

Choose and Book

Simon Walford

ABSTRACT – Choose and Book combines three major elements of NHS organisational development. Patients are offered increasing choice about where they receive specialist advice, they have more control over the booking of their appointments, and a Choose and Book information technology (IT) application is being implemented to facilitate both these aspects of care. By exploring these three elements, some of the causes of difficulty in clinical implementation and the additional information required to inform choice are identified.

KEY WORDS: appointment scheduling, Choose and Book, National Programme for Information Technology, NHS Connecting for Health, patient choice, patient information

Introduction

During the autumn of 2006, Choose and Book, the vanguard of the NHS National Programme for Information Technology in England, should complete its millionth booking. Already, patients referred by their general practitioner (GP) for routine specialist advice can choose which hospital to attend and should be offered a mutually convenient appointment. Increasingly, they are able to book that appointment directly through Choose and Book. After a difficult start, the technology looks more capable, more resilient and increasingly likely to achieve universal adoption, but there is still significant scepticism among clinicians.

To understand why the difficulties and complexities of these changes are so challenging to clinical practice, it is helpful to recognise that in Choose and Book three separate elements of innovation have been combined:

- Through the NHS Improvement Plan,¹ eligible patients are assured of a clinically appropriate choice from at least four hospitals or a suitable alternative provider when referred for a specialist outpatient opinion. Choice of provider is extending towards an ultimate goal of 'free choice' by 2008.
- Patients must be allowed to book a mutually convenient appointment.
- Choose and Book IT has been introduced to assist clinicians and patients in making

appropriate choices and booking convenient appointments.

Each of the three elements has presented significant demands for organisational change on tight timescales with a background of financial and organisational uncertainties in the NHS, and has clearly proved to be a formidable challenge across both primary and secondary care.

Choice of provider

Choice policy has met with a mixed reaction from doctors, and while medical institutions such as the BMA and the Royal Colleges have accepted the principle, practising clinicians have often struggled with their own philosophical uncertainty and practical constraints. Those of a rather paternalistic consulting style have found it particularly difficult to accept that patients should be encouraged to assert their own view of where they might receive treatment. They doubt that patients can be sufficiently informed to make a 'better' choice than their expert doctor.

For the sceptical clinician, one concern is about the information available to patients at a time when they may be feeling particularly vulnerable. Another is a suspicion that the introduction of patient choice is designed more to energise a market in efficiency and quality between hospitals than to increase the sense of patient autonomy and participation in decisions about their healthcare.

Enthusiasts have seen choice as an important way to involve and empower patients and to put pressure on hospitals to be more responsive to patients' needs. Enthusiasm is tempered, however, by concern about the time it might take a GP to discharge their new responsibilities as well as the need to make relevant information available to doctors and patients.

For all clinicians, concerns have been compounded by frustrations with the early and faltering implementation of Choose and Book IT. Many have difficulty separating ethical, clinical and technological elements which may influence their attitude, linking these frustrations with their more general sense of a loss of professional status and power.

Do patients want choice?

Clinicians have often been dismissive of the general notion that patients want choice. Research in this

Simon Walford MD
FRCP, Consultant Physician, Royal Wolverhampton Hospitals; Senior Medical Adviser, Commissioning Directorate, Department of Health

Clin Med
2006;6:473–6

field is inconclusive as to exactly what patients do want, but it leaves little doubt that the opportunity to make choice for oneself is highly valued. Patients describe a lack of explanation and conflicting information in their consultations and clearly express a desire for greater involvement in decisions about their treatment.^{2,3} The information needs of patients may change substantially at different points in their journey, often in ways that are well understood.⁴ Even in areas of care where self-management and education have long been a part of the care package, knowledge, perceptions of care and sense of empowerment still demonstrate many gaps. For example, when asked if their HbA1C had been measured in the past year, 40% of a national sample of people with diabetes said they did not know.⁵

It takes considerable skill on the part of the clinician to elicit and effectively address individual needs. Professionals must be sensitive to the priorities, interests and social realities of every patient; in practice many do not have the time nor perhaps the inclination to listen and resort instead to making assumptions. Consequently, patients often find it difficult to articulate their concerns and may leave these critical encounters without the answers they wanted and, potentially, with greater misunderstanding.⁶ Shared decision making is increasingly seen as the ideal form of clinician–patient relationship in which the patient optimises their sense of participation and the power within the relationship is equitably balanced. Amongst cancer patients, for example, 63% felt the doctor should take primary responsibility in decision making, whilst 27% felt it should be an equally shared process and 10% felt that they, the patient, should take the major role.⁷

Is ‘choice’ a threat to medical professionalism?

Although an element of patient choice is present in existing good practice, the commitment to offer universal and explicit choice of specialist service provider has not been part of NHS culture. Other well developed healthcare systems in Australia or North America, for example, routinely offer patients the choice of provider at many points on their journey. In these countries, choice will often include which specialist they see, where and when diagnostic investigation is done, and where and when to plan intervention when diagnosis is complete. People in these countries generally assume that they have choice. Even the beginnings of patient choice, to which the NHS is now committed, have been linked by clinicians to their uneasy sense of erosion of professional status whilst patients are starting to realise the opportunity of choice offered to them.

