Priorities in identifying unmet need in older people attending general practice: a nominal group technique study

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\textbf{Background.} Primary care practitioners are encouraged to identify unmet need in older people, but the best mechanisms for doing this are not known.

\textbf{Objective.} To identify common unmet needs, as perceived by older people and professionals, that could be enquired about during routine encounters in primary care.

\textbf{Methods.} This was a nominal group technique qualitative study conducted with older people in London and primary care professionals working in the same localities. Subjects were seven nominal groups of 5–12 participants each, four with culturally diverse user groups recruited through local community and voluntary sector resources and three with primary care professionals (GPs and nurses). Group interviews were conducted with two facilitators and one observer recording field notes and were tape-recorded and transcribed for data collection.

\textbf{Results.} Older people and professionals share some ideas about unmet need, but there are important differences. Older people may emphasize their autonomy and right to make choices, while professionals may use epidemiological knowledge to justify their own agendas, which may be considered intrusive. Nominal groups can be useful tools for capturing perspectives of different groups, but prioritization of themes identified by nominal groups may not always be feasible.

\textbf{Conclusions.} Unmet need is a complex concept, with different interpretations according to the perspective taken. Professionals relying on epidemiological knowledge to guide their enquiries about unmet needs in older patients may find that the needs that they identify are not perceived as unmet, or even meetable, by their patients.

\textbf{Keywords.} Ageing, health promotion, preventive medicine.

\textbf{Introduction}

There is evidence of consistent under-detection of health problems in older people by primary care practitioners.\textsuperscript{1,2} However, there is also a lack of clarity on optimal methods for reducing this under-detection in general practice.\textsuperscript{3–5} Multi-dimensional identification of problems with associated action may improve survival, functional abilities and reduce admission to hospital and care homes.\textsuperscript{6} In the UK, the National Service framework for Older People promotes a shared multi-dimensional assessment process for older people presenting complex problems to health and social care services, and at the same time argues that primary care professionals should actively explore unmet needs each time an older person consults.\textsuperscript{7} It is not practical to use a multi-dimensional assessment tool in an ordinary surgery consultation with a GP or practice nurse when average appointment times
There is a need for a shorter tool that builds on existing information rather than forming a comprehensive assessment in its own right. Studies using comprehensive assessments reveal a common pattern in unmet need. In the time-pressured environment of a surgery consultation, it is only practical to explore the most important unmet need(s), which raises the question: important to whom and on what criteria?

The divergence in beliefs about health, illness and disease between lay people and medical professionals has been well known for a long time. Older people’s concepts of health and illness reflect those of other lay groups in society and are contingent on sociodemographic and contextual factors. The concepts range from health: as an absence of disease, as a source of strength to resist illness and dependence and as having the capacity to function in everyday life. Multiple and sometimes conflicting beliefs are held simultaneously. Studies reporting older people’s reluctance to seek help for problems and declining treatment or services for identified problems provide evidence of this divergence, although other considerations such as social identity in old age, appropriateness and acceptability of services could provide other explanations. Health professionals also draw on multiple concepts of health disease and illness, but doctors are often characterized as primarily defining health as the absence of pathological disease.

There are few published accounts of older people’s priorities for primary care in addressing unmet need. This is despite policies for user inclusion, particularly of older people, in public service development. An older people advisory group to a national UK charity prioritized ‘dealing with problems of sight, hearing, teeth and feet, managing continence problems and bereavement and picking up early signs of diabetes or other conditions’. There is similarly little published of primary care health professionals’ priorities for older peoples health; more common are accounts of primary care professionals negative attitudes to identifying or addressing unmet need in older people. This paper sets out to address this by reporting on a study using a nominal group technique (NGT). NGT is a structured and focussed group interview that allows for the generation of ideas and development tool which has a particular role in analysing health care problems and can help bridge the gap between researchers and practitioners. More commonly used with health care professionals, NGT has been used specifically to identify patients and health professionals’ priorities in primary care. This study formed part of a larger project to develop a short clinical tool to aid identification of unmet need in older people in primary care. The overall results of this study are published elsewhere.

Study objectives

- (i) To identify and prioritize which unmet (hidden) health or social needs a GP or nurse should ask about during routine consultations.
- (ii) To explore the different perspectives of older service users and health professionals on the identification of unmet need.

