



A FRAMEWORK FOR EVALUATING PATIENT PARTICIPATION GROUPS IN WANDSWORTH PRIMARY CARE PRACTICES

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Introduction

Existing patient participation groups (PPGs) in Wandsworth predate the creation of the Primary Care Trust and the implementation of its strategy for patient and public involvement (PPI).

The first recorded patient participation group in a Wandsworth practice, at Balham Park Surgery then at 92 Balham Park Road, came into existence in February 2000. That PPG soon formed a relationship with the Balham, Tooting and Wandsworth Primary Care Group and secured funding from the PCG for one year. Wandsworth PCT was established in April 2002. Approximately one year later, a second PPG emerged at the Brocklebank Group Practice in mid-2003, before the PCT's draft patient and public involvement strategy was completed.

These two PPGs, therefore, did not have a strong historical connection or a planned relationship with the Primary Care Trust or its strategic approach to patient and public involvement. PPGs that emerge in the future, at the Putney Primary Care Centre for example, will benefit from the policy framework now in place and from the learning that could come from an evaluation of the two existing PPGs.

The PPGs at Balham Park Surgery and the Brocklebank Group Practice formed in large inner Wandsworth practices. Together they represent a combined patient population of almost 25,000. Once the patient and service user group at the proposed Putney Primary Care Centre establishes itself independently, the number of Wandsworth patients covered by PPGs will rise proportionately and this will generate higher levels of interest amongst other practices. Such "bottom up" user involvement initiatives cannot be ignored. It is essential to gain a better understanding of them in terms of three key factors:

- ❑ the benefits they bring to their members, their practices and the wider primary care NHS
- ❑ the source and level of resources they consume
- ❑ their implications for the evolution of the local PPI strategy

As a start to the process of improving local understanding of PPGs, the Lay Member of the Professional Executive Committee proposed and the Chair of the PCT agreed, that a possible evaluation framework should be devised to describe the "value" that PPGs created for their

members, for the practices which encouraged them and for the wider local NHS. It was agreed that this approach would be tested with one of the existing patient groups.

This report results from that effort. It also identifies some areas for further discussion regarding the source and level of resourcing of patient participation groups, particularly following the implementation of the new General Medical Services contract. No attempt at this stage has been made to describe the impact of the growth of PPGs on the local PPI strategy (see excerpts in Appendix 1), though that is a topic which should be considered by the PPI Steering Group in due course.

Looking at Patient Participation Groups in context

A simple web search demonstrates that PPGs are numerous. Documentation generated by and about them, however, is scattered and variable. Even a cursory reading of online material about PPGs shows their wide range of collaborative activities, mainly around improving the patient experience. Some representative examples from other PCTs are included in Appendix 2.

According to the Royal College of General Practitioners, a Patient Participation Group is “groups of patients, usually within a practice, which aim to develop self help and improve their own primary care. These Groups often help to benefit patient care within a practice, for example by arranging transport for elderly or disabled patients for medical appointments or by running self help groups, for example weight watcher sessions” (ref. www.rcgp.org.uk/patients/ accessed January 2004).

Local descriptions of Wandsworth's two PPGs bear out this national view:

At Balham Park Surgery

Balham Park Surgery Liaison Group (BPSLG) “are patients of the surgery who meet monthly to help shape the delivery of our services. We inform them of current issues and changes at the practice and they act as a voice for other patients when we are considering new initiatives. The group produce a regular newsletter and you are invited to join as an active member or just be on their mailing list for regular updates. There is a member registration form at the back of this booklet.” (*Balham Park Surgery Practice Booklet*, March 2004)

At Brocklebank Group Practice

At the Brocklebank Group Practice Patient Participation Forum “the patients and practice support each other by pooling resources, ideas, solutions and objectives. By sharing information in a structured and effective manner, the patients are able to highlight areas formerly unrecognised as having consequences on health. Through the Forum, the practice can then focus on the patients’ needs and requirements to bring them to the cutting edge of modernisation”. (Polly Healy, committee member, WPCT “PPI Across Wandsworth “ *PPI Newsletter* Nov 2003: p 3)

The small amount of formal evaluation work on PPGs suggests that there is no ideal way for such groups to develop. (ref: Brown I. “Patient participation groups in general practice in the National Health Service” *Health Expectations* 1999; 2(3): 169-178). A recent King’s Fund review, nonetheless, endorsed patient participation groups in practices as a valuable lever for change at this fundamental level of health care, because such initiatives could “... reach beyond the security of professional power to a more meaningful engagement with the values, interests and needs of the individual user” (ref: Anderson W et al *Every Voice Counts: primary care organisations and public involvement*. Kings Fund: London, 2002).