Recently, two constructive contributions have emerged which may help clinicians to understand their role in a contemporary context. In the first, the Royal College of Physicians (RCP) has examined medical professionalism in the context of the role of doctors in society.⁸ The RCP working party offered a definition of professionalism and a descriptive analysis of its components, emphasising that:

Medicine is a vocation in which a doctor’s knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient

and doctor, one based on mutual respect, individual responsibility and appropriate accountability.

In the second, Lakhani and Baker⁹ describe a vision for general practice where GPs might see themselves more as ‘navigators’ than ‘gatekeepers’ in the modern NHS. Again they emphasise a patient-centred approach where clinicians would be supported by highly developed strategic organisations collaborating with each other in a community network.

Patient choice and the ethics of autonomy

Within the context of a public service, the autonomy of the patient exercising choice cannot be viewed in isolation. There is an important balance to be maintained between the wants and needs of the individual and that of the whole community to ensure sustainable equity of the local health economy. In ethical terms, there will always be tension between autonomy of personal needs and the autonomy of integrity that preserves the system’s equity. This conundrum is at the heart of stories of ‘post code prescribing’ which varies access to expensive treatments within the ‘national’ health service.

Doctors find it difficult, on a day-to-day basis, to balance the competing claims of the individual and the equitable use of finite resources for the common good. Selfishly perhaps, patients trust clinicians to act in their best interest. Intellectually satisfactory referral guidelines designed to optimise effective use of resources based on careful evaluation of the scientific evidence may not always be so easy to sustain in a one-to-one consultation. Clinicians are uneasy about national standardisation and suspicious that national technology might be used to drive changes in behaviours, values and relationships. The advice to medical managers from the General Medical Council reinforces the view that:

Whether you have a management role or not, your primary duty is to your patients. Their care and safety must be your first concern. You also have a duty to the health of the wider community, your profession, your colleagues, and the organisation in which you work.¹⁰

Equity and distributive justice clearly take a distant second place – a powerful cultural influence which contributes to the responsible presentation of treatment choices. GPs are increasingly likely to face this dilemma as they are involved not only in enabling the individual patient to get what they need but also in helping to commission a broad range of services for the common good. Should patients be informed of the impact of their choosing on the rest of their community?

Information and choice

A direct consequence of the choice initiative has been an increasing effort to present useful information that is easy for patients to access. Patients want information about their illness, the service providers they are choosing between for treatment and, increasingly, the skills and track record of particular specialist services. Some organisations have already begun to extend the role of patient advice and liaison services to help those

looking to navigate their way most effectively through a complex healthcare system. For patients, such access to information is likely to stimulate their interest and understanding about what is happening to them.

There may be synergy between the requirements of good clinical governance and audit to define and monitor the quality of care from a professional point of view and the growing information requirements of patients who legitimately seek to know what outcome they might expect. Clinicians are beginning to tackle their reluctance and find methodology to avoid the pitfalls of misleading comparison. Early attempts to provide clinical outcomes data either by specialty, in the case of cardiac surgery,¹¹ or by institution, in the case of St George's Hospital,¹² have been controversial. The evidence suggests that as waiting times for access to specialists fall below about 10 weeks, these quality criteria become increasingly important to patients planning their care and a stronger driver than directive advice from the GP.¹³ The information needs of clinicians helping patients navigate are at least as great and there is much benefit in presenting reliable information to both based on common sources.

The commercial organisation Dr Foster has demonstrated how published official statistics can be represented in much more accessible ways. Sometimes their work, often in partnership with national newspapers to rank NHS organisations, has provoked irritation among clinicians and debate about fairness, but there are many examples of hospitals responding with critical reappraisal of their performance. The Healthcare Commission is taking a key role to publish validated comparative data about hospitals and clinical services. The BMA makes information about the management of common clinical conditions based on best clinical evidence available in a form accessible to non-medical readers.¹⁴ In all these examples, the same data sources inform both clinicians and patients. There is a reasonable concern that the reliability and objectivity of the information industry may need regulation, and the Department of Health (DH) is committed to the notion that officially recommended sources will be quality assured.

NHS.uk has been developed as an internet portal linked to the patient interface in the Choose and Book system that allows the patient to create comparative tables of information about the providers they might use. The DH has also started to promote the availability of easy access to relevant health information through the Public Library and Health Library Service, of which there are more than 3,000 sites in England. Currently, these initiatives focus on information about organisations rather than clinical services.

General practitioners have relied on informal and subtle information networks in local health communities to direct specialist referrals. Although clinicians place considerable store by these networks, it is hard to demonstrate any properties of consistency or objectivity. Neither can we reassure the public that they are free from discriminatory influences. We must acknowledge that they exist and can exert significant influence on the advice given by clinicians. As the scope of choice widens outside the geographical range of these networks, GPs are concerned about what sources will guide their advice.

