 bed days

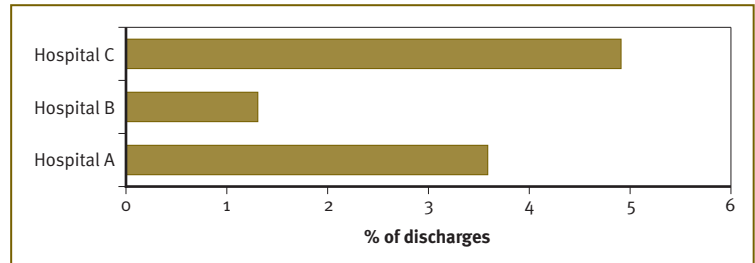


Surgical site infection rates as percentage of all procedures

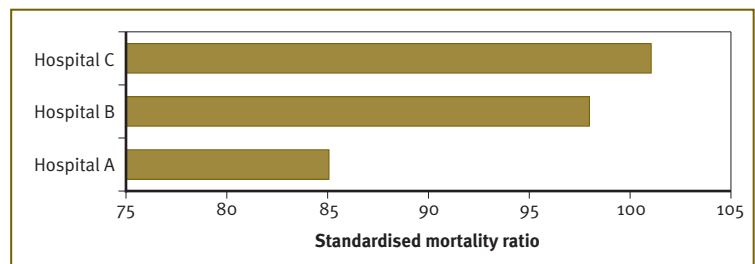


Outcome data *continued*

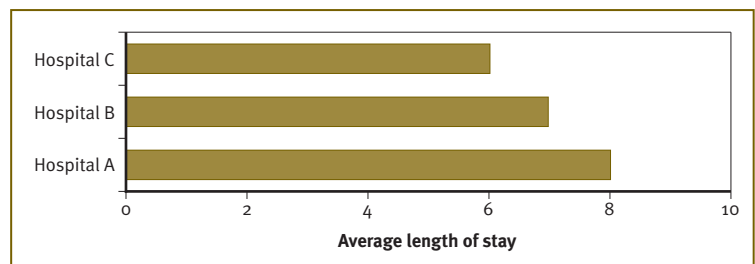
Readmission rates as percentage of discharges



Standardised mortality ratio by specialty (national average = 100)

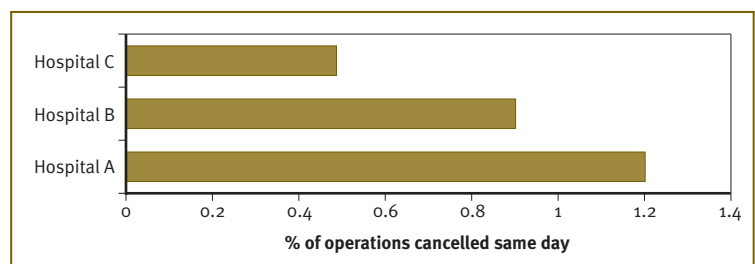


Average length of stay by specialty

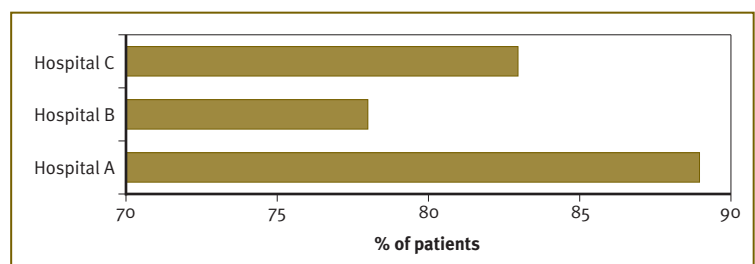


Convenience and efficiency

Percentage of operations cancelled same day by specialty



Percentage of patients satisfied or very satisfied with their care



CATEGORIES OF INFORMATION TO SUPPORT CHOICE

We asked GPs what categories of information were most important when choosing which consultant or hospital to refer to, giving them a choice of five different domains: clinical care; patient experience; access; facilities; and waiting times. A clear majority of GPs felt that clinical care was the single most important category, with information about waiting times second.

...because what we'd say is 'it's a real bugger to park and it's this, that and the other, the food's terrible but actually your care's going to be OK'.

(Crewe)

There is no point sending them to the Ritz if they haven't got the clinical outcomes.

(Westminster)

At the end of the day you are there to provide a health service. It is very nice to have things like a nice menu and Sky television but that's not important compared to the clinical outcome. The rest is just window dressing.

(Westminster)

Well, quality and waiting times really. I think those two parameters from my point of view are the most important ones.

(Croydon)

As noted above, many GPs argued that patients might have different priorities that vary according to circumstances. We noted above that the two most frequently mentioned domains thought to be of importance to patients were waiting times and convenience of access. However, these were often not seen as a GP's concern, so patients could research and assess those categories of information without GP support. Some felt that patients were more likely to prioritise non-clinical aspects, whereas, for doctors, clinical care was the most important factor.

I mean, for instance, the hospital facilities, parking, visiting hours, cleanliness of toilets that can all be on a website and patients can find that out for themselves. I don't want to be involved in that. But as far as I'm concerned, that is purely about their comfort. What I want to know is the competence of the surgeon, ie, what his disaster rates are, I want to know the infection rate of the hospital, I want to know the time that they're waiting, I want to know the length of stay and whether they are actually discharged appropriately at the right time, with the correct care organised for them afterwards. That's what I want to know. That's what would actually matter to me.

(Ashford)

Most patients when you say you're referring them will say 'when am I likely to be seen?'... That is the most important thing for the patients, not 'I don't want to be seen at [Hospital X]'.

(Croydon)

Everyone has different aspirations so for some people it might be ease of access, public transport and parking, for other people it might be I want the best top-quality surgeon who's going to do the best job, for other people it might be I want a hospital that's clean.

(Croydon)

The impact of patient characteristics on equity in choice

KEY FINDINGS

- For all GPs the single most important equity issue was access and the constraints of geography and transport. This was felt most acutely by GPs in rural areas but was present even for GPs in inner cities whose populations were deprived or elderly.
- There was a related view that choice was of interest to only a minority of informed privileged patients who had always been able to exercise more freedom in choice of provider.
- Many GPs do not see choice as an equity issue because they do not see it as providing benefit for patients.
- GPs saw practical difficulties in involving some groups of patients in discussions on choice but there was only limited support for spending extra resources to enable these patients to make choices.
- ‘Choice advisers’ and ‘choice support centres’ were proposed as ways of helping people with difficulty in obtaining information and/or making choices but many GPs were worried about the potential costs involved.

We asked GPs whether they felt an obligation to offer choice to all their patients, regardless of characteristics such as ethnicity, social class and language. A minority saw this as a moral obligation, emphasising their determination to treat every patient equally – even if this slowed down their consultations. Others were candid about their inability to achieve the same level of understanding about different services in all their patients. They cited language barriers, intellectual capacity and personality type as key determinants of what they would be able to achieve.

And we have an obligation to give everybody the choice, for every patient that is coming in.

(Ashford)

That's absolutely not possible, all people are at different places, different intelligence levels, different past experiences, different expectations, different levels of anxiety, so it is impossible to actually deploy this in a consistent way across the different social groups, age groups and all the kind of factors that people have.

(Crewe)

Yes, that's right. I hope that I treat my patients equally but I know very well some of them can't be engaged in this so I make the decision for them. But I hope I treat the rest of them equally.

(Dudley)

As already stated, many GPs felt that the choice agenda would only benefit those already able to exercise considerable choice. They recognised the political aspiration of extending opportunities available for the insured middle classes to the whole population but many doubted it would work. These observations were speculative but reflected a strong conviction.