In his opening address to Wandsworth PCT’s “Get Switched On” PPI strategy launch event on 24 March 2004 , Dr Michael Greco stressed two related aspects to answering the “why PPI?” in primary care question. These were:

- ❑ to build and maintain public confidence in the NHS, recognising that the psychological dimension of confidence goes beyond the domain of clinical competence into the relational and moral characteristics of care (trust, integrity, empathy etc)
- ❑ to learn from patients, particularly as reflected in the themes found in the Quality and Outcomes Framework of the new GP contract.

Greco’s understanding of PPGs parallels another GP commentator’s - Lewisham GP and PEC member Dr Brian Fisher, currently seconded to the Strategy Unit at the Department of Health. At our meeting in December 2003, he stressed the benefits of patient participation particularly from the standpoint of “shared decision making” in what happens to patients in terms of treatments, drugs, hospital referrals, lifestyle changes about smoking, drinking, weight etc. Fisher is compiling evidence about why participation in decision-making produces benefits

for patients and practitioners. This will be an important part of the answer to the question “how does patient participation make things better for the surgery?”

These messages from Drs Greco and Fisher are timely and should be heard more widely, especially to counter the finding from the Institute of Employment Studies three-year survey of the London NHS workforce which revealed that doctors do not see patients as an essential part of their job satisfaction criteria. The IES study found that patients were not ranked in the top five most important satisfaction factors in their work by doctors and dentists. (ref: Robinson D, Perryman S. *Health Attitudes: Quality of Working Life in the London NHS, 2000-2002*. IES: London, 2004).

The omission of patients from doctors' perceptions of their employment well-being criteria is more than a little concerning, because the evidence is that most patients take the opposite view. Users' perceptions of what constitutes a “good patient experience” revolve around the central role played by a service that they perceive to be responsible and well-delivered. The Department of Health's external research on a definition of “patient experience” found that a central component of the ideal user experience was a feeling of “pride”. This stemmed from a patient knowing that he or she was part of a system which cared for them, listened to what they had to say, worked with them in a highly skilled way to get a result and derived its satisfaction from doing so. (ref: *Results from a programme of consultation to develop a patient experience statement: final report*. Department of Health: London, 2004)

A recent *HSJ* commentary summed this up as follows: primary care “is the key vehicle for raising awareness of the views and needs of the public and placing them at the centre of health services. People identify with their GP surgery. For most it is their only contact with the NHS. Here they can make a genuine difference in shaping healthcare - a difference that will benefit patients, whether it involves public health issues, care of the elderly, or the handling of long-term chronic conditions.” (Palmer J. “On the public's priorities” *Health Service Journal* 5 February 2004, p 19)

Making a difference in shaping healthcare is unlikely to happen automatically because “developing *meaningful* [sic] patient participation” is “one of the most difficult aspects of clinical governance for primary care practices to implement”. (ref: Sweeney G, Sweeney K, Greco M, Stead J. “Primary care clinical governance: what's happening on the ground?” *Clinical Governance Bulletin* May 2002; 3(1):10-12). Low progress scores about patient experience and participation from the NHS Modernisation Agency's “Strategic Leadership of Clinical Governance in PCTs” pilot programme bear out this diagnosis (ref: *The Strategic Leadership of Clinical*

Governance in PCTs: Executive Summary, 2nd ed: 2004). Faced with this, it can be argued that direct, practice-level action by patients and service users is needed to help the process along, because “the only way to make an impact is to become involved” (ref: WPCT “Getting Involved” leaflet, November, 2003). From this perspective, patient participation groups can be, to repeat the imagery of the King’s Fund, that “valuable lever for change ... reach[ing] beyond the security of professional power to a more meaningful engagement with the values, interests and needs of the individual user”.

The outcomes of a recent NHS Alliance workshop of PCT chairs, chief executives and Chairs of PECs which I facilitated underscored the lack of serious participation initiatives in most areas at practice level (ref: “**Involving the Public: Can it Work? Does it Work?**”, **Workshop at “Three at the Top” Conference, London: 27 April 2004**). The workshop participants felt that many GPs could do with some “patient friends” to help them do things differently. Patients groups could provide the space and time for real discussions amongst “friends”. The new GMS/PMS contract might help people see this as a realistic possibility. But practices would need help and encouragement to understand how to bring it about and it would have to make sense in financial terms. The workshop felt that what was missing in most areas (with a few honourable exceptions), was a way for users to engage at GP practice/clinic level. If it existed more widely, this would create a critical mass of participation at the grass roots reaching far beyond the "usual subjects". It would also provide the "legs" for other PPI initiatives and the recruits with the capacity to engage in a more structured way with the PCT.

Questioning local Patient Participation Groups

Both Balham Park Surgery Liaison Group and the Brocklebank Group Practice PPG were keen to participate in this enquiry, but the logistics of their meetings timetable meant that only the BPSLG could make enough time available on two occasions for the necessary group work. It was only possible to have a preliminary, though valuable, discussion about the objectives of the work with the Brocklebank members. It is intended to follow the complete process with the Brocklebank group when time permits so that the results from the two groups can be compared.

