

# Patient Choice Deliberative Event: Report

For NHS Leeds CCG

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RESEARCH

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## Contents

<b>1. Executive summary .....</b>	<b>4</b>
1.1 Background and methodology .....	4
1.2 Findings and conclusions .....	4
<b>2. Introduction .....</b>	<b>8</b>
2.1 Research questions.....	10
<b>3. Methodology .....</b>	<b>11</b>
3.1 Method.....	11
3.2 Sample.....	12
<b>4. Key findings .....</b>	<b>13</b>
4.1 Barriers to accessing services .....	13
4.2 Choice in Direct Access Diagnostic Service .....	16
4.2.1 Range of convenient locations.....	16
4.2.2 Range of providers.....	18
4.2.3 Range of appointment times .....	19
4.2.4 Prioritisation .....	20
4.3 Choice in Short-term Outpatient Service.....	22
4.3.1 Range of convenient locations.....	22
4.3.2 Range of providers.....	23
4.3.3 Range of appointment times .....	25
4.3.4 Prioritisation .....	25
4.4 Choice in Long-term Outpatient Service.....	27
4.4.1 Range of convenient locations.....	27
4.4.2 Range of providers.....	28
4.4.3 Range of appointment times .....	29
4.4.4 Prioritisation .....	30
4.5 Community healthcare services .....	32
4.6 Communicating patient choice .....	34
4.6.1 Key messages for patient choice communications.....	34
4.6.2 Preferred methods of communication .....	35
<b>5. Conclusions .....</b>	<b>37</b>
5.1 Barriers to accessing services .....	37
5.2 Patient choice priorities .....	37
5.3 Barriers to using community healthcare services .....	39
5.4 Communicating 'Patient Choice'.....	40
<b>6. Appendix .....</b>	<b>41</b>
6.1 Qa discussion guide.....	41

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This research has been carried out in compliance with the International standard ISO 20252 (the International Standard for Market and Social research), The Market Research Society's Code of Conduct, and UK Data Protection law.

## I. Executive summary

### I.1 Background and methodology

CCGs have statutory responsibilities governing the provision and offer of choice in the NHS healthcare services to the patients for whom they commission such services. However, choice can involve a range of factors, including number and locations at which services are provided, the timings when services can be accessed, or having a number of different service providers to choose from.

A deliberative research event with 70 Leeds residents was carried out by Qa Research in early March 2020. The event aimed to gain insight from a representative cross section of Leeds patients and carers to establish which of these elements of choice were of the highest priority to them, and to explain their reasons why; in a number of different scenarios. These included :-

- Direct Access Diagnostic Services
- Outpatient services where the episode of care is expected to be short term
- Outpatient services where the episode of care is expected to be longer term.

We also took the opportunity to gain patient insight into other areas relating to their experiences and priorities in accessing services, these included :-

- Barriers to accessing services
- Views on using community healthcare services
- Communicating patient choice

This insight will be used in order to inform the design and delivery of the services that the CCG commissions; ensuring that they reflect local and national priorities, and reflect the needs and priorities of the population of Leeds.

### I.2 Findings and conclusions

The following findings and conclusions are general in nature. As anticipated, perspectives vary depending on personal circumstances, and the findings therefore do not reflect all patients in all situations. More detailed analysis, including the perspectives of different groups are covered in the main body of the report.

#### **Barriers to Access**

When conducting the sense check on the access priorities that are currently required for providers of newly commissioned services, the feedback confirmed that the four aspects listed were all important, and should be retained. These included :-

- Disability and access considerations
- Nearby parking
- Nearby public transport links
- Extended hours appointment.

An additional finding was that there needed to be a greater focus on addressing barriers through clear targeted communication for groups and individuals who may otherwise find it difficult to access information about the choices they may have.

As anticipated, these general findings conceal differences in priority amongst certain groups. For example, non-drivers are less concerned about availability of car parking, drivers are less concerned about availability of regular public transport, retirees are less concerned with availability of out of hours appointments than working people and so forth.

### ***Choice Priorities in the case of accessing a Direct Access Diagnostic Service***

In the scenario outlined, in descending order of priority, the favoured aspects of choice were :-

1. Range of locations
2. Range of appointment times
3. Range of different providers

A further finding on this scenario included the fact that a major priority for many was being able to access an appointment that offered the shortest possible wait time. Many patients would be prepared to travel further, or take time off work, if this was for a one off appointment that would provide the speediest diagnosis, ensuring that the patient could access the most appropriate treatment with the minimum delay.

### ***Choice Priorities in the case of accessing an outpatient service where the episode of care is expected to be short term.***

In the scenario outlined, in descending order of priority, the favoured aspects of choice were also:-

1. Range of locations
2. Range of appointment times
3. Range of different providers

Further findings on this scenario included ;-

- Some patients wished to have a choice of provider available in case they had a previous bad experience of care, and wished to be treated elsewhere
- Hypothetically, the more severe the condition, the more patients valued a choice in provider, (whilst having a greater priorities based on convenience for less serious conditions)

### ***Choice Priorities in the case of accessing an outpatient service where the episode of care is expected to be long term.***

In the scenario outlined, in descending order of priority, the favoured aspects of choice were :-

1. Range of locations
2. Range of different providers
3. Range of appointment times

Further findings on this scenario included ;-

- Some patients wished to have a choice of provider available in case they had a previous bad experience of care, and wished to be treated elsewhere
- Hypothetically, the more severe the condition, the more patients valued a choice in provider, (whilst having a greater priorities based on convenience for less serious conditions)

conditions). There was an assumption made by participants that longer term episodes of care by definition involved a greater level of clinical seriousness than was the case in shorter term episodes. This was not included in the scenario that was outlined, and may have to some extent distorted the relative importance of choice of provider.

### ***Cross cutting themes across the three listed scenarios***

- The longer the term of the episode of care, the greater the extent to which consistency and continuity of care were valued.
- The greater the severity of the condition/higher the level of clinical expertise required to manage the condition, the more patients were prepared to trade off the convenience of local provision, or appointments out of hours for having access to the best possible service.
- There was a very high level of trust in the quality of NHS services, and consequently a general lack of priority assigned to having a choice of provider. Where patients stated that they would value a choice of provider, the reasons listed were :-
  - So that they could avoid a particular provider with whom they had had a poor experience of care
  - (With serious/life changing conditions), so that they would have the option of choosing the best possible care.

These circumstances are however not strong reasons for having choice of a plurality of providers. (The first relates to issues of poor performance requiring of robust provider management/service improvement, and the second relates to provision of higher complexity services that tend to be regional in scope, and where patients already have the ability to choose which service they are referred to).

- There is a significant cohort of patients who do not feel comfortable exercising choice, feeling that they are ill equipped to make such choices, and that they would prefer for the choice to be made for them by the referring GP or other qualified clinician.

### ***Views on use of community healthcare services***

There remains a perception amongst many patients that services provided by community healthcare services are not of the same standard and quality as would be provided in hospital.

Concerns centred around :-

- Whether the quality of care would be equivalent to hospital services
- Whether consistency and continuity of care would be equivalent to hospital services
- Whether appropriate expertise could be accessed when required
- Whether staff professionalism would be equivalent to hospital services
- Whether hygiene and cleanliness standards would be equivalent to hospital services
- Whether there may be delays in care due to inadequate information/communication

Other issues raised concerned facilities, (particularly in relation to the barriers to access covered earlier in this summary), and potential lack of privacy, and security of data where it needs to be shared across providers.

A clear finding is that if there is to be greater uptake/enthusiasm for patients to use community services, patients need to be reassured that such services are able to demonstrate that the standard of quality in all of the fields listed above is entirely appropriate to deliver the high standard of service that they have been commissioned to provide. The key point for emphasis is that services are commissioned to be delivered by community healthcare services, because that is the best and most appropriate place for them to be delivered.

### ***Communicating patient choice***

Many patients were unaware that they had the right to choose, were unsure of how they should ask for choice, and were unsure as to what information was available to support them in making this choice. This makes effective use of choice extremely difficult.

If the CCG has a clear goal to ensure that their patients are aware of their right to choose, and empowered to make the best and most appropriate use of their choice options, the CCG will need to develop and implement a citywide strategy for delivering this.

The deliberative collated a number of questions about choice, raised by patients, that future communications could cover in order to inform and empower the Leeds population to exercise choice. Discussions around communications channels took place however no clear consensus was reached.

## 2. Introduction

'Patient choice' refers to the options that enable patients to make choices that best suit their circumstances, giving them greater control of their care, and hopefully, better results. The full range of choices that are currently available to NHS patients can be viewed in the [NHS Choice Framework](#). The entitlements to choice set out in this framework reflect those in the [NHS Constitution](#).

Currently, NHS patients have a legal right to choose:

- Their GP, and GP practice
- Where to go for their first appointment as an outpatient
- Who carries out a specialist test
- Access to required treatment in another European Economic Area Country (subject to change due to ongoing Brexit negotiations)

Patients may also be offered choice in the following services or circumstances :-

- Who provides their maternity services – depending on what is put in place by their CCG, and what is clinically appropriate for them and their baby.
- Who provides services in the community – depending on what is put in place by their CCG
- Accessing a Personal Health Budget – CCGs are responsible for ensuring that Personal Health Budgets are offered where appropriate
- Participation in health research
- Asking to change hospital if they have to wait longer than maximum waiting times

Clinical Commissioning Groups (CCGs) have a duty to enable patients to make choices which includes promoting patient involvement in their own care planning. However, the rise of multi-morbidities, as people live for longer with long-term health conditions, indicates an increasing demand for integrated care and joined-up services. This forms a key priority in the NHS Long-term Plan.

Leeds CCG, covering a population of 870,000, have reflected the Long-term Plan in their own priorities for the region, two of which are 'long-term health conditions' and 'integrated care'. The present shift towards integrated care is an appropriate moment to consider the role of patient choice within a changing healthcare system.