I think this is being done in the misguided intention that it will allow people who don't have a current choice to have a choice on the grounds that that may be a good thing to do. I don't agree with that, unfortunately. I think the only people who are going to benefit are white middle-class people... you know who speak English.

(Crewe)

Other participants highlighted other issues, including language and intellectual capacity, as barriers to achieving equity in choice:

There are patients who come in who will say 'I don't want to know too much about it' and there are others who may come along and even though I may want to and I might feel that they need to, there is no way of dealing with it because of their lack of knowledge or my lack of their language.

(Crewe)

If I have got someone who is intellectually challenged, to put it mildly, and I have some of those [patients], it is very difficult. If you are not going to spend a huge amount of time to do it and you have to in the end make the choice for them because I've got patients, and you probably have... who have trouble stringing two words together and I'm sorry, I'm not spending 20 minutes trying to get through this...

(Location not given to preserve anonymity)

More compelling were the comments of GPs from rural areas who had already started to exercise choice and whose direct experience showed them that few people were choosing the lengthy journeys to distant providers. Reported geographical influences on patient choice were particularly compelling, backed up by comments about poor transport links and – in some areas – a population that was largely unused to travelling around the country. In two focus groups held in towns with a single hospital provider, there was a consensus that only around 30 per cent of people were likely to choose a distant provider, with the other 70 per cent held back by a variety of constraints:

I think the other thing around it is that it works very well in big cities, and I don't think it works in rural locations.

(Crewe)

The issue that was evident in all groups and over which there was considerable consensus was around transport and access to non-local services – particularly, but not exclusively, in rural locations.

The transport existed to start with and then it was taken away but you could still arrange it, and now, under the contract, you don't have to arrange it and there isn't any. That inhibits patient choice and in some cases will actually deter the patients from attending appointments.

(Yeovil)

There is also the fact that it is a two-tier system because when one thinks about having choice and the need to travel, this assumes one has the economic means to do it and a lot of my patients are elderly and ask for transport. So there is no choice if you don't have the ability to take it.

(Yeovil)

Well no, it is also social and economic class, that I have got a car, as has my wife, I could drive to an appointment at any hospital within 50 miles of here; most of my

patients have not got a car and there isn't a decent public transport service that says they need transport.

(Ashford)

It is also worth noting that among the GPs who expressed doubts about whether offering choice was a benefit to patient, some explicitly said that equity with regard to choice was not a high priority.

And one GP from a minority ethnic group observed that cultural differences between ethnic groups may shape the extent to which information is shared and equal opportunities for choice are created:

In some cultures they don't tell patients all the information, that is the culture. So for some patients that is their culture, they are happier, they don't want to know... There is a lady who came from India or Pakistan and for 30 years I have been telling her what to do and all of a sudden I have to bring in this choice for her? It is not possible.

(Westminster)

The use of an independent choice adviser was raised as a way of increasing equity and improving access to information for those without sufficient resources. Most GPs were sceptical, seeing lack of education among some patients as the principal barrier to informed choice, but acknowledging the opportunity such service may present to overcome language deficits and other practical barriers:

There are so many different languages that come to us in surgery, try and explain a science system where you've got 3.6 per cent MRSA rate you know it's just impossible. I think it needs too much educating really, you couldn't really do it.

(Croydon)

Comments about a potential role for choice advisers or choice advice centres were presented earlier (see p 31) along with other comments expressing concern about the potential costs of such services. The opportunity costs of developing an infrastructure to support choice were raised by several participants.

6

Discussion

This study lays open the anatomy of GP referral decisions: the main influences on GPs' referral behaviour and on their advice to patients about choosing between different providers. It reveals varied current practice and highlights how GPs combine formal and informal information when they advise patients about referrals. Not every GP felt that they had a role in advising about choice. In terms of the information GPs are looking for to underpin their role in patient choice, the study revealed little consensus. There was significant distrust of data produced by NHS organisations about their own services and facilities. Recognition of the methodological problems associated with clinical outcomes data also influenced GPs' views about using such data as a basis for actively advising patients.

Overall, most GPs were pragmatic when deciding where to refer patients; decisions had to be made – with or without patient involvement in the choice – on the basis of sub-optimal information. They integrated available information into their thinking in different ways and, in their view, patients do something similar. At present, most GPs make referral decisions without reference to patients but recognise that, in future, more patients will want to participate in them. Some envisage involving patients by handing over the necessary information to them and leaving them to work through it, while others will actively advise patients.

In relation to equity, there was general recognition that in rural and small town settings, served by a single local hospital, distance and travel to alternative providers will act a significant barrier to patient choice. Other barriers to equity will include individual ability to manage and interpret complex information.

Limitations of the study

This small qualitative study offers detailed exploration of GPs' referral behaviour and support for patient choice. While it is reasonable to think that findings may be generalised to English GPs as a whole, a cluster of methodological points about the study may affect the overall reliability of findings.

- **Small number of focus groups** The six focus groups were held in contrasting rural, urban and suburban locations, involving GPs with differing access to multiple providers. Overall, 30 GPs participated in six focus groups but one involved only two GPs, reducing the opportunity for comments from a wider group to stimulate additional thoughts in these participants. All the groups were characterised by the diversity of views expressed, but the range of experiences and approaches to choice that were described was remarkably consistent across all groups. The 'new' data in each group was typically local anecdotes to illustrate a particular theme rather than illustrating a new issue *per se*. The key findings were remarkably similar across all groups – although the diversity of opinions held was not so obvious in the Dudley focus group.

- **The representativeness of participating GPs** We specifically selected telephone interviewees on the basis of their early involvement with Choose and Book or with choice pilots to avoid the risk of excessively negative responses such as ‘I don’t know’ or ‘I haven’t tried it yet’ rather than ‘I have tried X and I don’t like it because...’. This resulted in an interview group who were unusually aware of choice, with more understanding and experience of Choose and Book, and perhaps more enthusiasm about choice than typical GPs. The main aim of the interviews was to test out the draft focus group topic schedule and to identify gaps or other problems. They fulfilled this aim by revealing additional areas for exploration and the topic guide was duly modified. It is, however, possible that as enthusiasts, the interviewees failed to point out or underemphasised problems with choice that should have been explored during the focus groups.

Participants in the focus groups were recruited in a more random fashion from PCTs that were making good progress with Choose and Book. Participants were all GPs and it is possible that different insights into the implementation of choice would have emerged if other professional groups with a potential role in supporting choice (for example, practice nurses or receptionists) had been included. The groups included GPs who variously supported or opposed choice and had or had not used Choose and Book, as well as those with very mixed views about their role in choice. As such the focus groups were likely to be more representative than the phone interviewees. However, an important limitation of the study is the fact that although it describes how these GPs say they will respond to choice, we cannot be sure that this is what they will actually do in practice. The recommendations that follow must be considered with this fact in mind.

- **Time-bound nature of the study** The study took place at a particular point during the introduction of patient choice. The views expressed in the focus groups were inevitably restricted by GPs’ limited experience of using Choose and Book and a changing awareness about choice among both patients and doctors (as evidenced in recent surveys (MORI 2003, 2005) at a time when active pursuit of choice by patients is limited. It is hard to know how responses might change as awareness of choice grows. Work by Coulter and Jenkinson (2005) shows that around 25 per cent of patients do not want to actively participate in decisions about their care, but the other 75 per cent do want to. The surveys mentioned above reveal growing public awareness about choice that may change patient expectations of their GP in the near future. The same focus groups conducted 6–12 months from now may produce quite different results if GPs start to experience more pressure from patients to involve them in choices about referrals. It is also possible that a different study design – following individual patients with specific conditions through a longitudinal series of choices about diagnosis and treatment – would have revealed variations in GP support for choice at different stages of an illness or condition. Exploration of this idea would require additional research.