In parallel with informal professional networks, a mechanism now exists to capture the self-reported opinions of recent patient experiences and to publish them with potentially powerful influence on the internet.¹⁵

Making an appointment

It is common for a patient to leave a consultation with their GP with a triple uncertainty. Firstly, the need for a specialist opinion indicates the possibility of serious illness, but with an uncertain diagnosis. Secondly, they know that a visit to hospital is required, but not where or when it is to take place. Thirdly, they know little or nothing about the specialist to whom they have been referred. The commitment that specialist referrals will be booked with the minimum of delay and at the patient's convenience is an important step in improving the patient referral experience.

Those GP practices using Choose and Book report the positive reassurance experienced by a patient who can leave the surgery already knowing where, when and with whom their specialist advice is to be given. Gone are the weeks of uncertainty waiting for an appointment that have been the norm, of letters lost or delayed or appointments never received. The new system supersedes information exchanged between the GP, the specialist and the patient in an unstructured way, often through insecure routes. Using the Choose and Book IT application, the GP can automatically construct a letter containing the key details of the patient's past history and treatment, together with the reason for referral. It facilitates the selection, not only of the available choices where specialist help may be provided, but also a specific appointment in a particular clinic. The patient has the option of having further time to decide and book or change their appointment using the telephone or the internet. All these communications take place in a resilient and secure national NHS communication spine.

Audits of the work of primary care administrative staff using traditional, paper-based systems, confirm a variable but substantial task keeping track of referrals for specialist advice and the responses. Not only do direct booking and communications systems provide clarity, flexibility and reassurance to the patient, they will also reduce the burden of administration within the GP surgery. At the hospital, the specialist can review the referral information electronically and modify the priority or redirect the patient if necessary. Some hospital specialists are concerned that direct booking to their clinics reduces their flexibility to plan an appropriate path for the patient. It is important for hospital clinicians to recognise how much better the Choose and Book experience is proving to be for patients and to mitigate their concerns by careful review of the clinical and management processes operating in their clinics. It is in this respect that moving towards a patient-led process is perhaps having the greatest impact on specialist services.

Conclusion

Choose and Book encompasses a complex triad of changes to clinical practice across the entire span of primary and secondary

care. The task could scarcely have been larger or more challenging. Clinicians generally want the NHS to embrace new technology and they support the principles of greater choice for patients. As practical realisation of those aspirations has begun it has proved extremely complex at every level. Within the wider NHS modernisation framework set by the government, the evolution of appropriate and greater patient choice about their care is still open to shaping by constructive clinical influence. Enabling patients to book themselves directly into specialist clinics requires considerable adjustment for some services to develop clear and consistent pathways. Within the National Programme for IT, the Choose and Book application is both pathfinder and pioneer. On reflection, it is no wonder that Choose and Book is sometimes the source of frustration and difficulty. There is reason to believe that we are beginning to see the benefits and the substantial potential gain for perseverance.

Acknowledgements

The article includes reflection on an informal workshop held with members of the Royal College of General Practitioners and the Royal College of Physicians in London in January 2006. The author thanks Ruth Lewis for help in developing the article and colleagues for constructive criticism. The content and views expressed are entirely the responsibility of the author and should not be taken to represent the position of any organisation.

Conflict of interest

The author is seconded to work in the Department of Health and makes a significant contribution to the Choose and Book Implementation Team.

References

- 1 Department of Health. *The NHS improvement plan: putting people at the heart of public services*. London: DH, 2004. Cm 6268.
- 2 Coulter A. Engaging patients and citizens. In: Leatherman S, Sutherland K (eds), *The quest for quality in the NHS*. London: The Nuffield Trust, 2003.
- 3 Park A (ed). *British social attitudes: the 22nd report*. London: Sage Publications Ltd, 2005.
- 4 Rees CE, Bath PA. The information needs and source preferences of women with breast cancer and their family members: a review of the literature published between 1988 and 1998. *J Adv Nurs* 2000;31:833–41.
- 5 Raleigh VS, Clifford G. Knowledge, perceptions and care of people with diabetes in England and Wales. *J Diabet Nurs* 2002;6:72–8.
- 6 Teutsch C. Patient-doctor communication. *Med Clin North Am* 2003; 87(5):1115–45.
- 7 Sutherland HJ, Llewellyn-Thomas HA, Lockwood GA, Tritchler DL, Till JE. Cancer patients: their desire for information and participation in treatment decisions. *J R Soc Med* 1989;82:260–3.
- 8 Royal College of Physicians. *Doctors in society: medical professionalism in a changing world*. London: RCP, 2005.
- 9 Lakhani M, Baker M. Good general practice will continue to be essential. *BMJ* 2006;332:41–3
- 10 General Medicine Council. *Management for doctors*. London: GMC, 2006.
- 11 The Healthcare Commission. *Heart surgery in Great Britain*. heart-surgery.healthcarecommission.org.uk (accessed 10 August 2006).
- 12 St George's Healthcare Trust. *Mortality at St George's*. www.stgeorges.nhs.uk/mortalityintro.asp (accessed 10 August 2006).
- 13 Burge P, Devlin N, Appleby J *et al*. Understanding patients' choices at the point of referral. RAND Europe, City University and The King's Fund. London: DH, 2006.
- 14 www.besttreatment.co.uk
- 15 Patient Opinion. www.patientopinion.org (accessed 10 August 2006).