'Patient choice' as a model requires and assumes a number of things:

- Patients are aware of their ability to choose
- Patients value and want to have a choice
- Patients have access to relevant and appropriate information on quality of providers
- Quality is the dominant factor that determines patient choices

The reality of patient choice in practice may manifest differently; this piece of insight aims to explore perspectives on choice within the Leeds population. It will seek to understand which elements of choice are most valued among Leeds residents and why, how this varies depending on the type of service being accessed, and how best to communicate choices to patients. The focus of this insight is firmly on :-

- Choice of where to go for first appointment as an outpatient
- Choice of who carries out a specialist test
- Choice of services provided in the community



This is because these are services that are directly commissioned by the CCG, and where the relative importance of priorities such as availability of local access, choice of a plurality of different providers, and the facilities that providers of services need to be able to offer must be weighed up, and decisions made which will influence how and where services are delivered. Leeds CCG will therefore be able to make decisions based on this insight when commissioning future services in the context of the NHS Long-term Plan and CCG region priorities, while being assured that they are representing the priorities of the population served.

It will also explore issues such as barriers to attendance and access of healthcare, as well as attitudes and barriers to community healthcare, an increasingly utilised commissioning model.

Leeds CCG commissioned Qa Research to carry out this qualitative piece of insight in January 2020. This report outlines the research questions, method, findings and conclusions.

Sources:

<https://www.england.nhs.uk/patient-choice/>

<https://www.england.nhs.uk/long-term-plan/>

<https://www.leedscg.nhs.uk/about/our-priorities/>

## 2.1 Research questions

The overall aim is to use the following insights to inform future commissioning decisions, ensuring they are based upon the priorities and best interests of the Leeds population.

Primary research questions:

- Understand which choices are most important for Leeds patients to have, when it comes to delivery of NHS services, and why
- Explore the differences in these priorities between different healthcare scenarios and services
- Investigate the key messages and methods of communication that will best empower patients to exercise their rights to choice

Secondary research questions:

- Understand if users' access needs/requirements are being met by the current services; are there additional access considerations that are acting as barriers to attendance?
- Explore any barriers to accessing future community healthcare services, and what reassurances are needed to encourage access of community healthcare

### 3. Methodology

#### 3.1 Method

The research was conducted as a qualitative deliberative event, the key features of which are:

- Large representative sample of 60-70 participants
- Multiple tables in one room, each with its own moderator
- Event takes 3-4 hours, split into short activity/discussion sessions
- Activity sessions are interactive (e.g. placing post-its on a large sheet) which forms the 'data' – discussions are not audio recorded

The event was held at Shine, Harehills, Leeds on Saturday 14 March 2020. Participants received a £50 incentive as a thank you for their attendance and insights, and to cover travel costs.

There were seven discussions throughout the day, as shown in the running order below. Each discussion was guided by table moderators using a pre-agreed discussion guide. Discussion 1 was a 'warm-up' exercise and, as such, is not included in the findings. A representative from Leeds CCG introduced the topic of Patient Choice and explained the context of the discussions in a presentation. The discussion guide in full can be found in the appendix.

**Table 1. Running order**

Time	Activity
10.00 - 10.30	Registration
10.30 - 10.40	Introductory Presentation Welcome by Qa
10.40 - 11:00	Ice-breaker (5 min) – introduce neighbour Discussion 1 (15 min) – demands on your time
11.00 - 11.15	Discussion 2 (15 min) - Barriers to accessing services
11.15 – 11.25	Presentation 1 Explaining Patient Choice (Leeds CCG)
11.25 – 11.30	Presentation 2 Introducing Direct Access Diagnostics Scenario (Leeds CCG)
11.30 - 11.50	Discussion 3 (20 min) - Direct Access Diagnostic Service
11.50 - 12.20	LUNCH
12.20 - 12.25	Presentation 3 Introducing Outpatient Consultation Services (Leeds CCG)
12.25 - 12.40	Discussion 4 (15 min) - SHORT TERM Outpatient Consultation Service
12.40 – 13.00	Discussion 5 (20 min) - LONG TERM Outpatient Consultation Service
13.00 – 13.10	Discussion 6 (10 min) – Accessing Community Services
13.10 – 13.25	Discussion 7 (15 min) - Communicating and empowering choice
13.25 - 13.30	Closing

An analysis session with all moderators took place following the event, where findings were discussed, drawing out similarities and exceptions, as well as noting non-verbal data to contextualise the activity outputs.

### 3.2 Sample

70 people overall were recruited to take part in the event. The sample was made up of 64 members of the public from Leeds and 6 family carers recruited in partnership with Carers Leeds.

The 64 public participants were recruited face-to-face by Qa's specialist recruiters against a set of quotas, outlined in the table below, in order to ensure the profile of the room was broadly representative of the demographic profile of the Leeds CCG area by gender, age, ethnicity, household composition and working status.

**Table 2. Target sample**

Criteria	Suggested target % <sup>[1]</sup>	Suggested target #
<b>Gender</b>		
Male	49%	31
Female	51%	33
<b>Age</b>		
18-29	27%	17
30-44	26%	17
45 -59	22%	14
60+	25%	16
<b>Ethnic group</b>		
White (British, Irish, Gypsy, Traveller, Other)	85%	54
BME (Mixed/multiple, Asian/Asian British, Black/African/ Caribbean/Black British, Other)	15%	10
<b>Household make-up</b>		
One-person household	33%	22
Two+ adult household, with no dependent children	40%	26
Household with dependent children	25%	16
<b>Working Status</b>		
Work full-time, part-time or self-employed	60%	39
Student / in training / Looking for work / unemployed	18%	11
Retired / Looking after home or family / long term sick or disabled / other "at home"	22%	14
<b>Postcodes</b>		
Postcodes throughout the Leeds CCG area	Good spread	
<b>Total</b>		<b>64</b>

[1] These proportions have been derived from the demographic profile of the Leeds local authority area population from the 2011 census <https://www.nomisweb.co.uk/reports/localarea?compare=1946157127>

## 4. Key findings

In this section we set out the main research findings from the deliberative event.

Sub-sections are ordered according to the sequence of activities undertaken at the event. Key themes are discussed and, where relevant, are illustrated with quotes taken from the activity post-its and selected from multiple tables.

### 4.1 Barriers to accessing services

Participants were shown four key access requirements that providers of newly commissioned NHS providers must demonstrate that they are able to meet;

1. Disability & access considerations (compliant with Equality Act 2010)
2. Nearby parking
3. Nearby public transport links
4. Extended hours appointments

Participants were asked to give reasons why these access requirements were important to them and helped them overcome barriers to attending healthcare appointments. They were also asked to consider any further barriers to attending and accessing services.

#### ***Disability & Accessibility***

Participants who were either disabled or elderly themselves, or cared for a disabled or elderly relative, were particularly invested in appropriate disabled access in all healthcare services. All participants recognised that accessibility requirements were vital to enable all members of society to attend healthcare services.

Key barriers / requirements in terms of accessibility and disability included:

- Wheelchair access & available wheelchair on arrival
- Sufficient blue badge parking available
- Trained support staff to help disabled & elderly especially if attending alone
- Close, clearly identifiable, accessible toilets – ideally with cleaning facilities
- Telephone appointments offered to those with mental health conditions –attending in person can be overwhelming for some
- Flexibility in missed / rescheduled appointments for patients with disabilities / long-term health conditions – a barrier is not feeling well enough to attend

#### ***Nearby Parking***

Almost all participants strongly felt that ample, nearby parking was a key requirement to enable attendance, as the majority attended appointments by car. Certainly, lack of parking acted as a barrier to attending promptly and in an appropriate state of mind to receive healthcare; many noted the stress that lack of parking could cause.

Somewhat unsurprisingly, the price of parking featured heavily in the discussions; many felt the high cost could be addressed to pose less of a barrier to attendance. Participants with low income (notably full-time carers) were keen to highlight cost of parking as a barrier, sometimes finding taxis a cheaper, although still expensive, option.

Key barriers / requirements in terms of parking included:

- Free or subsidised parking, particularly for those on low income
- Enough spaces to accommodate all patients, including preventing non-patients from using the car park for other reasons
- Drop off zones available at all services
- Ensure security and safety of patients, visitors and their vehicles – particularly in large hospital car parks e.g. St James' Hospital
- Reduce or remove fines at car parks – particularly when caused by delays / waiting times when using the healthcare service
- Ensure car park rules are clear, particularly to those with communication needs, otherwise they can be penalised
- Pay on exit or by app rather than on entry – majority unsure how long their stay will be, end up overpaying, collecting a fine or having to emergency top-up which causes stress

### ***Nearby Public Transport Links***

Nearby, and regular, public transport links were most important to those without access to their own transport, as well as elderly participants who were mobile and used public transport on their bus passes.

Key barriers / requirements in terms of public transport included:

- Not only nearby but also regular public transport links
- Access routes from rural areas
- Specialised public or private transport to assist elderly patients or those living with dementia, who may not always have family or carers available
- Secure place to leave bicycles

### ***Extended Hours***

Accessing extended hours appointments was crucial to many participants, which is elaborated on in detail in the following sections (4.2; 4.3; 4.4). Particularly affected by a lack of out of hours appointments were those who work full-time or in shifts, although accessing out of hours appointments was preferred by all but retirees.

Key barriers / requirements in terms of extended hours included:

- Out of hours appointments to fit around working and caring commitments
- Increased availability of out of hours appointment times
- Ability to book extended hours appointments on the day as well as in advance
- Accessible booking system, with the ability to book appointments online

### ***Communication***

In addition to the requirements and considerations in the above categories, participants identified communication as another key barrier to attendance. Communication barriers manifested in a number of ways, ranging from interpersonal communication to language and learning disabilities.