Methods

Seven nominal groups were conducted, with 5–12 participants in each (Table 1). The groups were purposively selected to represent as diverse a range of views as possible and to seek views of those traditionally ‘hard to reach’ such as older people from ethnic minorities. Four user groups were conducted, one in an general voluntary group setting (Age Concern Day Centre), one in a local community group, one in an African Caribbean and one in an Asian Elders group. Three of these were held with groups of older people who met together on a regular basis for social activities. One was convened specifically with volunteers from a community older people’s organization. Three professional groups were held, two for GPs and one for practice nurses. The methodology was identical for all groups.

Each group was co-facilitated by members of the research team experienced in nominal group methods and a user representative of the research team. The Asian elders group was also co-facilitated by a local...
representative who translated the discussion into Gujarati for non-English speaking participants.

The group discussions were designed to follow the same NGT process\(^{27}\): introduction and clarification of the research task; silent generation of ideas; generation of ideas as a group (offering ideas in turn for recording on a flip chart); refining the list by adding, merging or removing ideas; individually ranking the five most important ideas; and group review of the aggregate ranking and then closure. The introduction included obtaining consent from participants and the closure phase included the invitation of all participants to a research feedback event. Each group was asked to generate a priority list of important unmet needs that they felt would be appropriate to be introduced in a routine GP or practice nurse consultation with an older person. Unmet need was defined as a problem that an older person had, that may be hidden or not immediately obvious to their doctor or nurse and that had not been adequately addressed either by themselves, their family and friends or professionals. The discussion was recorded by an observer taking detailed notes and by audiotape that was later transcribed.

The NGT creates two types of data. The first is the written ideas and prioritization, validated by the group as part of the process. The second is the wider discussion generating and clarifying the ideas. This second type of data was transcribed and a content analysis\(^{32}\) undertaken by two members of the research team independently and then compared. A Local National Health Service Research Ethics Committee reviewed the study.

**Results**

**Identifying the unmet needs for general practice consultations**

Each group through the generation of ideas and subsequent discussion identified a list of ‘unmet needs’ that could potentially be addressed in the context of a routine consultation with a GP or practice nurse. The ideas list from the nurse group is given as an example (Box 1).

<table>
<thead>
<tr>
<th>Box 1  Overall topic/question list ideas generated by practice nurse group</th>
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</thead>
<tbody>
<tr>
<td>How have you been since the last contact?</td>
</tr>
<tr>
<td>Is there any thing you think we could help you with?</td>
</tr>
<tr>
<td>Do you have any worries?</td>
</tr>
<tr>
<td>How are things at home? (feelings, relationships and practicalities)</td>
</tr>
<tr>
<td>Are you happy with the way things are?</td>
</tr>
<tr>
<td>Do you live alone?</td>
</tr>
<tr>
<td>Are you lonely?</td>
</tr>
<tr>
<td>Do you have any help?</td>
</tr>
<tr>
<td>Who are your next of kin?</td>
</tr>
<tr>
<td>Are you sleeping ok?</td>
</tr>
<tr>
<td>How are you feeling?</td>
</tr>
<tr>
<td>What is your memory like?</td>
</tr>
<tr>
<td>Do you have any breathing or chest problems?</td>
</tr>
<tr>
<td>Can you cope with your medications? Do you know what they are for?</td>
</tr>
<tr>
<td>Have you had any falls recently?</td>
</tr>
<tr>
<td>Problems with mobility, getting about, getting to the surgery?</td>
</tr>
<tr>
<td>Problems with your accommodation?</td>
</tr>
<tr>
<td>Problems with undertaking housework?</td>
</tr>
<tr>
<td>Do you cook for yourself?</td>
</tr>
<tr>
<td>Are you able to care for your self such as washing and dressing?</td>
</tr>
<tr>
<td>Problems with pension, finance, bills?</td>
</tr>
<tr>
<td>Continence (do you get to the loo in time? Problems with your water works?)</td>
</tr>
<tr>
<td>Problems with eyesight &amp; hearing (sensory impairment)?</td>
</tr>
<tr>
<td>Any change from last time we met in the surgery?</td>
</tr>
</tbody>
</table>

Professionals identified eight other domains of potential importance that were not raised by users, such as housing, poverty, nutrition, self-care, incontinence and alcohol. The older users highlighted the problems associated with caring for sick relatives themselves and the need for information on any medical problems, which were not raised as issues by professional groups.

There was a broad consensus across all four user groups about important unmet needs and little differences were identified between the views expressed from the groups of different ethnic origin. Similarly, there were little difference in the ideas generated between the GPs and the nurses groups.