Application of key findings for the development of choice

It is important to interpret these findings in relation to the context in which they have been obtained. Current policy is predicated on an assumption that better information will support a better and more informed type of rational decision. In reality, there are various constraints on the rational integration of information into personal decisions. The problem of information overload is well recognised (see, for example, Berger 2003 and Hoffman 2005). Other authors have discussed patients’ need for skills in making complex and

unpredictable decisions (Hastie and Dawes 2001) and their desire for support and advice on how to understand and use available information (Rosen *et al* 2005).

There is also research exploring how doctors use information to make clinical decisions, describing how the influence of formal information is modified by context and experience (Chinburapa *et al* 1993; Denig *et al* 1993). GPs in this study were clearly aware of the importance for patients of the practical characteristics of different providers and they gave different views on how to obtain relevant information and build this into referral choices. However, it is the additional element of patient values and preferences that cannot be so easily captured through information. Our classification of GPs as paternalists, enthusiasts and sceptics goes a little way towards revealing the range of GP responses to incorporating patient preferences into referral decisions, but our study did not explore how GPs support underlying choices – about whether a treatment (that is, referral) is wanted at all and which type of treatment (for example, conservative versus medical versus surgical management) patients prefer.

Recognising, then, that the study has been conducted to support current policy assumptions, and not to examine constraints on choice, what are the implications of the findings for the practical support needed to embed choice into routine clinical practice? What do the findings tell us about how to engage GPs and provide the necessary information to equip them to advise patients? What about ensuring that choice is equally available to everyone? Below, we discuss the findings and make recommendations about possible methods to engage GPs in choice and to enable them to support patients in making choices. The recommendations should be seen as those of a small-scale study of how GPs report they will behave in the future. They reflect early GP responses to choice and Choose and Book that may change as their experience grows. They should be considered alongside other current studies and in the light of existing literature on the limits to rational informed decision-making.

IMPLICATIONS FOR ENGAGING GPs IN SUPPORT FOR CHOICE

We know from the Discrete Choice Experiment (DCE) (Burge *et al* 2006), conducted at the same time as this study, that, when choosing between different hospitals, patients value information about how an intervention will affect their health and information on the ‘experience of care’ particularly highly. Advice from their GP was also highly valued but was unlikely to override other information sources unless their advice was negative towards a particular provider. A King’s Fund study of public views about choices found that those who were enthusiastic about choice were also concerned about how to obtain and interpret the information they needed for choice and typically wanted GPs to advise them (Rosen *et al* 2005).

Our findings demonstrate a number of important points in relation to the first two research questions defined on page 5:

1. How far is current referral practice shaped by existing relationships and knowledge of providers, and how much by objective information on quality?
2. Are GPs proactive (that is, initiating advice) or reactive (responding to requests for advice) when advising patients about referral choice and do they steer patients in a positive or negative way?

The relevant findings are as follows:

- GPs envisage different roles for themselves in advising patients about choice. ‘Enthusiasts’ envisage proactively informing patients about different hospitals and actively engaging with them to support decision-making. But we also encountered ‘sceptics’, who wanted simply to hand over information and leave patients to decide, and ‘paternalists’, who continue to want to advise patients about the best place to go to. Very few GPs said they simply would not advise patients about choosing between different providers but, at present, the majority will wait to be asked for advice by patients.
- GPs described being particularly influenced by information relating to quality of clinical care, waiting times and convenience of access, with the majority emphasising the importance of clinical quality over other factors. (This was true when describing patient referrals and even more evident when considering referrals for themselves or a relative.) GPs described patients as valuing an overlapping group of aspects of care but, typically, with more emphasis on access and waiting times than on clinical quality.
- The information GPs use to inform their referral decisions combines formal and informal information. The latter is obtained from multiple sources (patient comments, consultant letters, personal knowledge of consultants, clinical experience of complications, and so on) that are hard to measure. The balance between use of different information sources when deciding on or advising on a referral varies from doctor to doctor and for the same doctor in different circumstances. And as one doctor pointed out: ‘I wouldn’t like to commit to paper why I choose. I wouldn’t like to stand in a court of law and say I wouldn’t send someone to there.’
- Although many GPs are sceptical about the validity and/or methodological quality of formal information such as published data on clinical quality and outcomes (including waiting times), many will combine this information with their informal knowledge when making referral decisions or advising patients. If the sum of information is ‘neutral’ – suggesting all of the departments or clinicians they know about are perfectly OK – they will either do a ‘default’ referral to the closest provider or that which seems most convenient to the patient or respond positively to patient preferences for a particular provider (as long as PCT policies allow this).
- GPs will, typically, only try to influence or override preferences expressed by a patient if they believe, through a combination of formal and informal information, that a specific consultant or hospital department is particularly good or particularly bad – or if they are aware of sub-specialty interests or hospital facilities that are relevant to the patient.
- There was widespread concern that – with the advent of Choose and Book – informal knowledge about distant providers would be lacking, although it might build up over time as patients report on their experiences at other hospitals. But for the time being GPs envisage that there will be a gap in their knowledge.

Our observation that GPs use a variety of formal and informal information is consistent with the conclusions of a study of the impact of Scottish clinical resource and audit data on four groups of stakeholder decision-makers by Mannion and Goddard (2000). It is also worth considering these findings alongside those of the DCE. The DCE concluded

that patients particularly value information about impacts on health. This information is typically methodologically difficult to collect and little is available. Selected hospitals and departments collect post-intervention SF36 data (see, for example, BUPA 2006) and a few specialties collect and publish selected clinical outcomes (Society for Cardiothoracic Surgery in Great Britain and Ireland 2006). The informal information that GPs typically carry in their head may be seen as a substitute for formal sources of information about outcomes and quality that are not available.

Advice from GPs may be the main information available to patients about the clinical quality of many specialties, hospitals and departments. Another possibility is that patients find it too hard to cope with obtaining and evaluating complex clinical information. In these situations, obtaining advice from a GP could be seen as a rational course of action.

We suggest above that GPs will typically only assert such information (with or without being asked) if it indicates poor or excellent care in a particular provider. The DCE findings that patients are particularly sensitive to negative recommendations from GPs suggest that one of the reasons patients seek advice from GPs is in case it warns them off a particular provider. Our findings suggest that GPs also try to steer patients towards particularly good providers or clinicians but the DCE findings showed less patient sensitivity to such advice. This is perhaps at odds with findings from another study, which concluded that GPs want to act as signposters towards information rather than as advisers *per se* (MacKenney 2005).

Recommendations for practice and policy

In practical terms, advice from a doctor about which provider to choose seems to have a significant effect on patient choice and is particularly relevant where there is informal evidence of poor performance or very good performance. Given our observation that GP advice is underpinned by informal information carried in their ‘mental filing cabinets’, it seems that GP involvement in supporting patient choice should involve more than simply identifying possible providers, distributing leaflets and leaving patients to decide.

- ✓ Work to engage GPs in supporting patient choice should emphasise and provide evidence for the extent to which patients value GP advice.
- ✓ GPs’ informal knowledge about local services should be recognised as a legitimate influence on patients’ decisions about choice until such time as more valid and reliable outcome data is available.

IMPLICATIONS FOR THE ONGOING IMPLEMENTATION OF CHOOSE AND BOOK

Our findings about early experiences of Choose and Book shed light on how to enhance patient access to the range of information and advice they need. The data also highlights the constraining influence of referral management centres and restrictions on which organisations can join the choice menu, with implications for the implementation of Choose and Book.