Key barriers / requirements in terms of communication included:

- Language barriers particularly in certain areas of Leeds with high non-English speaking populations – translation facilities for appointments needed (e.g. Language Line), but also written communication available in alternative languages, especially invitations to appointments and online booking
- Easy read versions of communications available for those with learning disabilities
- Large print communications for partially sighted individuals
- Some commented on ‘intrusive’ questions and lack of empathetic communication when attempting to book appointments, which puts them off attending
- Some noted lack of communication in terms of test results or supporting information being available when they are at the appointment, which acts as a barrier to appropriate care

## 4.2 Choice in Direct Access Diagnostic Service

Participants were asked which elements of choice would be important to them when accessing a 'Direct Access Diagnostic Service'. The key features were explained in a presentation as:

- A test to confirm or rule out a specific diagnosis, which will inform decisions on future treatment/management of the patient
- A one off event – not usually repeated
- Does not ordinarily involve treatment being provided
- Examples: imaging e.g. Ultrasound for musculoskeletal conditions, or upper GI Endoscopy

Three choices (a range of **locations**, a range of **providers** and a range of **appointment times**) were made available to participants, who were asked to first give reasons why each was important to them, followed by a group exercise where the choices were placed in order of priority; each table reached a group consensus.

### 4.2.1 Range of convenient locations

#### ***Important - Minimise disruption by having close to home or work***

Visiting a diagnostic service that was close to home or work was unanimously identified as being generally more convenient than having to travel a long distance. A closer, more convenient location would minimise the disruption to daily life by reducing the travel time involved. It was important to many participants that healthcare should not impact on their daily routines of work and family commitments, insofar as it is possible.

*Convenient for work or home important as I'm busy*

*Location so can get there easy - would prefer local to where I live*

*Take less time away from travelling preventing other things being done*

Another element to minimising disruption is the preference for a familiar location. Some participants noted that an unfamiliar location could add both time and distress, should they get lost or struggle to navigate an unfamiliar health setting.

*Being in pain plus getting lost = distress*

*Familiar location important*

#### ***Important – Groups more likely to value location***

Participants identified that elderly or disabled people are more likely to benefit from a range of nearby, familiar locations. This is both in terms of their own familiarity and access needs, along with reducing the disruption for accompanying carers.

*Nearer home important due to incontinence (Carer)*

*As someone with chronic pain location is key*

Some parents also noted that an inconvenient location could impact their ability to pick their children up from school.



It was clear that location was of greater importance to those participants without access to their own transport. Having to rely on walking, cycling or public transport would only increase the travel time and therefore disruption caused by a distant location.

*Not far to travel as my only transport is walking / cycling*

It was also noted that the importance of a convenient location was likely to depend on the health condition and level of severity and pain experienced. The given example of a painful shoulder needing an ultrasound meant few would want to drive a long distance for the scan.

#### **Not as important – Groups less likely to value location**

Many of those who were retired were less likely to want to choose a convenient location, as travel time was not an issue for them. However this was dependent on their relative levels of mobility and independence.

*Not important as could always manage to get there - retired*

Another group less concerned about location was those with access to their own transport, as they could travel anywhere within reason in their car.

*I can drive to any location so this is less important*

#### **Not as important - Specific nature of DADS scenario**

The features of a direct access diagnostic service meant that many participants felt location was less important in this service. As a one-off test, the majority of participants felt they could handle the disruption of this isolated event, regardless of how far they had to travel or the time this would take.

*A routine diagnostic so less important to be close*

*More willing to travel further for a one-off so less important*

Furthermore, given that the purpose of the service is to provide a diagnosis, the primary concern of most participants was to be seen as soon as possible to obtain a diagnosis and proceed to treatment and a rapid recovery. They would therefore be happy to travel in order to be seen quicker.

*Don't mind travelling if helps speed of being seen, don't want to wait too long due to the worry of wondering what was wrong*

#### **Other location considerations**

Other considerations when it comes to location are the parking (availability and price), public transport and accessibility of these locations, covered in section 4.1. Other participants mentioned that it would help to avoid planning services in congestion areas of Leeds, which can only add to the disruption caused, particularly around rush hour.

## 4.2.2 Range of providers

### ***Important – Factors in choosing provider***

Although the vast majority of participants were not interested in having a choice in provider for a direct access diagnostic service, some factors in choosing a provider emerged.

The familiarity of the provider was important and reassuring to some, including those with mental health problems who are in need of consistent care.

*Mental Health specifically would be more comfortable talking to the same provider*

As a one-off scan for a diagnosis, it was important to some that the provider had high quality equipment to provide the correct diagnosis, although it was generally assumed patients would be sent to a provider with the correct equipment.

*If I had a low res scan that couldn't find the issue I would pick a better scanner*

For those who had had a previous bad experience, it was important to be able to choose a particular hospital or service to avoid a repeat experience. Many noted that this choice would largely come down to word of mouth and reputation of health services.

*Reputation of hospital - word of mouth*

### ***Not as important – Assumption of quality***

There was a general assumption among the majority of participants that as long as the quality standard is consistent, they would be happy to go with any provider as long as they receive the service they need.

*Provider, least important, as long as the service is consistent - I don't mind who the provider is!*

Furthermore, participants largely reported and expected a high quality of service and trust in the NHS to provide this, as well as trust in their doctor to send them to right provider.

*Never had doubts, trust 100% in NHS*

*The responsibility should rest with the NHS to ensure all providers are suitable and competent.*

The nature of the scenario, being both a one-off and a routine test, meant that the majority were happy to receive the 'minimum' standard as it is potentially less variable than services (e.g. outpatient) which need clinical expertise.

*Not so much, as long as it's the same standard of service in a clean and pleasant environment it's fine*

*That shouldn't even be an issue for a routine test*

*As one-off this wasn't as important as would just choose somewhere else if treatment was required afterwards*

### **Not as important – Unsure how to choose**

Some participants felt that choosing a provider should not be their responsibility as a patient and the health service should send them to the most appropriate place.

*I don't really feel qualified to make that decision*

*I would rather trust the doctors opinion*

Many were also unaware that they had a choice; they felt unsure as to how they would make it, questioning whether it should be based on recommendations, reviews, or reputation. These participants were unsure how they would decide and based on what information, with a few concerned about becoming overwhelmed by the decision.

*I didn't even know I had a choice so this is definitely least important*

Some participants also felt that services with 'good' reputations may become oversubscribed and quickly bottleneck, meaning standard of care could reduce. Furthermore, this could cause problems and inconveniences if said oversubscribed services happened to be the most local or convenient for them.

*Too much choice will mean a negative outcome as people will vote with their feet and word of mouth will create a hierarchy*

### **4.2.3 Range of appointment times**

#### **Level of importance dependent on work**

Whether or not a range of appointment times, especially evening and weekend appointments, was important to participants depended heavily on their working status. Those who worked full-time generally valued an 'out of hours' appointment greatly, in particular those who worked on commission, in shifts, were self-employed, or worked on the basis of 'billable hours'.

*This is important to me as I work full-time*

*Work on chargeable hours so can't take time*

*Salary commission based*

However, employer attitudes and practices regarding health and discretionary leave for appointments massively impacted how important an 'out of hours' appointment was. Those with flexible and understanding employers were more than happy to go during the working day. Those with inflexible working practices, or who did not wish to disclose health information to an employer, felt appointment times were extremely important.

*Work good with compassionate leave but still wouldn't want to*

*Out of work hours, I like to keep it private for personal circumstances*

Understandably, those who were retired were less constrained by timings and generally happy to take appointments during the working day. Carers' opinions depended on personal circumstances; full-time carers had greater flexibility to travel to appointments at any time, whereas part-time carers were more stretched and needed out of hours times.

*Full time carer / lots of flexibility (Carer)*

*I prefer late evenings & weekends as I work full-time (Carer)*

### **Importance linked to location & transport**

Appointment times were repeatedly linked to location of service as well as transport. If an appointment was close to work, for example, then an out of hours appointment was less important as it would be less disruptive given the reduced travel time.

*Location and timings interlinked*

*Timing depends on location*

Furthermore, those with access to their own transport were more likely to value an 'out of hours' slot as they were less concerned about location.

### **Important to have range of times to suit varied personal circumstances**

Rather than simply making 'out of hours' times available, many participants noted that the key issue with appointment times was having a range of times available to meet the varied personal circumstances of the population. Some of these include:

- Disability / chronic pain means certain times of day are better
- If accompanying somebody / caring need to co-ordinate two diaries so more complex
- If a parent, needs can vary e.g. day appointment so back in time for pickup, or need evening appointment to have them looked after by friends / family
- Quieter in the day so preferred by some e.g. mental health / anxiety issues

### **Not important – Specific nature of DADS scenario**

Similar to location, the features of a direct access diagnostic service mean that an evening or weekend appointment is less important than it would be in a longer term episode of care. Having a one-off appointment means most participants felt able to make the exception and justify the disruption.

*Less important as one-off, more likely to make it work*

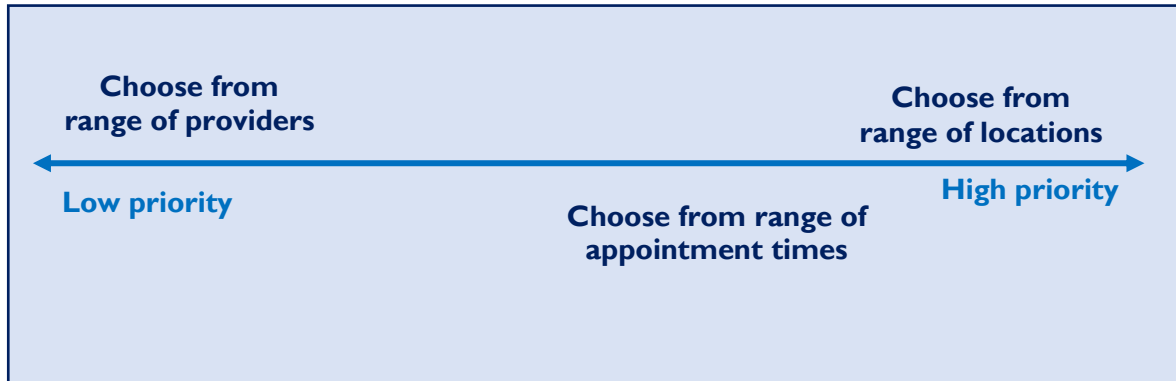
Once again, given the purpose is to diagnose, the majority of participants were more inclined to be seen as soon as possible, regardless of the time of day, although this was dependent on the severity of the condition.