The prioritization or ranking process where participants were asked to select which five of unmet needs were most important was found to be difficult for all groups. This was particularly so for the user groups, who were unable to complete this last stage of the process. Analysis of the transcripts of each group discussion reveals two overarching themes with both users and professionals that illuminate both their ideas and
their difficulties in prioritization. These were themes of feasibility and acceptability.

Feasibility

All groups, user and professional challenged the feasibility of undertaking the opportunistic identification of unmet need in routine consultations. This challenge arose from a number of different concerns. Both professionals and users pointed to the demand upon and the time constraints of usual general practice consultations as prohibitive barriers to exploring unmet needs. Many users described short to the point consultations with GPs:

My doctor always has a full waiting room. I see him and then when the five minutes is up and you’ve got your prescription and that’s the end of it, you know. I don’t think he can be interactive like this in five minutes. Male 4, (User group 4)

The professionals not only recognized the constraints of a normal surgery consultation but some pointed to the demand upon and the time constraints of usual general practice consultations as prohibitive barriers to exploring unmet needs. Many users described short to the point consultations with GPs:

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The professionals not only recognized the constraints of a normal surgery consultation but some pointed to the complexity of the needs of some older people:

The elderly need more than ten minutes in consultation. They don’t come very often and have polypharmacy and polypathology. GP3 (GP Group 1)

Another challenge from both professional and user groups was the implied presumption of homogeneity in older people. Members of the user groups argued that similar ages did not automatically result in the same health issues. The professionals argued likewise. The practice nurse group pointed out that prior knowledge from medical records and previous consultations shaped the types of questions they would pose of unmet need. The consensus opinion in the nurses group was that open-ended questions provided an opportunity for the patient to bring their own agenda into the consultation and allow for that heterogeneity. There was less consensus on this in the GP groups. Examples of open questions that were suggested included:

Any changes since last time? How are things at home? Nurse 5 (Nurse Group)

In all the user groups, individuals identified that some GPs appeared to be disinterested in the problems they, as older people, brought to them and therefore unlikely to pursue a proactive, preventative approach:

Some doctors, after you are 65, they don’t want to know you. Female 3 (User group 2)

There was generalized agreement among the users that the doctors’ communication style was pivotal in creating the consultation in which unmet needs might be discussed. As part of this discussion, there were extensive narratives of problems in gaining appointments in general practice, in attending both practices and hospital outpatient appointments and waiting times for social service/occupational therapy assessments. Most of the problematic narratives in primary care were matched by a briefer, more positive narrative from another member of the group, illustrating the diversity of experience.

Acceptability

A second overarching theme was the acceptability of identifying unmet needs in general practice consultations. Competing views were offered. One user group identified that some people might not want to ‘bother’ the GP with problems and proactive questions would, in a sense, give permission for those to be raised. In contrast, views were raised in other groups that the process was unacceptable as it implied deficits in them as adults by virtue of their age alone:

Really, I don’t think its necessary because I know I’m alright…. We’ve still got our marbles. Even though we’re getting old! Female 6 (User group 1)

Some people questioned its acceptability on the grounds that it ignored the choices and responsibilities patients have:

<table>
<thead>
<tr>
<th>Box 2</th>
<th>Potential unmet needs identified by user and professional groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domains of unmet need identified by</td>
<td></td>
</tr>
<tr>
<td>Both older users and health professionals</td>
<td>Older users only</td>
</tr>
<tr>
<td>Physical health</td>
<td>Caring for sick relatives</td>
</tr>
<tr>
<td>Medication review</td>
<td>Information on condition/treatment</td>
</tr>
<tr>
<td>Mental health</td>
<td>Falls</td>
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<tr>
<td>Access to services</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Eyesight</td>
<td>Self-care</td>
</tr>
<tr>
<td>Hearing/communication difficulties</td>
<td>Incontinence</td>
</tr>
<tr>
<td>Mobility, including use of aids</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Memory</td>
<td>Intimate relationships</td>
</tr>
<tr>
<td>Social isolation loneliness/support networks</td>
<td></td>
</tr>
</tbody>
</table>

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We are the person who have to help along the National Health Services by doing things, by telling the doctor things, not expecting the doctor to do it all. Male 2 (User group 3)

Discussion

This study of lay and professional perspectives on health needs in later life has identified two aspects of direct clinical and practical relevance: the first is the different perspectives of users and professionals and the second is different views of mechanisms required to elicit unmet needs in consultations.