Many GPs did not see it as an appropriate use of their time to talk through data on waiting times and hospital facilities. Most saw it as part of their role to advise on clinical quality,

although, as noted above, would typically do so only if specifically asked. A few saw even this advice as beyond what should be expected of them – either due to medico-legal risks or due to a consumerist view of choice that patients should take full control of and responsibility for reviewing available information and making their own decision. These views about how GPs should be involved shaped the way in which Choose and Book was organised in different GP surgeries.

We described four different ways in which Choose and Book is being implemented within practices and a fifth approach at PCT level involving referral management centres. While it seems reasonable to assume that technical problems and information deficits in Choose and Book will settle down, the organisation of Choose and Book in practices has longer-term implications for patient access to GP advice.

Many practices are organising Choose and Book in ways that depend on reception staff or secretaries to advise about different providers and make bookings. These arrangements may deprive patients of access to the informal knowledge held by GPs.

Frustrations about constraints on named consultant referrals – though not universal – are also potentially important. There is good evidence that different consultants achieve different clinical outcomes (*see, for example, Harley et al 2005*) but there is little routine data to describe these variations locally. We described above how GPs resort to judgements based on informal knowledge. It is beyond the scope of this study to judge the validity of comments made in focus groups about ‘not touching somebody with a bargepole’ or ‘not sending a dog there’. We have presented a range of comments to explain how GPs develop these opinions, and to demonstrate their significant scepticism about NHS data. The willingness of many GPs to make recommendations to patients based on a blend of formal and informal information could be seen as a pragmatic response to uncertainty; in situations of uncertainty, we often rely on the recommendations of trusted advisers, and GPs are the most trusted professional group in the country (British Medical Association 2004). It is perhaps unsurprising that many patients want GP advice about choosing a provider.

Our data suggests that informal knowledge about most consultants will not attract particular attention from GPs. But where it does – for reasons of good performance or bad – many GPs want to be able to steer patients specifically towards or away from specific clinicians. Constraints on referrals to named consultants restrict this ability.

Descriptions of the impact of referral management centres were speculative and lacked any formal evidence. A cluster of GPs from Yeovil and Croydon were concerned that their own advice to patients would be over-ridden by referral management centre staff pursuing PCT-driven goals about waiting lists and pre-paid contracts with independent providers. This raises interesting questions about the scope of advice given by non-clinical advisers – be they in referral management centres or in other possible settings (for example, ‘choice advisers’ in high street settings as suggested by some participants) – and the interplay between formal and informal information. With many GPs resisting giving advice on non-clinical characteristics of providers, the availability of specialist advisers must be welcome. It would, however, require a detailed study of interactions between patients and referral management centre staff to understand the way in which their advice interacts with any clinical advice the patient may have received from a GP.

Recommendations for policy and practice

We have argued that GPs have an important role to play in advising patients that cannot be passed on to others in the practice. Their informal knowledge of clinicians and departments represents an important source of information – particularly in relation to excellence or poor performance.

- ✓ Future guidance on implementing Choose and Book/choice should stress:
 - a central role for GPs in advising on clinical care
 - the domains of knowledge and competence of non-clinical choice advisers and bookers.
- ✓ Where referral management centres exist, there should be explicit policies about the range of advice that can appropriately be provided and the way in which it is imparted to ensure that it complements advice from the GP or other referring clinician.
- ✓ Choose and Book systems should include the option to refer to a named consultant as a default setting that is only removed as a result of a specific local decision.
- ✓ PCT rules for developing a choice menu should allow clinical departments in local hospitals to be included even if they have long waiting lists.
- ✓ Further research is needed to understand how non-clinical advice to support choice is mixed with informal clinical information and what impact this has on patient preferences.
- ✓ There may be medico-legal consequences if advice from GPs is overturned after discussion with a choice adviser or vice versa.

IMPLICATIONS FOR DEVELOPING INFORMATION AIMED AT GPs TO SUPPORT CHOICE

The study set out to address the following three questions in relation to GP information needs (see p 5).

3. In the new choice environment, what kind of information on quality and other issues do GPs want in order to support the advice they give to patients?
4. What are GP preferences in terms of the content, style and presentation and scoring or ranking mechanisms for information on quality?
5. How sensitive are they to information, at what threshold would they change their advice, and do they have a preference about how they would like this information to be presented?

There was remarkably little consensus about the range of information required and about preferred style of presentation. Consensus did exist that hospital star ratings were irrelevant to clinical decision-making. There was marked support for providing data on MRSA rates – because patients were interested in this issue – but also concern that patients may overvalue this information in the face of extensive press coverage. Waiting list data was considered important but often distrusted and clinical outcomes data was desired but seen by some to be methodologically problematic. These qualitative findings are slightly at odds with other reported findings, which reveal waiting list data to be the most highly valued domain for GPs as well as patients, although outcomes data was not far behind (Doctors.net 2005).

The distrust of data produced by NHS organisations about their performance was typically based on personal experience of the methods used to distort data (such as A&E figures) in order to meet targets. This led many GPs to downgrade the value of specific data sets but not to reject it all together. For example, many participants described their pursuit of short waiting times or a conveniently accessible provider to which to refer. These data sets were typically blended with formal and informal clinical information – with or without consultation with patients – in order to decide where to refer. We did not investigate their preferences for printed booklets comparing performance data across different providers, and some claim that GPs find these particularly useful.

For other domains of information, the methodological problems raised by a small cluster of participants alerted other group members to their potential problems. This led some participants to re-emphasise their preference for referring to a department rather than a named clinician since data at departmental level would be less susceptible to the effects of small patient numbers.

In terms of presentation style, there was again no consensus and a range of quotes was presented to illustrate how doctors defended their personal preferences. Confusion over some of the terminology indicates a need to pilot different forms of information in order to avoid such problems.

Finally, the issue of a specific threshold or data value at which they might change their advice to patients was impossible to pin down due to their higher level concerns about the accuracy and validity of available data. Comments about steering patients towards or away from particularly good or bad providers (see pp 18–19 and pp 21–22) suggest that some sort of threshold exists but we were not able to identify a quantitative value to define the threshold.

Recommendations for policy and practice

- ✓ Performance data about different providers should be available in multiple formats that allow online information users to manipulate the data into the format of their choice (see, for example, National Committee for Quality Assurance 2006).
- ✓ As data sets are developed they should be piloted for both their clarity and credibility before they are widely disseminated.

IMPLICATIONS FOR ENSURING EQUITY IN CHOICE AT POINT OF REFERRAL

The study set out to investigate the following question in relation to equity in choice (see p 5).

6. Do patient characteristics affect the extent of GP involvement in choice and how can choice be delivered equally to all groups?

The strongest consensus was that in locations with a single local hospital, many miles from other providers, choice was meaningless for the majority of patients. The need to provide excellent services in the local hospital was stressed repeatedly to ensure local residents who could not (or did not want to) travel to distant providers did not lose out.

We did not survey the socio-economic circumstances of the patients from rural practices but repeated comments suggested that middle-class car drivers would be the least disadvantaged. Recent announcements about NHS payments for travel costs to alternative providers go some way to improving this situation (NHS in England 2006). However, the other factors that restrict willingness or ability to travel, such as older age and physical pain, will not be resolved by the hospital travel cost scheme.

Aside from geography and travel costs as restrictions on equal uptake of choice, there were mixed views on the impact of other patient characteristics. A general feeling was expressed that language differences, lack of knowledge and lower intellectual capacity restricted the ability to choose. This triggered a range of responses in GPs. Some were determined to give an equal opportunity for choice to all – even if overcoming barriers would take a long time. Others felt that not everybody was capable of processing the information needed to make choices and they would not be able to treat everybody equally. These perceived barriers to choice are likely to be more prevalent in lower socio-economic groups and selected ethnic groups – with the possible implication that choice will be less popular in these groups. Yet findings from the British Social Attitudes survey (Appleby and Alvarez-Rosete 2005) show that people on lower incomes and in semi-routine and routine occupations are more pro-choice than professional groups.