#### **4.2.4 Prioritisation**

When prioritising the different choices available for a Direct Access Diagnostic Service, participants were largely unanimous with some variation in priority of timing and location. The figure overleaf visualises the level of priority that was generally given to each of the choices.

Figure 1, and subsequent diagrams for other services, are purely for visualisation and should not be seen as a quantification of the results; as a qualitative research exercise, this would be an inappropriate presentation of the data. Instead, the figure aims to illustrate the direction of conversation for the bulk of participants, and therefore show the strength of feeling regarding each of the three choices.

Fig. 1 Prioritisation of Direct Access Diagnostic Service choices



It was clear from discussions that being able to choose a provider for this particular service was a very low priority for participants, due to the routine nature of the service as well as general trust in the quality standards of any NHS provider.

Convenience took priority in this scenario, in the sense that a one-off appointment should disrupt daily life as little as possible. Location and appointment times were intrinsically linked here; a nearby location meant appointment time was less important, while an evening or weekend appointment generally meant location could be further away.

Life circumstances were also important, as full-time workers needed greater flexibility in appointment times, while those without personal transport relied on nearby and easily accessible locations. Children and caring responsibilities also played a role in prioritisation, although not with any strict rhyme or reason; this was personal to the situation and available resources.

Despite the 'ideal' of nearby location and out of hours appointments, many participants were willing to forgo either if this meant they would be diagnosed quicker; the inconvenience of rearranging daily life for the appointment was outweighed by the greater assurance offered by a swift diagnosis, prompt treatment and return to good health.

### 4.3 Choice in Short-term Outpatient Service

Participants were next asked which elements of choice would be important to them when receiving a 'Short-term Outpatient Service'. This was classified in the presentation as:

- A situation where specific clinical expertise and advice is required
- Outcomes of first outpatient consultation may include further diagnostic tests, agreement of a treatment plan, or the treatment itself
- Service provided over a relatively short term, only 2 or 3 appointments
- Examples: Dermatology, Ear Nose and Throat

Three choices (a range of **locations**, a range of **providers** and a range of **appointment times**) were made available to participants, who were asked to first give reasons why each was important to them, followed by a group exercise where the choices were placed in order of priority; each table reached a group consensus.

#### 4.3.1 Range of convenient locations

##### ***Important – convenience for home / work***

As with direct access diagnostic services, the location of short-term outpatient services was important to the majority of participants, who would prefer services to be in a convenient location to access from either work or home.

The presiding reason behind this was the increased travel time involved in a more distant location, resulting in greater disruption to daily life. Ideally participants would limit the level of disruption, so it does not take a whole day, for example, or they have to repeatedly travel a long distance.

*Would like close to home/work so it doesn't take all day*

*To me is important if I need to keep coming back don't want to travel miles*

However, there was some acknowledgement and expectation that specialist services would only be available at certain locations, which may mean limitations on location. Some participants expected, and were happy, to travel a greater distance in order to receive specialist care.

*Not too fussed as I know it's a specialist. Almost expect to travel*

##### ***Importance for different groups similar to DADS***

There were no real differences in opinion from the direct access diagnostic service, when it came to which groups valued a convenient location.

Once again, mobile retirees were less concerned by location due to their free time. Full-time workers were guided by the flexibility of their employment situation. Those with access to personal transport felt less constrained by location and happier to travel.

*Location not important as I can still drive to any location*

### **Mixed importance – specific nature of short-term outpatient service**

A short-term outpatient service is characterised by two or three appointments with a specialist clinic over a relatively short period of time. Participants were mixed on what effect this might have on how important location was to them.

Some participants felt that this was still a small number of appointments, and that the disruption that an 'inconvenient' location might cause was permissible given this was a discrete, short-term situation. Therefore, to this group (not identifiable by any particular life stage or circumstance), location was still not of great importance. A convenient location would be 'nice to have', but not top priority.

*As long as it is reasonably close to my home then I'm not bothered about the location for only 2 visits*

Conversely, multiple appointments meant for some participants that location was now a high priority as this was no longer 'exceptional', and was now regarded as 'regular'. This group valued a convenient location that fit into their schedule with minimal disruption.

*If more than 1 appointment it should be close to home*

### **Other location considerations**

Some participants were less concerned about where their services were located, provided that they were at the same location each time, to ensure consistency of care and familiarity.

Others did not have a preference on location provided that parking and public transport links were good; this took priority in their eyes as access was more of a disruption.

### **4.3.2 Range of providers**

#### **Important – Seeing the 'best specialist'**

Largely speaking, choosing a provider of short-term outpatient care was still of fairly low importance to participants and echoed the reasoning behind the direct access diagnostics. However, some participants felt this was more important due to the need for specialist knowledge.

*Provider would be most important so they would have experience*

Unlike location and appointment times, there were no particular demographic groups or life stages that were more keen to choose a provider. Instead, previous experiences and personalities influenced how important a choice of provider was.

For some participants, although by no means a majority, it was most important that the service had the best knowledge, expertise and standard of care. Some justified this as it would help prevent recurrence or escalation of their health condition.

*Best provider to prevent it reoccurring*

Many, usually those for whom transport was not an issue, felt happy to travel in order to see the most suitable specialist. Additionally, participants who had had a bad experience in the past were more keen to have a choice, in order to avoid certain providers.

*Happy to travel further to see a provider more suited to me for treatment*

### **Consistency of care most important**

For a large portion of participants, having continuity and consistency in care was the most important part of the outpatient experience, in terms of maintaining familiarity, trust and rapport.

Therefore, as long as the provider is able to guarantee consistency, many did not feel the need to choose. However if certain providers are known for more (or less) consistent care then this may factor into the decision making process.

*Whichever provider you start with should be maintained throughout*

*Continuity of care was more important than finding the 'very best' provider as you build trust with people*

### **Not as important – Assumption of quality**

Once again, participants were confident in the level of care they would receive from any NHS provider, and therefore making a choice was less important. Particularly relating to specialist care, there was a general perception that specialists and consultants were highly skilled and certainly of sufficient expertise to treat a short-term episode.

*If you're going to see a consultant you expect to see a consultant - quality is consistently high*

*The provider I feel is still not important due to the quality of care having a criteria to meet NHS standards*

Indeed, many participants found it hard to imagine being unhappy with the level of care received from a consultant, some noting that they would simply be grateful to access specialist care.

*If in that situation, you're happy enough to see a specialist*

### **Not as important – Unsure how to choose**

Many participants had only learned their ability to choose provider on the day of the event. As such, some were unsure how they would go about choosing a provider, which acted as a barrier, meaning they were less likely to want a choice of provider.

*Wasn't aware there is a choice of provider so wouldn't have an impact*

Participants questioned whether their GP would recommend a provider or consultant, or whether they were to research this themselves; a task that some did again not feel 'qualified' to do. Some participants went as far as to reject choice of provider, as they felt this would add another obstacle and therefore increase their waiting time.

*But don't know how to choose - what criteria? (Carer)*

*Don't want to complicate things and make them more long-winded*



### 4.3.3 Range of appointment times

#### ***Important – Convenient given multiple appointments***

As short-term outpatient care may require multiple appointments, many participants felt having a conveniently timed appointment was of higher priority. This was because multiple appointments were more time consuming and more disruptive to routines and lives, so minimising this through convenient appointments was valued greatly.

*Needs to be more convenient for me as its more time consuming*

*More important for multiple appointments therefore need to work around work and care commitments*

Preferred times for most participants included standard 'out of hours' (evening and weekend) along with appointments at the start and end of the working day.

#### ***Level of importance dependent on work***

Once again, a person's working situation influenced whether or not appointment times was a high priority choice. Many in full-time work felt uncomfortable or unable to repeatedly take time off for appointments, however others were more than happy to share the situation with their employer and make necessary adjustments to their schedule.

*Work wouldn't be happy going regularly to appointments*

*Can have any time off work for hospital appointment*

Parents were also constrained by the timings of school and childcare, while retirees were on the whole less concerned about choosing appointment times, and happy to take any time.

#### ***Not as important – Specific nature of short-term outpatient service***

Some participants considered choosing an 'out of hours' or convenient time to be less relevant for this service, as specialist services tend to be booked further in advance therefore any time of appointment could be accommodated with such advance warning.