The first aspect identified is that the perspectives of lay people and professionals overlap significantly around a largely medical agenda, but with unique differences for each group. We characterize these differences as ‘active agent’ from the lay perspective and ‘epidemiological/intrusive’ from the professional perspective. Active agents are older people who are thinking about their health and well-being, solving problems and seeking help only when they so choose. This can include choosing not to respond to a symptom if they did not want to; or it could be expressed as an informed willingness to take a risk with their health. The epidemiological/intrusive perspective allows professionals to draw conclusions about individuals from population data, and pursue their own agenda in consultations. Knowing that depression and disability are associated then allows a family practitioner to ask a patient with, say, extensive osteoarthritis, about depression, even if this has not been raised by the individual.

The common ground between lay and professional perspectives shown in Box 2 contains a predictable medical agenda constructed around illness, medication use and access to services. Disabilities—mobility loss, visual function loss and hearing problems—are also shared, matching the scale and impact of these problems. Both these categories are essentially tractable, with potential for significant improvement in the quality of life of older people, and there is nothing surprising about the agreement between lay and professional perspectives. Our study identified social isolation as an unmet need, but there is little evidence that this need can be met effectively. Service providers experience significant levels of concern and frustration, and a sense of powerlessness in meeting the needs of isolated older people.

Professionals encouraged by current policy to identify unmet need, and who heed the endorsement by older people of social isolation as such a need, may find themselves seeking a problem for which they have, as yet, no solution.

Perspectives unique to professionals ranged from an ecological view of ill-health being related to poverty, poor housing and nutrition, through a concern with frailty (falls, self-care) to topics that are highly personal and sensitive (incontinence, intimate relationships, alcohol misuse). These perspectives focus on the older person as the object of external forces, or becoming increasingly dependent, or concealing important hazards and risks. Older people themselves express a view where they are active as carers, and in need of more information about their health. The two perspectives could not be more different, and the differences are relevant to the second aspect identified in this study, the way in which unmet needs are identified.

The second aspect identified that there were different views of mechanisms required to elicit unmet needs in consultations. Again the user groups presented older people as active agents in consultations, rather than passive recipients. The professionals are divided about techniques they should adopt in trying to elicit unmet need, between those taking a checklist approach and those preferring a conversational style of working with older people. Our findings suggest that practice nurses were just as likely as GPs to want to use open-ended, conversational styles of enquiry, and less enthusiastic about checklist approaches to identifying unmet need. The anecdotal perception that nurses are more structured in their thinking and practice, and therefore more systematic than doctors, is not supported by our data.

Both users and professionals in the study challenged the feasibility of the proactive search for unmet needs in general practice consultations, raising questions for protocols or guidance that encourage such ‘proactivity’. Both users and professionals in this study disputed the premise that similar age in patients equated to similar or standardized health problems. Indeed, the issues raised of acceptability prompt the question as to whether this type of proactive searching for unmet needs embodies an epidemiological/intrusive professional philosophy that is at odds with other professional values and public policies that decry ageism in health and social care services.

These findings and questions of feasibility and acceptability influenced the larger study aimed at developing a brief assessment instrument. As a consequence, we shifted the emphasis from creating an instrument to creating a heuristic i.e. a set of ‘rules of thumb’ to be used in general practice.

Limitations of the study

This is a small-scale study, offering some findings that can be generalized at a theoretical level. It used a NGT with both professionals and users, and user groups failed to complete all stages of that process. The participants, particularly the users, were not easily deflected from narratives of aspects of health and social care they considered more important. Both professionals and users challenged the feasibility and
acceptability of the initial question on identifying unmet needs in routine consultations in very illuminative ways but ultimately in ways that rendered the last NGT phases impossible. This highlights the potential difficulties of using a structured approach such as NGT with a potentially controversial topic generating a broad range of views. In the larger study, this problem was addressed through supplementary consultation processes with users and professionals. In the UK, government policies advocate greater consultation with the public in prioritizing primary care services and commissioning, although there is yet no accepted method for doing this. We would suggest that this experience should add a note of caution to those considering using NGT with the public.

Conclusions

Unmet need is a complex concept, with different interpretations according to the perspective taken. Professionals relying on epidemiological knowledge to guide their enquiries about unmet needs in older patients may find that the needs that they identify are not perceived as unmet, or even meetable, by their patients. Nominal groups can be useful tools for capturing perspectives of different groups, but prioritization of themes identified by nominal groups may not always be feasible and may require supplementary methods.

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Declaration

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Conflicts of interest: None.

References