The potential for choice aids or advisers to support individuals in making choices offers one way around the above problem. We have already flagged up the potential difficulties of such a role – for example, if a choice adviser provided advice that contradicts what a doctor has said. Nevertheless, additional support and resources may benefit those for whom choice is difficult.

Recommendations for policy and practice

- ✓ Future guidance on implementing choice should encourage providers to develop and improve transport to their facilities.
- ✓ The costs and benefits should be evaluated of introducing choice advisers or choice support centres aimed particularly at those individuals for whom choice is difficult.

Further research

A number of further pieces of research would usefully add to the work presented here and strengthen the knowledge base to support the further development of patient choice: first, a literature review of what is currently known about the influences on patient and doctor choice and decision-making; second, a longitudinal study of the choices made about investigation, diagnosis and clinical management of specific conditions or symptoms to examine how choice and decision-making varies at different points on the clinical pathway; and third, ongoing research into what GPs actually do as the introduction of patient choice becomes more embedded into daily practice.

Appendix 1: Question schedule for telephone interviews

Overview

1. What hospitals/services do you currently refer to and why? Please give the number and distance from where they are located to your practice and please include tertiary referrals.
2. Do you know how many referrals you make each week or month? If not, could you guess? Would you consider yourself a 'high' or 'low' referrer?
3. What do you think patients want in relation to choice?

Considering your current referrals

1. Do you have any choice of provider at present?
2. What information do you have to enable you to distinguish between services at present?
3. What proportion of patients already are aware they have or will have choice?
4. For those patients who want to choose between providers, what information will you offer to support them:
 - a) proactive (initiating advice) or reactive (responding to requests for advice)?
 - b) positive (towards good) or negative (avoid bad)?
5. What currently available indicators (waiting list, infection, stars) on providers are useful? What is the most useful?
6. If you, or a close relative, need a minor operation (for example, hernia repair) how do you choose a provider at the moment?
7. If you, or a close relative, need a more serious operation (for example, coronary artery bypass grafts (CABG), how do you choose a provider at the moment?

Considering choice in the future

1. How do you perceive recent PCT activity in relation to choice?
2. Do you think you will try to actively support patients in choosing between different providers?

If no, please answer the following questions as if a patient has specifically pressed you to help them make a choice.

3. What information would you like about different local services:
 - a) access and convenience, for example, closeness to facilities, visiting hours, complaints?
 - b) hospital facilities and standards, for example, standard of rooms, food quality?
 - c) patient treatment and care, for example, languages spoken, degree of patient involvement, explanation of treatment options?
 - d) impact on future health, for example, readmissions, side-effects, infection rates, best practice, team experience?
 - e) waiting times from referral to treatment?

4. What information do you think would MOST influence your own referral patterns:
 - a) characteristics and reputation of the hospital?
 - b) relationship with consultant or other hospital staff?
 - c) marketing materials from hospital?
 - d) views on underlying data and composite scores?
5. What information do you think will MOST influence patient preferences in the future:
 - a) characteristics and reputation of the hospital?
 - b) relationship with consultant or other hospital staff?
 - c) marketing materials from hospital?
 - d) views on underlying data and composite scores?
6. In what format do you want information provided to support choice:
 - a) composite scores?
 - b) specific information, for example, on infection rates, mortality rates and case mix, and on clinical outcomes by consultant, specialty and hospital?
 - c) a ranking of local providers against each other or an individualised score for each provider?
7. Do you have any views on the advantages and disadvantages of these different ways of presenting the data?
8. Do you have views about the 'level' or 'threshold' at which such information would influence your advice to patients? For example, would a 'bad' overall score encourage you to steer patients away from a hospital? Or would a ranked score, where a hospital's performance score is given relative to other providers, have greater influence on your referral advice and behaviour?

Equity

1. Do you think you will offer the same level of support for choice to all patients?
2. What kind of patient characteristics might influence the way in which you advise on choice?
3. What would help to ensure equal support for choice for all patients?

Facilitation and barriers

1. What would help or hinder the smooth introduction and successful implementation of choice?

Appendix 2: Focus group topic guide

Practice profile for each GP to be obtained via a short questionnaire.

1. Introduction, short explanation of research, assurance of confidentiality and outline of group process

2. Patient views on choice (5–10 mins)

- What do you think patients want in relation to choice?
- Are many patients interested? If so why?
- What sort of information do you think patients want?

3. Thinking about current referrals (20–25 mins)

- What do you do now when you make a referral? Do you refer to a department or an individual clinician? Offer choice? Discuss options?
- How do you envisage this changing in the future?
- What information do you have to enable you to distinguish between services at present?
- What currently available indicators (waiting list, infection, stars) are useful? Which of these is the most useful?
- What informal information sources do you have?
- Do you know the local consultants? How does that influence your decisions?
- How do you currently use such information?
- If you, or a close relative, need a minor operation (for example, a hernia repair), how do you choose a provider at the moment?
- If you, or a close relative, need a more serious operation (for example, a CABG), how do you choose a provider at the moment?

4. Early experiences of Choose and Book (20–30 mins)

- How do you perceive the following recent PCT activity in relation to choice:
 - software installation?
 - training?
 - supporting GPs' understanding of choice?
- How have you found your early experiences of Choose and Book and enabling patients to choose provider?
- What support or advice do you think you will offer to help patients to choose between different providers? Who will provide this advice? You? A receptionist? A health adviser?

- For those patients who want to choose between providers, will the information you offer to support them be:
 - proactive (initiating advice) or reactive (responding to requests for advice)?
 - positive (steering patients towards good providers) or negative (steering patients away from bad providers)?
- What information would you like about different local services:
 - access and convenience – for example, closeness to facilities, visiting hours?
 - hospital facilities – for example, room standards, food quality?
 - patient treatment and care – for example, languages spoken, degree of patient involvement, explanation of treatment options?
 - impact on future health – for example, readmissions, side-effects, infection rates, best practice, waiting times from referral to treatment?
- Which domains of information do you think will MOST influence your own referral patterns? The characteristics and reputation of the hospital? Your relationships with consultants or other hospital staff? Marketing materials from hospitals?

5. Presentation of information

- What are your views on the advantages and disadvantages of these different ways of presenting the data? What's good and bad about summary scores such as hospital star ratings, scores for different domains of hospital performance (for example, cleanliness, access, service), raw data, and benchmarking of one hospital's score against the national average, etc?
- What are your preferences between basic data adjustment (age/sex/case mix) or modified data that allows the presentation of data in different currencies into a single/summary score (for example, regarding cleanliness – how to combine infection rates with patient views gathered in a survey versus Healthcare Commission inspection report, etc)?
- In what format would you most like the information provided to support choice (interactive session using laminated cards to compare the following formats):
 - composite scores?
 - specific information – for example, on infection rates, mortality rates and case mix, and on clinical outcomes by consultant, specialty and hospital?
 - a ranking of local providers against each other, or an individualised score for each provider?
- At what level or threshold would such information influence your advice to patients? For example, would a 'bad' overall score encourage you to steer patients away from a particular provider? Or would a ranked score, where a hospital's performance score is given relative to other providers, have greater influence on your referral advice and behaviour?

6. Equity

- Do you think you will offer the same level of support for choice to all patients?
- What kind of patient characteristics might influence the way in which you advise on choice?
- What would help to ensure equal support for choice for all patients? Would it be the role of GPs, others in the practice or others elsewhere? Other than personal advice, what approaches could support choice?