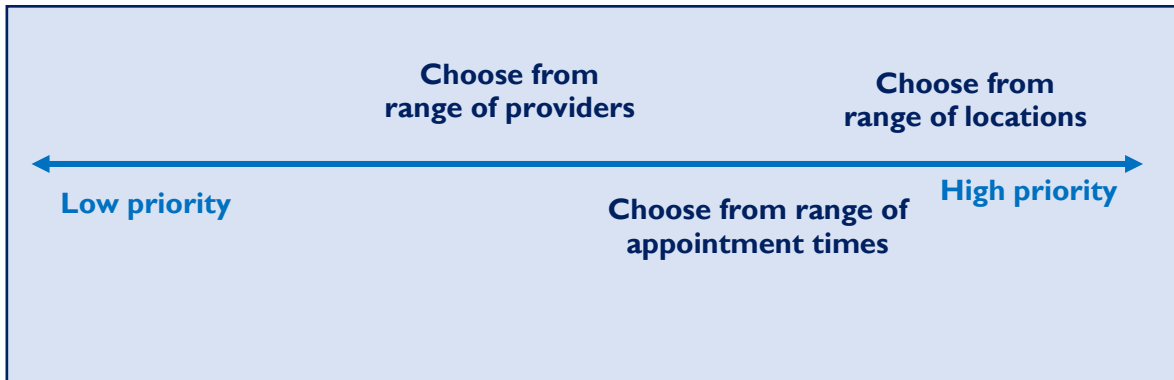
*Consultant booked more in advance so can arrange time*

### 4.3.4 Prioritisation

The prioritising exercise was slightly less straightforward for Short-term Outpatient Services, as many participants felt this required specialist knowledge, expertise and equipment which was more likely to vary between providers. Therefore provider, while still lowest priority in this scenario, was of higher importance to a number of participants than in the previous scenario.

Once again, the figure overleaf is purely a qualitative visualisation of the prioritisation discussions.

Fig. 2 Prioritisation of Short-term Outpatient Service choices



However, the majority still indicated convenient location and appointment times as their top choices, for reasons such as minimal disruption on work and home life, children and caring responsibilities, and preference for a familiar and accessible location.

As shown in the figure 2 on the previous page, location was slightly more important than timings overall. This was because the driving factor here was convenience and lack of disruption; a close location reduced the amount of time overall spent on the appointment, whereas a convenient appointment only controlled when that time was taken out of their day.

As a short-term outpatient service only requires two or three appointments, some were still happy to treat this as an exception and rearrange their life around it. However others felt repeated appointments would require a greater level of convenience in terms of location and time; something they would be happy to wait for.

Another important factor which cannot be illustrated in this general prioritisation is the severity of the condition. Hypothetically, the more severe the condition, the more participants valued a choice in provider, while choosing based on convenience for less serious conditions.

## 4.4 Choice in Long-term Outpatient Service

Participants were next asked which elements of choice would be important to them when accessing a 'Long-term Outpatient Service'. This was classified in the presentation as:

- A situation where specific clinical expertise and advice is required
- A longer-term relationship following the first outpatient consultation, with regular review appointments possibly over a number of years
- Examples: Physiotherapy, Rheumatology

Three choices (a range of **locations**, a range of **providers** and a range of **appointment times**) were made available to participants, who were asked to first give reasons why each was important to them, followed by a group exercise where the choices were placed in order of priority; each table reached a group consensus.

### 4.4.1 Range of convenient locations

#### ***Important – Regular visits means location more important***

A longer term episode of care, which would mean regular, ongoing appointments with a specialist, prompted participants to place greater importance on choosing a conveniently located service.

Frequent and regular appointments represented a greater time commitment and disruption, therefore a convenient location could help to minimise the time this takes away from their work and caring commitments.

*Convenient as will be going repeatedly*

*Close to home, if frequent visits*

Unlike more short-term episodes, the majority of workers felt their employer would accommodate a long-term health condition, and thus leaving work for appointments. However, most wanted to limit the time they spent missing work in order to maintain good favour with their employer and co-workers, considering the regularity of appointments, so convenient location was a priority.

*Will have to tell boss, more likely to be okay with time off as a 'disability'*

*You don't want other staff to resent you if taking repeated time out of working day*

#### ***Important – Long-term condition could limit ability to travel***

Another important consideration is that a long-term health condition could impact a patient's ability to travel long distances, or at least make travelling uncomfortable. Some participants picked up on this regarding the given example of rheumatoid arthritis.

*Important as your mobility may be reduced*

Others noted that if a long-term health condition worsened over time, they would not want to be committed to a specialist in a distant location.

*If condition worsened over years location of treatment v important*

### **Public transport considerations**

Public and alternative transport was advocated as a more important factor in long-term specialism locations, due to the repeated nature of visits. Participants who could otherwise rely on family or friends for lifts, or afford a one-off taxi, felt that they could not continue to do so regularly and over a prolonged period of time.

### **Not as important – Accept limits of specialist care**

Location was not important to all participants however; some were accepting that a specialist in a particular long-term health condition may only be at a few locations, and expected an element of travel. Others were happy to travel further if that meant they were receiving the ‘best’ or most suitable care to manage their condition, rather than choose based on convenient location.

*If specialist I would expect to travel further*

*Best treatment - would be prepared to travel*

#### **4.4.2 Range of providers**

### **Important – Quality and expertise**

The introduction of a long-term scenario altered the conversation around choosing a provider, which became significantly more important to many participants. Discussion shifted from a need to be seen quickly and conveniently, towards a need for the best and most appropriate care, given the potentially life-altering nature of a long-term health condition.

*Long term = quality of life issues. I want a great service and the best help*

The extent to which choosing ‘the best’ specialist service varied, particularly regarding the severity of the condition; participants were less focused on choosing the best provider if the condition was less serious.

*Importance depends on severity of condition, if a life-changing condition want the best quality care but if less serious but requires regular appointments, timing and location more important*

Aside from expertise of the consultant and clinical team, participants would look for high quality facilities and support staff, which many be deemed to play a greater role in a long-term relationship.

### **Consistency of care most important**

As with a short-term specialist service, participants placed high importance on continuity and consistency of care when choosing a long-term specialist service provider. Reasons for this included building a relationship with the specialist so that they did not have to repeat themselves and could receive personalised care, particularly if they have multiple or complex needs.

*Patient - doctor/specialist relationship, you don't want to keep repeating your condition to someone new*

*Continuity most important when it comes to provider*

Another reason why continuity was important is familiarity, both in the environment and the staff. This was particularly imperative to participants with anxiety or mental health problems, although was echoed from all groups.

*Keeping same medical professional throughout. Prevents patients with anxiety escalating issues with added mental health stress*

#### **Not as important – Trust in quality**

Although choosing a provider was undoubtedly more important to participants when it came to long-term care, many continued to reject choosing a provider as priority. Largely this came down to trust in the general high standards of health service specialists.

*I don't mind as much you trust you're seeing a consultant who will be at a certain level*

Some were not used to having a choice and would prefer to keep it that way, perhaps not feeling informed enough on the specialism to discern the highest quality. This was echoed by others, who acknowledged it was important to have choice of provider, but ultimately felt it was not their choice but rather that of their doctor. This was particularly resonant if the condition was severe and therefore the stakes higher.

*I still don't want a choice of provider only location and timings which affect choice. NHS/GP should choose provider with appropriate expertise*

*What do we compare? Which is better? I'm not sure I'm qualified to choose!*

#### **4.4.3 Range of appointment times**

##### **Not as important – Long-term condition taken seriously**

Choosing from a range of appointment times was largely less important to participants discussing long-term services. Where previously discussion had centred on minimising disruption to daily life, it was accepted that a long-term health condition was likely to alter daily life regardless, so making time for appointments at whichever time would be a priority.

*You'll sort your life around it, a long-term condition you have no choice*

*I would make time if a long term condition*

Additionally, most participants felt that employers would be understanding of a long-term condition and allow time out of the working day to attend appointments. However some, including those on commission or billable hours, would still rather limit absences.

##### **Important – Convenience for workers and carers**

A number of participants still felt that choosing convenient timings was of high priority for long-term specialist services planning. For those with busy lives in set routines, an appointment at consistent and regular time was greatly appreciated. Some workers would be more content with appointments around the beginning and end of the working day, if out of hours was not available for specialist care.

*Does still need to be convenient + consistent. Can't just be ad hoc*

Participants with caring responsibilities once again highlighted the need for choice in appointment timings (not necessarily just out of hours), due to the need to co-ordinate multiple calendars.

*Long-term view to plan support staff like carers to come along*

### **Considerations for appointment times**

Some participants queried whether a system could be put in place whereby preferences for appointment times could be recorded when receiving long-term specialist care.

Others felt that the long-term condition should be taken into account when booking times, for example appointments later in the day for chronic pain which is harder to manage in the morning, or appointments at quieter times for those with mental health issues.

*Should take into account the condition*

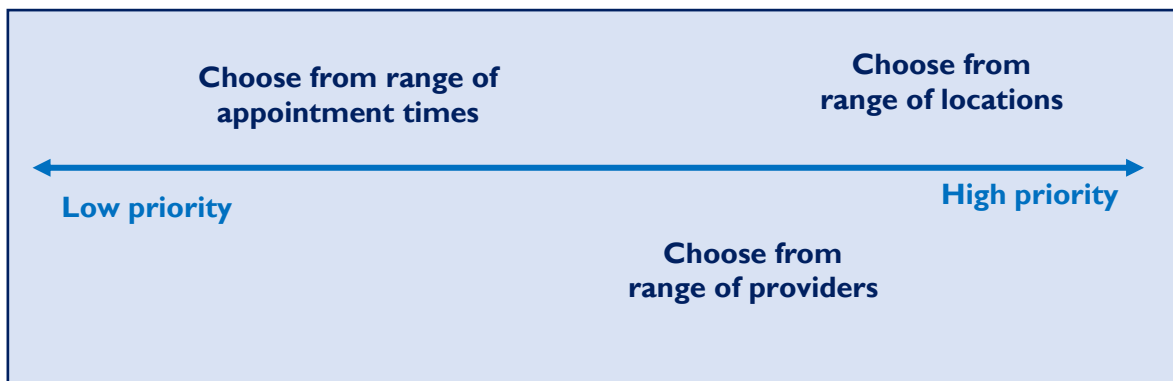
*For someone with chronic pain timing is very important. They can't get to an early morning appointment but later on in the day they can.*

### **4.4.4 Prioritisation**

As depicted in the below figure, participant priorities in choices for a long-term outpatient service changed fairly dramatically compared to the previous two services. Choice of provider became more of a priority for many participants, while having a range of appointment times dropped in priority.

To reiterate, the below should not be taken as a black-and-white quantitative depiction, rather a visual representation of the general strength of priorities and how they change between services. Variation was common in all discussions which largely depended on personal circumstances.

Fig. 3 Prioritisation of Long-term Outpatient Service choices



These altered priorities stemmed from the impact a long-term health condition often has on daily life. Most participants felt they would make room in their schedules and routines for something this important and long-lasting, so timing became less of an issue. Similarly, the perceived severity of a long-term health condition, despite many long-term conditions being of low or medium severity, meant that many prioritised seeing 'the best' provider.

The assumption that longer-term conditions equate to greater clinical severity was noted throughout several discussions. It is possible that this assumption distorted the relative importance placed upon choice of provider in this scenario.

However, the regularity of appointments meant that location was still the most prominent factor for a large portion of participants. Participants were mixed in whether they prioritised location or provider as their key choice; this depended greatly on their personal circumstances. Those with fewer restrictions on movement (caring responsibilities, personal transport) had the 'luxury' of prioritising choice of provider.

## 4.5 Community healthcare services

Participants were prompted to discuss community healthcare services, more specifically what concerns they had that might prevent them from using community healthcare services, or make them less willing to do so.

It is important that, as services move out into the community, patients' concerns are addressed and they are reassured so that they feel confident and able to utilise them. These barriers generally centred around three things; quality of care, community facilities, and more general concerns over community services and whether there would be a choice.

### **Quality of care**

One of the greatest concerns of participants, when it came to potentially using community health services, was whether they would receive the same standard and quality of care that they would find in a hospital or central service.

Key questions around quality (ordered by how frequently cited a concern):

- Will I receive the same quality of care that I would in hospital?
  - Amount of time with doctor / health practitioner
  - Knowledge and experience same level
  - Support staff available and trained
  - Medication and equipment standardised
  
- Will I receive consistent and continuous care in community services?
  - Familiarity of the same doctor / health practitioner
  - Elderly or those with mental health issues keen for continuity in care
  - Don't want to repeat patient history each time, detract from treatment
  
- What if there are situations where expertise is needed?
  - Second opinion sometimes needed
  - Some needing experienced phlebotomist to take blood, waste of time otherwise
  
- Can I be reassured that community staff will have the same levels of professionalism?
  
- Can I be reassured that hygiene and cleanliness standards match the hospital services, especially in home visits?
  
- Will there be delays in care due to communication problems?
  - Will they have my patient history?
  - Will there be good communication between community and hospital based services?



## **Facilities**

Another barrier to accessing community health services was the concern that facilities of community clinics would not match hospital standards.

Key questions around facilities (ordered by how frequently cited a concern):

- Will smaller clinics within communities have appropriate disabled access?
  - Wheelchair access and wheelchairs
  - Blue badge parking
  - Additional needs e.g. hearing loop, large print, support staff
- Can GP surgeries cope with the additional capacity of a satellite clinic?
  - Parking – most important
  - Waiting room and toilet facilities
- Will sufficient high-quality and specialist equipment be available in the community?

## **Other concerns about choosing community services**

A number of other concerns were raised about community services, which questioned if patients would be able to choose whether or not different community services suited them. Although some concerns could be addressed and patients reassured, some participants felt it was important that they were not forced to use community services if they really did not want to.

Key questions on choosing community services (ordered by how frequently cited a concern):

- Concern about the lack of privacy in specialist clinic if they are in the local area, especially worried about stigmatised or sensitive services e.g. HIV or alcoholism
  - Will there be private areas to wait to avoid being recognised by locals?
- Home visits feel invasive, do I get a choice in whether I receive in-home services?
- Who is looking at my data if it is being shared across multiple clinics and in the local area?
  - Can data security be guaranteed? Is it anonymised?
- What if I can't make the appointment days or times?
  - Some are pop-up clinics on certain days, can I still access services if I can't make that day?

## 4.6 Communicating patient choice

Participants were asked to indicate the best way in which the NHS could communicate their rights to patient choice, in a way that would inform and empower them to exercise this right.

This was especially important as many participants were not aware that they had the right to choose healthcare services before taking part in the research, so raising that level of awareness is key if patients are to utilise choice.

They were first asked what the key messages of any communications would be, focusing on the questions they had about choice which would need answering in any information materials.

They were next asked to identify methods of communication that they felt would resonate and have the greatest impact.

### 4.6.1 Key messages for patient choice communications

#### *Content of communication – key questions*

Participants identified a number of questions and concerns that they had about patient choice as a concept and a process, which any communications would need to address.

Key questions / messages (ordered by how frequently cited a concern):

- That patients have a choice! What are you fully entitled to?
- What services do I have a choice of and where are they located?
- How do I ask for a choice? How does choice work in practice? (Online book, at appointment, referral letter?)
- What information will be available to help make the choice between providers?
  - Information on quality of care?
  - Information on reviews / others experiences?
  - Information on specialist knowledge & qualifications?
  - Information on facilities?
  - Information on access & parking?
  - Can the GP advise or decide for you?
- Will waiting times for treatment / services be affected by choice?
- Who is choice available to? Children as well?
- What does non-NHS provider mean and will I have to pay for it?
- Where will 'out of hours' options be available?
- Can you challenge your GP if they don't offer you a choice? How do you do this?
- Who can I ask for more information or if I have questions?

### ***Style of communication – key features***

Participants also commented on the style of communication they felt would be most impactful in terms of educating and empowering patients in their healthcare choices. Key features included:

- Clear headlines that stand out
- Easy read, large print & multiple languages available
- Short and to-the-point bullets
- Minimal jargon, lay terms
- Avoid information overload but don't just link to more information

#### **4.6.2 Preferred methods of communication**

##### ***GP surgeries or pharmacies***

For a large number of participants, displaying information on the televisions or posters at GP surgeries and pharmacies was seen as an effective way to disseminate messages about patient choice.

Many felt it an appropriate method as it would be relevant to all patients considering they would already be in a healthcare setting, meaning the information would be fresh in their mind in the GP appointment, which may well lead to a patient choice scenario.

On the other hand, others felt the GP waiting room was too late on in the patient journey to be introduced to choice; they would not have time to digest the information enough to feel confident in their rights to choice.

Some commented that they read all the available information as a way to pass time in the waiting room, however others spent more time looking at their phones, so felt this communication would not reach everyone in the room.

Others noted that GP surgeries and pharmacies are already filled with information which can lead to 'information overload' leaving them unable to take in information.

##### ***Text from GP surgery***

A popular method of communication was through a text message from their GP, otherwise known as MJOG. The majority of participants claimed to consistently pay attention to direct text messages from their surgery, as these felt both personal and of high importance.

There was debate on how the text should best direct patients to further information and resources, given the limited space in a text message. Some favoured a link to a website, while others distrusted links and would rather an option of a phone conversation.

Another positive of this method is it would reach all NHS patients, not just those attending GP services, and it would give patients time to understand and research choice before being confronted with a choice of their own.

##### ***Face to face explanation at GP***

For some participants, the best way to get messages across remained a face-to-face conversation with GP staff, so they could ask questions and relate it to their specific situation rather than receive generic information. This was particularly popular among older participants.

### **Online advertising**

A number of participants suggested online methods of advertising and communication, including:

- NHS website
- GP website when booking
- Social media
- Phone apps

During discussions, many participants agreed that digital advertising does not always stick in their minds, and websites are only useful if they have been directed to them.

### **Printed advertising**

Participants had mixed opinions about printed advertising and how effective it might be. While some felt that the time for leaflets and printed media had passed, others felt traditional posters such as billboards and buses remained effective forms of communication.

### **Community groups / hubs**

Community groups and local information hubs were identified, by older participants and carers in particular, as being effective methods of communication. This would ideally require information distribution to these groups / hubs, as well as visits from health professionals to explain patient choice and answer questions.

Some potential groups include:

- Carers' associations
- Disability and long-term condition support groups
- Leeds City Council One-stop centres
- Local information & community hubs e.g. libraries

Although acknowledged as a time and resource-intensive option, some participants felt this method would build confidence in those who are most likely to access healthcare and therefore make choices.

## **5. Conclusions**

### **5.1 Barriers to accessing services**

#### ***Disability & accessibility***

All participants, particularly those related to or caring for disabled and elderly patients, felt that disabled access was important for any NHS service to have. In addition to wheelchair access and standard disabled facilities such as blue badge parking, other considerations included having trained support staff, accessible toilet facilities, telephone appointments and flexibility with missing appointments due to being unwell.

#### ***Nearby parking***

Parking was a key concern for the majority of participants, who mostly travelled by car. Ample, low-cost, and safe parking was requested. Furthermore, participants felt that paying on exit rather than entry would prevent overpaying by having to estimate the length of visit, along with reducing fines if they exceeded paid parking periods.

#### ***Nearby public transport***

For the minority of participants that relied on public transport, affordable and regular links were vital to attendance. Other concerns raised included a safe place to lock bicycles, along with specialised transport links for elderly patients or those living with dementia.

#### ***Extended hours***

Availability of extended hours appointments was a crucial proviso for many participants accessing healthcare services, usually due to work commitments. Additional access requirements in this category centred around the booking systems for appointments, which could be frustrating, unclear or have very few appointments available.

#### ***Communication***

Another barrier to accessing services that emerged from discussions was poor communication. Participants identified possible language barriers, similarly some patients may need easy read or large print communications. Others focused on communication skills of reception staff, which some felt could be improved to be less 'intrusive'.

### **5.2 Patient choice priorities**

#### ***Common themes & influential factors***

Convenience dominated priorities for choice for the vast majority of participants, with preferred options being those that caused minimal disruption for the patient's daily life and commitments. 'Convenience' referred to both location and timing of appointments, depending on individual circumstances.