7. Facilitators and barriers for introducing choice

- What will help or hinder the smooth introduction and successful implementation of choice?

Appendix 3: Key findings from telephone interviews

Views about choice and influences on referrals

All the interviewees felt that patients typically want to be seen as locally as possible and as quickly as possible. Some were sceptical about whether patients actually want more choice, although one London GP argued that her patients were already used to choosing between different providers:

Offering people a choice has always been fairly automatic for us. We also look after a population who are quite demanding and are not afraid of coming in to say 'I would like to be referred to Mr X at such and such a place'. So you see when I read the comics and some GPs being horrified at patients having choice it kind of makes us laugh slightly because our lot have been doing it for years.

(Dr C, London)

The interviews provided initial insights into the referral practices of GPs and the early impact of policies to increase choice. They drew unexpected attention to two themes: first, the ways in which GPs combine published data about the NHS with informal sources of information about hospitals, departments and individual clinicians; second, mixed views about the limits imposed by Choose and Book on referrals to named consultants. These two issues were incorporated into the focus group topic guide for further exploration.

Interviewees stated that their established referral practice was typically shaped by a combination of habit, knowledge about different hospitals and patient preferences. The quote above illustrates that some patients already push for choice. But for other GPs, the key influences on referral practice were the distance to different providers, patient ability and willingness to travel, waiting times, and soft or informal intelligence about local services.

A combination of local geography and patient characteristics were clearly key influences on the amount of choice desired by patients and the referral decisions of one GP:

...it's this thought of – you could go to Peterborough if you wanted, which is 60 or 70 miles away. A lot of them have never been there in their lives... So why on earth would they want to go there?... [Hospital X] would be a good hour's drive with parking and Peterborough further and Ipswich probably an hour by the time you've parked – versus 10–15 minutes drive locally...

(Dr M, Suffolk)

And subsequently, the same interviewee said:

...if you ask a patient to go to [Hospital X], more than 50 per cent of them don't want to go there. Another 50 per cent haven't got a car to go there.

These constraints led the GPs to emphasise the importance of having a good local hospital. But another interviewee described more complex patient expectations, suggesting that a blanket assumption that, in rural areas, people just want a good local provider is too simplistic:

I think first of all patients have a very clear idea about whether they think a local hospital is good or bad, safe or not, based upon what happened to granny, mother, auntie etc. Most patients here, for example, are more than happy to go to any of our local providers, apart from a handful

of people who would have had a horrible experience for whatever set of reasons, so that's the first thing. Patients do have a clear idea where they don't want to go and most of the time if they don't have any absolute contra-indications in their own mind, they want the local hospital that's within walking distance, it's easy to get there.

(Dr B, London)

For three interviewees, the main priority was waiting times. They actively sought out services with the shortest waits and routinely made referrals to 'Dear colleague' rather than to a named consultant so that patients could be allocated to the consultant with the shortest waiting time:

No, we can still refer to a named consultant for most specialties. There are a couple of specialties where that no longer applies. One is orthopaedics but I think if we wrote a letter directly to the consultant I think it is still likely they would pick that up. But I tend to refer to 'Dear Colleague' anyway in order to try to get people in on the shortest wait.

(Dr G, Colchester)

This was in contrast to reports from the others, who quite deliberately chose to refer to a named consultant, drawing on their informal knowledge of different consultants and the departments and hospitals in which they work.

When asked to explain what information they used to distinguish between different services, GPs drew attention to various sources of information about services and consultants:

Well I actually think that 'services' is the wrong title. It's between different consultants. I know how they have reacted to my previous referrals and whether they have talked to a patient or not and I know whether they are interested in a particular area of their specialty.

(Dr S, Crewe)

It would be my personal knowledge of the consultants in the hospital having heard them speak when they come to our practice and hearing about all the complication rates and whether they're nasty to staff and by informal means, getting an idea of who the best locally available was.

(Dr M, Suffolk)

Another interviewee illustrated how she blended the influence of data about waiting times with other information on local services:

We get a [waiting list] report from the hospitals, and our secretary knows very much who is moving quicker on certain fronts. But that's probably the first thought. The second thought is what knowledge we might have about the particular department that might make us choose one department over another. We choose, well let's say we suggest they might do better to go to one place.

(Dr C, London)

The interviewees (selected for their early involvement in Choose and Book or choice) all said they would actively offer patients a choice of provider. However, two mentioned that they were constrained by PCT policies. In one, this was related to a requirement to direct activity to certain local providers, for example, where a contract had been negotiated with a local treatment centre and those slots needed to be filled. For another, a local financial crisis resulted in strong pressure from the PCT to stick with the local provider.

Our PCT has informally told us that they are so utterly strapped for cash that if we did any referrals elsewhere it would be significantly more expensive. So anyone referring anything to [Hospital X] is really doing the PCT and local population an enormous disservice because it's going to cost 15 per cent more with [Hospital X] being a foundation trust.

(Dr M, Suffolk)

Until the advent of Choose and Book, the interviewees said they would typically suggest a particular provider and check the patient was happy with that, rather than proactively offering choice. Where patients wanted to choose a particular provider, they would typically respect this view unless they had a specific reason to try to influence the patient's choice. These reasons may be negative – to steer patients away from a particular provider – or positive – to direct patients towards a better or more appropriate provider or doctor:

I would be interested in advising in a consultation of the choices they should not make on clinical grounds so that if they were going to have an operation that would require high dependency or ICU support afterwards, I would direct them away from choices where they wouldn't have those facilities.

(Dr G, Colchester)

Descriptions of more recent referral practices – since becoming involved in Choose and Book – varied. Two GPs saw the choice agenda as pretty irrelevant for geographical reasons. Two were actively engaging with Choose and Book, although implementation problems were restricting the ability of one to offer choice at the point of referral. Another, London-based, GP with access to several local providers did not proactively offer choice, referring to whichever provider she thought would be most convenient for the patient, stating that most patients simply 'take my advice'. However, she was happy to defer to patient requests for a particular provider if asked. No interviewee indicated they proactively discuss detail about differences between services unless specifically asked to, and even then some felt this was not their role.

When asked to consider how they would make a decision about which provider to use if they themselves or their family required treatment, they generally applied the same criteria they would apply to patients. They also mentioned seeking out additional information about the experience of the surgeon, about clinical outcomes, and about the speed with which they would be seen (although one GP expressly stated he would be prepared to wait longer for a particular consultant).

For tertiary referrals, some GPs expressed confidence in their nearest tertiary provider, and the others said they would seek additional information through their own networks to supplement this. In the words of one interviewee:

I think if I knew that there was a specialist whose outcomes were twice as good and who was up in Leeds I think I might want to go up to Leeds.

(Dr C, London)

Information to support choice

All interviewees saw the availability of reliable information about different services as essential to support choice. For some GPs, the PCT had not yet added information about alternative providers to the Choose and Book system. For another, ongoing problems with Choose and Book were limiting the availability of information to the point where it was almost impossible to make bookings despite his strong support for the policy:

If Choose and Book doesn't work, the alternative the Department of Health have proposed is something called 'manual choice' which means the PCT collates the information by hand, prints that information off and sends it out to GPs on a supposedly regular basis. But when you consider there are something like 300 different clinic types, for which they have to collect information from each and every service provider five different times, there would be 1,500 sets of data of the granularity you are talking about.

(Dr G, Colchester)

At the time of the interviews, the main publicly available information for GPs was seen to be waiting times and star ratings. The Healthcare Commission star ratings were universally distrusted as a

source of information. This was partly as a result of the way they aggregate information such as financial performance with other more clinical markers, making the rating as a whole useless for informing GP referral decisions.