Location of services and the timing of appointments were intrinsically linked; if one of these two were convenient, then the other did not matter so much to participants.

Individual circumstances played a role in decision making and prioritisation of choice elements. These included:

- Caring responsibilities
  - Full-time carers more flexible with time & location, but sometimes struggled with facilities & finances (e.g. paying regularly for parking)
  - Carers who worked were more likely to be time poor and thus needed highly convenient services
  - Parents of young children had varying needs in terms of timings, which depended on individual situations and the resources they had available
- Access to transport
  - Those with regular access to personal transport prioritised location less and had the 'luxury' of choosing provider as a higher priority
  - Those dependent on public transport were less willing to travel due to time and cost implications.
- Employment
  - Retirees were on the whole flexible with appointment timings and usually location, due to their availability in the day time
  - Self-employment, working on commission / chargeable hours, or flexibility of employers regarding time off, all influenced how highly prioritised 'out of hours' and minimal work absence was

Many participants prioritised being seen as soon as possible, and would be willing to forgo the convenience of a nearby location or evening / weekend appointment, in order to get seen quicker. If possible, showing wait times when offering choices would allow these participants to weigh up the options in order to make the most appropriate decision for them.

Severity, or perceived severity, of condition played a key role in prioritising choices. The more severe the condition, the more participants were willing to give up convenience and prioritised getting the highest quality care, and as soon as possible.

Similarly, the longer the period over which a patient was expected to need care, and live with their condition, the more choosing an appropriate and high quality provider was prioritised. Therefore, choice in provider moved from 'low priority' to 'high priority' as the severity of condition and length of relationship increased.

However, a consistent theme when discussing choice of provider was the general trust in the high standards of any provider working under the NHS. The quality of routine diagnostics was never questioned, while many felt specialists and consultants were of sufficient high quality to treat any situation. Therefore, many did not feel the need for options in provider.

One priority aspect of outpatient services, and indeed healthcare services in general, was continuity in care. It was important to most patients that they see the same specialist, in the same location, with a familiar support team. For some this stemmed from becoming anxious in unfamiliar situations, but the majority worried about repeating themselves across appointments and this impacting on the quality and consistency of their care.

A final concern about choosing a provider, which de-prioritised it for many, was that participants felt unsure or unable to make the choice. Some felt they did not have the information or expertise to base this decision on, and would rather take a recommendation from their GP. Others commented that they would need access to reviews or information on quality of services in order to make an informed choice.

### ***Direct Access Diagnostic Service***

For diagnostic services, convenience was most important to participants, most importantly in terms of location (highest priority), followed by a range of appointment times (second highest priority) including 'out of hours'. However, as a one-off, participants were largely happy to make an exception for either of these, although this depended on their access to transport and time off work.

Choice in provider was very low priority for this scenario, as participants assumed a similar standard would be met in all routine tests.

### ***Short-term Outpatient Service***

Priorities regarding short-term outpatient services varied slightly from diagnostics, as the need for specialist expertise meant that choice in provider was more important to some, who felt levels of experience, standard of care and facilities would be more variable in outpatient functions.

However, provider was still the least important choice; the convenience of a choice in location (highest priority) and appointment times (second highest priority) still took precedence. For some, multiple appointments meant that convenience was even more vital, due to the increased time commitment.

### ***Long-term Outpatient Service***

Priorities changed somewhat when it came to long-term outpatient services, given the substantial impact developing a long-term health condition can have. Participants became far less concerned about choosing a convenient appointment time (lowest priority) as many would adjust their schedules for an ongoing health issue.

Instead, participants leaned towards choosing a provider in order to ensure they received the best quality care for their condition. However, location remained high priority given the regularity of visits that would be expected from a long-term episode of care, and potential to be limited by long-term pain or mobility. Location and provider were of roughly equal high importance; different situations engendered different priorities.

It is also important to note that when participants discussed wanting to see the 'best' for a complex condition, these services tend to be regional in scope and patients already have the ability to choose which service they are referred to, so would not be affected by plurality of providers.

## **5.3 Barriers to using community healthcare services**

One of the greatest concerns of participants, when it came to potentially using community health services, was whether they would receive the same standard and quality of care that they would find in a hospital or central service.

Concerns focused on whether staff would have the same level of knowledge, expertise, and professionalism. Participants also wanted to know if the appointments would be the same length, and if the care they received would be consistent. Continuity in care was a particularly widespread concern as community services were perceived as more disparate and ad hoc.

Facilities were another concern, as some participants were unsure if equipment, hygiene standards and accessibility would match that of a hospital.

Some patients worried that community care would be 'forced' on them, even if they really did not want it. Reasons against it included home visits being 'invasive' or concern about visiting local specialist services for sensitive or stigmatised health issues.

## **5.4 Communicating 'Patient Choice'**

### ***Key messages when communicating choice***

Participants identified a number of key questions about patient choice that future communications would need to address. Some of the questions included were:

- What choices are patients fully entitled to and who is entitled to them?
- How do I ask for choice and how does it work?
- What information will be available to help make the choice?
- Will waiting times be affected?
- What options of location, provider and appointment times will be available?

Participants also commented that any communication must be clear, simple and free of jargon. Alternative languages, easy read and large print versions should be available where possible. Some also noted that there should be an option to find out more information and ask questions, however the communications should also work standalone.

### ***Method of communication***

A number of different communication methods were suggested as ways to communicate patient choice to the Leeds population, some more popular and viable than others. Popular choices included text message from GP surgery or GP / pharmacy information on TV screens and posters.

Some participants were in favour of a face-to-face explanation which would help them understand choice properly by being able to ask questions. This was either at a GP appointment, or through visits to community groups and information hubs. Another option is to deposit printed communications at such community groups.

Printed and online advertising methods were of mixed value to participants, who debated the effectiveness and cost.



**6. Appendix**

**6.1 Qa discussion guide**



**NHS Leeds CCG  
Patient Choice**

**Discussion Guide**

**Deliberative Event**

**14 March 2020**



**Icebreaker**  
***Straight after welcome***

TIMING	5 minutes: 10.40-10.45
TASK	Hosts to introduce themselves and give one interesting fact about themselves (simple - where you're from, what you do, pets etc).  Ask Ps to turn to their neighbour and take it in turns to tell them their name and one fact about them. Ask them to introduce their neighbour to the table afterwards.

**Discussion 1 – Demands on time**  
***Follow straight on from 5 min icebreaker***

TIMING	15 minutes: 10.45-11.00
AIM	Understand P's demands on their time, this will get them thinking about the factors that underpin choices as a patient, can later use these as prompts when thinking about choices
TASK	<p><b>Q: Thinking about your daily life, what are the different demands on your time?</b></p> <p>Participants to put post-its on communal sheet (SHOWCARD I) which has some prompts of categories (i.e. work, family, travelling, leisure)</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• How much time do you spend doing this?</li> <li>• What fills up most of your time?</li> <li>• Would you say you have a routine or things change week on week? If they change, what does that depend on?</li> <li>• Do you have people who depend on you to be places or do certain things?</li> <li>• Do you feel like you have lots of free time or not much?</li> </ul>
MATERIALS	SHOWCARD I – demands on time Post-its (Yellow) Pens

**Discussion 2 – Barriers to accessing services**  
**Following Discussion 1**

TIMING	15 minutes: 11.00-11.15
AIM	To check that the current service accessibility specs (extended hours, available car parking, bus route access, disabled access) are indeed important to patients, and most importantly are there any more missing that haven't been considered?
TASK	<p><b>Q: When you have an appointment at a hospital, doctors, clinic or other health service, which of these is it important to have?</b> (Disability and access considerations, nearby parking, extended hours appointments, close to bus routes)</p> <p><b>Why are these factors important to you, or those you care for?</b></p> <p>Participants to put post-its on communal sheet (SHOWCARD2) with accessibility/barriers on, of why each of the accessibility/barriers that are important to them</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• If these were NOT available to you, which is/are going to make it difficult for you to attend your appointment? Why is that?</li> <li>• How do people tend to travel around? Own transport? Public transport?</li> <li>• What about other people you know e.g. family?</li> </ul> <p><b>Explain: This first sheet shows what all <u>new NHS services</u> must have to make sure everyone can get to their appointments.</b></p> <p><b>Q: Can you think of any other practical barriers that might make it difficult for you to access your healthcare appointments and services?</b></p> <p>Participants to put post-its on communal sheet (SHOWCARD3) for open suggestions on barriers and access solutions.</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• Can anyone think of a time they've struggled to make a healthcare appointment? Why was that, what were the reasons behind it? Anything the NHS could have helped with?</li> <li>• Some of you put that travel could act as a barrier – can we think of any more to do with travel?</li> <li>• Some of you put that disability / mobility access was a barrier – any more on that?</li> <li>• Any more on extended hours? (Don't push too much on this as will come up later)</li> </ul>

**Discussion 3 – Direct Access Diagnostic Service, Choice Priorities**  
**Following the second presentation by Steve, which explains patient choice & what it means for direct access diagnostics**

TIMING	20 minutes: 11.30-11.50
AIM	To understand the reasons why different choices are important to participants, and gain a group consensus on priority (out of: <i>multiple providers, location, convenient appointments</i> )
TASK	<p><b>Moderator to ensure participants understand the scenario (ultrasound for a pain in shoulder, one-off diagnosis), what it includes/doesn't, and what the three choices are</b></p> <p><b>Q: Thinking about if you were in this scenario, and you're at the point where it's time to choose your appointment, which out of these three would be important to you and why? Which would be less important?</b></p> <p>Three separate sheets of paper (SHOWCARD4i, 4ii, 4iii) with the 3 different choices on. Participants apply green (why this choice is important) and pink (why the choice is less important) post-its with their reasons. We are looking for the <b>WHY</b> these choices are important.</p> <p>After an initial 'free for all', go through each of the three one by one:</p> <ul style="list-style-type: none"> <li>• Location – why is it important to be close to home or work for a one off diagnostic? Are there other location considerations?</li> <li>• Timing – why is it important to have evening and weekend appointments in this scenario?</li> <li>• Provider – why is it important to have multiple providers doing one-off diagnostics?</li> <li>• <b>For all three, are there any reasons why this choice isn't important to you?</b></li> </ul> <p>Prompts (can bring up discussion 1 &amp; 2):</p> <ul style="list-style-type: none"> <li>• Travel and transport</li> <li>• Mobility and access</li> <li>• Working patterns</li> <li>• Family and caring commitments</li> <li>• Severity of condition / pain</li> <li>• Research quality / reputation of provider</li> </ul> <p><b>Q: Having talked about the reasons why each of these choices are important, can we come to a group decision on a ranking of high priority to low priority?</b></p> <p>Moderator uses these as a prompt for group discussion about priority of each choice, the group comes to a consensus on low-high priority.</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• This sheet has a lot of positive reasons on, would we say this is high priority? Why? Anyone disagree?</li> <li>• This sheet has fewer reasons on, but does anyone think this should be high priority still?</li> <li>• Which out of these choices is going to make a one-off diagnostic easiest for you?</li> </ul> <p><b>Moderator notes priority on sheets.</b></p>

**Discussion 4 – Outpatient Clinic Short-term Episode, Choice Priorities**  
**Following lunch and second presentation by Steve**

TIMING	15 minutes: 12.25-12.45
AIM	To understand the reasons why different choices are important to participants, and gain a group consensus on priority (out of: <i>multiple providers, location, convenient appointments</i> )
TASK	<p><b>Moderator to ensure participants understand the scenario (2 or 3 appointments with a specialist dermatologist), what it includes/doesn't, and what the three choices are</b></p> <p><b>Q: Thinking about if you were in this scenario, and you're at the point where it's time to choose what specialist clinic you go to, which out of these three would be important to you and why? Which would be less important?</b></p> <p>Three separate sheets of paper (SHOWCARD5i, 5ii, 5iii ) with the 3 different choices on. Participants apply green (why this choice is important) and pink (why the choice is less important) post-its with their reasons. We are looking for the WHY these choices are important.</p> <p>After an initial 'free for all', go through each of the three one by one:</p> <ul style="list-style-type: none"> <li>• Location – why is it important to be close to home or work for a short term episode of care like this?</li> <li>• Timing – why is it important to have evening and weekend appointments?</li> <li>• Provider – why is it important to have multiple providers for short-term outpatient service?</li> <li>• <b>Q: This situation would be different to the one-off diagnostic, because you'd be going back a few times and you'd be getting treatment, how does this make a difference to your priorities, if at all?</b></li> <li>• <b>Q: For all three, are there any reasons why this choice isn't important to you?</b></li> </ul> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• Travel and transport</li> <li>• Mobility and access</li> <li>• Working patterns</li> <li>• Family and caring commitments</li> <li>• Severity of condition / pain</li> <li>• Research quality / reputation of provider</li> </ul> <p><b>Q: Having thought about the reasons why each of these choices are important, can we come to a group decision on a ranking of high priority to low priority?</b></p> <p>Moderator uses these as a prompt for group discussion about priority of each choice, the group comes to a consensus on low-high priority.</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• This sheet has a lot of positive reasons on, would we say this is high priority? Why? Anyone disagree?</li> <li>• This sheet has fewer reasons on, but does anyone think this should be high priority still?</li> <li>• Which out of these choices is going to make a short-term outpatient service easiest for you?</li> </ul> <p><b>Moderator notes priority on sheets.</b></p>

**Discussion 5 – Outpatient Clinic Long-term Episode, Choice Priorities**  
**Following Discussion 4**

TIMING	20 minutes: 12.40 -13.00
AIM	To understand the reasons why different choices are important to participants, and gain a group consensus on priority (out of: <i>multiple providers, location, convenient appointments</i> )
TASK	<p><b>Moderator to ensure participants understand the scenario (ongoing relationship for rheumatoid condition e.g. arthritis), what it includes/doesn't, and what the three choices are</b></p> <p><b>Q: Thinking about if you were in this scenario, and you're at the point where it's time to choose what specialist clinic you go to, which out these three would be important to you and why? Which would be less important?</b></p> <p>Three separate sheets of paper (SHOWCARD6i, 6ii, 6iii) with the 3 different choices on. Participants apply green (why this choice is important) and pink (why the choice is less important) post-its with their reasons. We are looking for the WHY these choices are important.</p> <p>After an initial 'free for all', go through each of the three one by one:</p> <ul style="list-style-type: none"> <li>• Location – why is it important to be close to home or work for a long-term episode?</li> <li>• Timing – why is it important to have evening and weekend appointments?</li> <li>• Provider – why is it important to have multiple providers for long-term outpatient services?</li> <li>• Q: This situation would be different to the short-term specialist, because you'd be going back many times over a long period, and receiving ongoing treatment, how does this make a difference to your priorities, if at all?</li> <li>• Q: For all three, are there any reasons why this choice isn't important to you?</li> </ul> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• Travel and transport</li> <li>• Mobility and access</li> <li>• Working patterns</li> <li>• Family and caring commitments</li> <li>• Severity of condition / pain</li> <li>• Research quality / reputation of provider</li> </ul> <p><b>Q: Having thought about the reasons why each of these choices are important, can we come to a group decision on a ranking of high priority to low priority?</b></p> <p>Moderator uses these as a prompt for group discussion about priority of each choice, the group comes to a consensus on low-high priority.</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• This sheet has a lot of positive reasons on, would we say this is high priority? Why? Anyone disagree?</li> <li>• This sheet has fewer reasons on, but does anyone think this should be high priority still?</li> <li>• Which out of these choices is going to make long-term outpatient services easiest for you?</li> </ul> <p><b>Moderator notes priority on sheets.</b></p>

**Discussion 6 – Community Healthcare Services**  
**Following Discussion 5**

TIMING	10 minutes: 13.00 -13.10
AIM	<p>What would put people off attending community healthcare services?</p> <p>What are people’s worries around community healthcare? What questions do they have?</p> <p>This is to understand what the CCG need to do to give people confidence that community services are every bit as good as hospital services.</p>
TASK	<p><b>In the future, many healthcare services that are usually in hospitals may be provided out in the community i.e. in your home or smaller ‘satellite’ clinics</b></p> <p>Examples: Ophthalmology and Ear, Nose and Throat is already on a community basis, something like Rheumatology could be in the future</p> <p><b>Q: If it is planned that more services are to be delivered in community settings instead, what would put you off attending these?</b></p> <p><b>Q: What assurances might you need/what might influence you to attend community provided services? What would make you feel confident in community services?</b></p> <p>Encourage group discussion about influences / assurances on using community healthcare, participants put thoughts on post-its on SHOWCARD7. Any barriers on the BARRIERS side, and assurances or questions they have on the ASSURANCES side.</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• Quality of care / receiving same treatment?</li> <li>• Availability / as quick as in hospital?</li> <li>• Emergencies?</li> <li>• Continuity in care /same practitioners or nurses?</li> </ul>

**Discussion 7 – How to communicate choice rights and options to public?**  
**Following Discussion 6**

TIMING	15 minutes: 13.10-13.25
AIM	<p>How can NHS/CCG best communicate patient choices to the public, so they feel empowered to exercise their choices?</p> <ul style="list-style-type: none"> <li>- <b>What</b> patients need to know about choice, the key messages that need to be communicated.</li> <li>- Best <b>method of communication</b> to encourage patient empowerment to exercise choice.</li> </ul>
TASK	<p><b>Q: Quick show of hands, before today how many of you knew that you had the right to choose where you got your NHS care?</b></p> <p><b>Now we're going to think about how the NHS can best communicate this so that everyone who needs to know this feels like they have enough information to exercise their right to choose services.</b></p> <p><b>Q: What are the key messages or questions you would want answering, if you were to be told about the choices you're able to make as a patient?</b></p> <p>Open task where participants place post-its on sheet, moderator facilitates discussion on key messages; what is needed, what questions on choice would they want answered?</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• What have you learned today about patient choice that you think is useful or important information?</li> <li>• Anything confusing that needs extra care taken to explain?</li> <li>• How much information is enough to make you feel confident to talk about choice and make choices about your care?</li> <li>• How much is too much and would make you switch off?</li> </ul> <p>Prompts (but try to keep as spontaneous as possible!):</p> <ul style="list-style-type: none"> <li>• What services you can / can't choose</li> <li>• How to bring up choice / who to bring it up with</li> <li>• What to do if you're not allowed choice</li> <li>• Where to find out more info</li> <li>• <b>More images or more text/info?</b></li> </ul> <p><b>Q: Now we've discussed the content, what's the best way to get this to the public? What's the best method of communication to get the message across?</b></p> <p>Open task where participants place post-its on sheet, moderator facilitates discussion on pros/cons/reasons for suggestions, why would these be effective? What's realistic?</p> <p>Prompts:</p> <ul style="list-style-type: none"> <li>• Why would this method be effective? Why might it not be most effective?</li> <li>• Who would this method get the message across to?</li> <li>• Who would pay attention if they saw a message about the NHS / choice here?</li> </ul> <p><b>Q: Where in your patient journey would you prefer to be told about choices?</b></p> <ul style="list-style-type: none"> <li>• Way beforehand (society-wide understanding of choice)</li> <li>• When first engage with health services (e.g. when book GP appointment)</li> <li>• Just before appointment (e.g. GP waiting room)</li> <li>• At appointment (e.g. in GP appointment – at point of choice)</li> </ul>