I think some of the hospitals that I would have no trouble going to at all have fallen down on their star ratings for things like financial reasons or people didn't like the food or for something that does not matter when it comes to whether you're going to be OK at the end of the day.

(Dr B, London)

Star ratings are not helpful because they're too general.

(Dr G, Colchester)

Some GPs had been regularly receiving waiting time information. Although this was seen as useful by some, it was felt to be out of date or unreliable by others. One GP reported no longer receiving it since the local trusts had achieved the waiting times targets. Another (see below) acknowledged that, although important to patients, waits tended to be similar even when they looked different.

Length of wait is important to people and it does affect what people want to do and very few people want to wait more than the minimum and they just want it done as quickly as possible and will frequently go for something that's quicker. Most of it is of relatively little use because most of the waits are about the same anyway even if they look different.

(Dr S, Crewe)

WHAT WOULD YOU LIKE TO RECEIVE?

Interviewees were asked specifically about the information they would like to receive about different services, the format in which they would prefer to receive it and their views on the limitations of such data.

Infection rates were frequently mentioned because patients would be interested in them rather than because the information they provided was reliable. One GP felt very strongly that information about MRSA had been distorted by the press and led to patients refusing hospital treatment due to anxiety about MRSA.

The 'hidden' waits for treatment after an initial consultation – particularly surgery (both inpatient and day case) or invasive investigations – were also highlighted as important.

Information about the special interests of consultants was mentioned by some GPs, although many complained they could no longer refer to specific consultants so this would limit how useful it would be. Some of this information was provided by private hospitals. Another claimed that providers 'bombard us with directories about the special interest of consultants'.

WHAT FORMAT?

There was no consensus on how the interviewees wanted information presented. One suggested that information could be available online with high level indicators or 'headlines' that could be expanded to provide more detail if the user so wanted. Alternatively, pivot tables could be used so that GPs could access the particular information they required. Another suggested that printed information could be provided annually in a 'user guide' with an accompanying website that was regularly updated. A six-monthly newsletter was also suggested to alert GPs to new procedures or service changes.

LIMITATIONS OF DATA

All the interviewees acknowledged the limitations of available data, and commented that while an overall score for a hospital could be useful, it could mask differences between departments, wards or specialists within a department. They felt it would be very difficult to interpret the information sensibly – either for themselves or for patients. It was also acknowledged that it would be hard for individual specialists to publish information on outcomes because of the variability of their case mix.

I think when you are in the profession you realise things like infection rates and success rates are very kind of biased assessments... I think for myself like a lot of doctors, we are slightly cynical about published figures that only represent one side of the story.

(Dr C, London)

I don't have time to go through all of those individual [measures] for every individual speciality and make a decision with the patient. But equally any kind of global score is not going to meet my needs either. It won't give me the requirements of actually being able to tell because it will be somebody else's composite score.

(Dr S, Central Cheshire)

Equity of access to choice

Problems associated with equity of access to choice were acknowledged, although views on this issue varied and different interviewees highlighted different areas of potential inequity. One felt that pressure from the local PCT to send patients to a local provider would reduce his ability to offer choice to all patients. Most assumed that patients who were better off and better educated would get a better deal from patient choice.

Well I think that locally our population do push themselves ahead of the queue a bit and I sometimes feel slightly uncomfortable about that knowing that in other parts of the borough there are people who are less bright, with language difficulties and perhaps with less pushy GPs and it's not an equitable arrangement.

(Dr C, London)

One GP highlighted the fact that disadvantaged communities in inner cities were often served by excellent teaching hospitals that were better than the general hospitals servicing the affluent suburbs. She was worried that choice would attract suburban patients to the teaching hospitals, further disadvantaging patients from the deprived areas.

Other factors seen to affect equity of choice included geography, access to a car or other form of transport, level of understanding of the patient and their demands for information from the GP and time constraints within the consultation.

Suggestions for tackling the problems of ensuring equity included use of a referral management centre that had the task of explaining the choice to patients although it was acknowledged that the patient may want clinical input from the GP. One GP thought Choose and Book could increase equity as patients could leave the surgery with an appointment booked, thereby overcoming the problems of lost letters or chasing up referrals. Two GPs said they felt they would make the choice for the patient; this was described by one as 'paternalistic' but by the other as 'advocacy'.

Appendix 4: Practice profile information for focus group participants

ASHFORD FOCUS GROUP

Practice name (PCT)	Singleton Surgery (Ashford PCT)	Kingsworth Medical Practice (Ashford PCT)	Woodchurch (Ashford PCT)	Hamstreet (Ashford PCT)	Wye Surgery (Ashford PCT)
No of sessions	10	8	6	9	7
No of GPs (Full-time)		6		4	6
No of GPs (Part-time)	1	1	3		1
List size	3,000	10,000	3,300	6,200	8,500
No of referrals per week	>10	<5	5–10	>10	>10
High referrers?					
Medium referrers?	✓	✓	✓	✓	
Low referrers?					✓
Secondary care providers referred to	William Harvey	William Harvey Kent and Canterbury St Saviour's	William Harvey St Saviour's	William Harvey St Saviour's Other	William Harvey Private
Percentage of patients referred to secondary providers		90% William Harvey 5% Kent and Canterbury 4% St Saviour's		90% William Harvey 5% St Saviour's 5% Other	75% William Harvey 25% Private
Tertiary providers referred to	Guy's St Thomas'	King's College		Guy's St Thomas'	
Percentage of patients referred to tertiary providers	1% Guy's 1% St Thomas'	5% King's College		40% Guy's 40% St Thomas'	
Computer system	VISION	TOREX	TOREX SYNERGY	EMIS PCS	SYNERGY (PREMIER)
Access to electronic booking?	No	Yes	Yes	Yes	Yes
Are current providers listed?		No	No	No	No
Percentage of bookings made		None – temporarily suspended	<1%	20% decreasing	25%

CREWE FOCUS GROUP

Practice name (PCT)	Ashfields Primary Care (Central Cheshire PCT)	Danebridge Medical Centre (Central Cheshire PCT)	Merepark Medical Centre, Alsager (Central Cheshire PCT)	Grosvenor Medical Centre (Central Cheshire PCT)	Danebridge Medical Centre (Central Cheshire PCT)	Ashfield Primary Care Centre (Central Cheshire PCT)
No of sessions	8	3	9	9	4	8
No of GPs (Full-time)	7	10	3	8	10	7
No of GPs (Part-time)	3	6	1	1	6	3
List size	20,500	24,000	5,900	14,300	24,000	21,000
No of referrals per week	5–10	5–10	5–10	>10	5–10	5–10
High referrers?						
Medium referrers?			✓	✓	Medium to low	
Low referrers?	✓	✓				✓
Secondary care providers referred to	Mid-Cheshire South Cheshire Private Hospital Other NHS Other private	Mid-Cheshire North Cheshire Private Cheshire and Wirral	Mid-Cheshire University Hospital of North Staffordshire	Mid-Cheshire Cheshire and Wirral University Hospital of North Staffordshire	Mid-Cheshire Countess of Chester Cheshire and Wirral	Mid-Cheshire University Hospital of North Staffordshire
Percentage of patients referred to secondary providers	65% Mid-Cheshire 25% South Cheshire Private Hospital 5% Other NHS 5% Other private	80% Mid-Cheshire 5% North Cheshire 12% Private 3% Cheshire and Wirral	60% Mid-Cheshire 40% University Hospital of North Staffordshire	90% Mid-Cheshire 5% Cheshire and Wirral 5% University Hospital of North Staffordshire	7% Mid-Cheshire 7% Countess of Chester 10% Cheshire and Wirral	95% Mid-Cheshire 5% University Hospital of North Staffordshire
Tertiary providers referred to	University Hospital of North Staffordshire Wythenshawe	University Hospital of South Manchester Royal Liverpool		Very few, if any		
Percentage of patients referred to tertiary providers	<1% University Hospital of North Staffordshire	<1% University Hospital of South Manchester				
Computer system	EMIS	EMIS	EMIS	EMIS	EMIS	EMIS
Access to electronic booking?	Limited – not working at moment	No partners using it	Yes – but limited to Leighton and North Staffordshire	Yes	Limited	No
Are current providers listed?	Think so but haven't seen for a while	Not 100% but probably 97%	Yes	No	Don't know	Yes
Percentage of bookings made	<1%		10%	10–20%	<5%	

CROYDON FOCUS GROUP

Practice name (PCT)	Shirley Medical Centre (Croydon PCT)	South Norwood Hill Medical Centre (Croydon PCT)	South Norwood Medical Centre (Croydon PCT)	Morland Road Surgery (Croydon PCT)	Heathfield Surgery (Croydon PCT)	Thornton Road Surgery (Croydon PCT)	Parkway Health Centre 3 (Croydon PCT)
No of sessions	12	9	8	9	10	8	8
No of GPs (Full-time)	2	3	3	4	2	2	1
No of GPs (Part-time)		2	2		3	2	4
List size	5,000	6,000	6,000	7,200	3,800	4,200	2,800
No of referrals per week	10	5-10	5-10	5	5-10	5-10	5-10
High referrers?				✓			✓
Medium referrers?	✓		✓		✓	✓	
Low referrers?		✓					
Secondary care providers referred to	Mayday King's College St George's St Helier	Mayday King's College	Mayday King's College St George's St Helier	Mayday St George's King's College	Orthopaedic Dermatology Cardiac Rheumatology	Mayday St George's St Helier Others	Rheumatology Diabetes IHD Surgical
Percentage of patients referred to secondary providers	95% Mayday 2% King's College 2% St George's 1% St Helier	90% Mayday 10% King's College	85% Mayday 10% King's College 3% St George's 2% St Helier	90% Mayday 3% St George's 4% King's College		90% Mayday 2% St George's 3% St Helier 5% Others	20% Rheumatology 20% Diabetes 20% IHD 60% Surgical
Tertiary providers referred to				St George's King's College	Mayday	St George's	Neurology Orthopaedic
Percentage of patients referred to tertiary providers				50% St George's 50% King's College			20% Neurology 20% Orthopaedic
Computer system	EMIS	EMIS	EMIS	EMIS	EMIS	EMIS	EMIS
Access to electronic booking?	No	No	Yes	Yes	No	Yes via CAS	Yes
Are current providers listed?			Not known		No	No Croydon CAS	Yes
Percentage of bookings made		When available almost all	60%	20%		90%	80%

DUDLEY FOCUS GROUP

Practice name (PCT)	Dr R A Johnson (Dudley South PCT)	Dr R W Gee and Partners (Dudley Beacon and Castle PCT)
No of sessions	9	8
No of GPs (Full-time)	1	4
No of GPs (Part-time)		1
List size	8,500	20,500
No of referrals per week	5-10	5-10
High referrers?		
Medium referrers?		
Low referrers?	✓	✓
Secondary care providers referred to	Dudley Group Sandwell Queen Elizabeth's	Dudley Group Wolverhampton Royal Orthopaedic UBH
Percentage of patients referred to secondary providers	90% Dudley Group 5% Sandwell 5% Queen Elizabeth's	60% Dudley Group 20% Wolverhampton 15% Royal Orthopaedic 5% UBH
Tertiary providers referred to		Wolverhampton UBH
Percentage of patients referred to tertiary providers		50% Wolverhampton 50% UBH
Computer system	ISO + Synergy	Vision in practice
Access to electronic booking?	Limited – web-based interface	Yes – DGOH was a non-compliant system
Are current providers listed?	God only knows!	Yes
Percentage of bookings made	None at all. It is a dog's dinner	<10%

WESTMINSTER FOCUS GROUP

Practice name (PCT)	Westbourne Green Surgery (Westminster PCT)	Bayswater Medical Centre (Westminster PCT)	Maida Vale Medical Centre (Westminster PCT)	Fitzrovia Medical Centre (Westminster PCT)	Mayfair Medical Centre (Westminster PCT)
No of sessions	8	10	8	7	12
No of GPs (Full-time)	2	2	3	3	1
No of GPs (Part-time)				2	1
List size	2,500	7,800	8,000	6,300	2,300
No of referrals per week	<5	>10	>10	5–10	<5
High referrers?					
Medium referrers?		✓	✓	✓	✓
Low referrers?	✓				
Secondary care providers referred to		St Mary's Chelsea and Westminster	St Mary's Royal Free Chelsea and Westminster	University College London St Mary's	University College London St Mary's
Percentage of patients referred to secondary providers		90% St Mary's <5% Chelsea and Westminster	80% St Mary's 10% Royal Free 10% Chelsea and Westminster	95% University College London 5% St Mary's	99% University College London 1% St Mary's
Tertiary providers referred to			National Hospital for Neurology and Neurosurgery		National Hospital for Neurology and Neurosurgery RTNE
Percentage of patients referred to tertiary providers			<5%		? ?
Computer system	EMIS	INPS	EMIS	EMIS	VISION
Access to electronic booking?	No	Yes	Yes	University College doesn't use it and we haven't had training	No
Are current providers listed?	Yes, only recently	No	No	No	?
Percentage of bookings made		When available almost all	60%		

YEOVIL FOCUS GROUP

Practice name (PCT)	Hendford Lodge Medical Centre (South Somerset PCT)	Oaklands, Yeovil (South Somerset PCT)	Springmead Surgery (South Somerset PCT)	Essex House Medical Centre (South Somerset PCT)
No of sessions	9	6	7	10+
No of GPs (Full-time)	4	0	2	5
No of GPs (Part-time)	5	2 x 3/4 WTE	2 job share	
List size	13,250	3,350	6,000	9,600
No of referrals per week	15	5-10	5-10	5-10
High referrers?				
Medium referrers?	✓	✓	✓	✓
Low referrers?				
Secondary care providers referred to	Yeovil Shepton Mallet Yeatman Taunton and Somerset	Yeovil RNHRD Dorchester	Taunton and Somerset Yeovil Royal Devon and Exeter Axminster	Taunton and Somerset Chard Royal Devon and Exeter
Percentage of patients referred to secondary providers	85% Yeovil 5% Shepton Mallet 5% Yeatman ?% Taunton and Somerset	98.9% Yeovil 1% RNHRD 0.9% Dorchester	90% Taunton and Somerset 10% Yeovil 1% Royal Devon and Exeter 1% Axminster	65% Taunton and Somerset 30% Chard 2-3% Royal Devon and Exeter 1-2% Yeovil
Tertiary providers referred to	United Bristol	Frenchay (cardiac, plastics) Royal Devon and Exeter (renal, plastics)		Royal Devon and Exeter United Bristol
Percentage of patients referred to tertiary providers	5% United Bristol	0% Frenchay 0% Royal Devon and Exeter		Very few, Royal Devon and Exeter
Computer system	Mediter (Synergy)	EMIS	?	EMIS
Access to electronic booking?	Yes	Limited – all appointments made at RMC		Limited – software not fully capable yet
Are current providers listed?	Yes	Yes	Yes	?
Percentage of bookings made	30%	100% – for the last 2 weeks	0% at present	

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