BPSLG set aside time in several of their meetings to discuss the project’s objectives with me and to complete prioritisation questionnaires reflecting the outputs of initial discussions. These are described below.

What emerged from the initial discussions towards the end of 2003 with both groups gave shape to an outline “evaluation framework” identifying different kinds of “value” (in the sense of adding something) stemming from the activities of these groups. “Value” was understood by the groups to have three dimensions:

- ❑ value for PPG participants as individual patients
- ❑ value for the practice as a whole
- ❑ value for the local NHS in Wandsworth.

Of these, the most important aspect for group members was the personal dimension.

This approach lent itself logically to considering three questions in group sessions. These discussions were facilitated and when written up, formed the second stage of the work in early 2004. The three questions were described in a handout used with the Balham Park Surgery Liaison Group as follows:

1. The first question for us as patients and users of the practice’s services to answer is **“what do we as individuals get out of participating in BPSLG?”** We could all be doing other things with our time, so why do we choose to do this? Looked at another way, if BPSLG did not exist what would we as individuals be missing?
2. The second question which our colleagues from the practice can answer is **“what does the practice get out of having BPSLG?”** There is a related question for the practice, namely **“how does this benefit achieving the practice’s wider objectives?”** Looked at another way, if BPSLG didn’t exist what would the practice find harder to do or not be able to do?
3. The third question is about the benefits to the PCT and further afield such as easy and direct access to patients. Could we generate some thoughts on that this evening?

In addition, organisational characteristics of the PPGs under the following headings were identified as essential descriptors to collect in any formal evaluation:

<u>Governance:</u>	Who is in charge and accountable for what the group does? How is the group's funding handled (bank account, Treasurer, financial reports to meetings, annual audit by PCT etc)? Are there regular meetings, notes taken, agreed by members and copies kept as a permanent record? Are there well-publicised annual open meetings? Are there strategic objectives and regular reviews of progress?
<u>Communications:</u>	What types of communications are used? How does the group reach the wider practice population? How is feedback from the wider practice population handled?
<u>Networking with patient and public involvement activity:</u>	Are any group members linked in with initiatives like the expert patients programme? Is it part of the National Association for Patient Participation? ; Do members have links with the Patients' Forum? Are some group members participating on PCT committees, working groups or consultation exercises;

BPSLG had no difficulties supplying comprehensive information about the governance, communications and networking questions, but that information is not reproduced in this report.

The most revealing outputs were from the "what does it mean for me?" question in the initial discussion sessions. Views from this section were standardised and randomised into a twenty statement questionnaire (reproduced at Appendix 2). BPSLG was able to provide time for this to be worked through at a group meeting in February 2004. The Brocklebank Group hopes to complete it later in the year. The results of the exercise with the Balham Park Surgery Liaison Group open committee are described in the following section.

Trying out the Evaluation Framework

Identified value of participating to individual members

Twelve questionnaires were completed anonymously by regular attending members of BPSLG, a very high level of response from this diverse group of members who comprise the “open committee” steering the group’s activities.

Questionnaires were analysed for frequency of statement chosen and rank ordered in terms of frequency (the two left hand columns on the following table). Each statement was then assigned a weighted score where 1st choice = 10 ... 10th choice = 1. Statements were then ranked in terms of total weighted score (the two right hand columns).

Frequency	Rank	STATEMENT	Weighted Score	Rank
5	=7	"I can meet all the staff, not just doctors"	20	10
10	3	"I get to hear about local and national NHS developments and policies that affect us locally"	60	2
2	=10	"I don't feel an outsider any more"	12	<10
2	=10	"I have the confidence to ask more questions"	10	<10
8	=4	"I get up-to-date surgery news"	55	=4
4	=8	"What I learn helps me take decisions about my own health"	31	=9
8	=4	"It helps me learn how the practice operates"	55	=4
3	9	"It's a chance to meet other patients who come to the Group and to realise they are ordinary people and not 'experts'"	6	<10
7	=5	"We help raise health awareness among other patients with our educational sessions"	31	=9
8	=4	"I know that at our surgery they are making the best of the many changes going on in the NHS"	44	7
7	=5	"It's a chance to have discussions with other patients and with surgery staff"	42	8
8	=4	"We encourage and support each other"	49	6
7	=5	"It develops a more equal relationship between doctors and patients"	56	3
5	=7	"We can make good contacts with the Patients' Forums at the PCT and the local Trusts"	18	<10
2	=10	"I can appreciate the pressures the NHS copes with"	6	<10
11	2	"Our group helps to build good relationships between patients and health professionals"	53	5
2	=10	"There is opportunity to discuss ways of improving liaison and record keeping between our surgery and hospitals so problems don't arise"	7	<10
4	=8	"We can get to know patients in other practices who are interested in the same things as we are"	7	<10
12	1	"We can make a difference as a group better than as individuals"	73	1
6	6	"I appreciate the type of complaints and compliments the surgery receives"	17	<10

There was a strong correlation between highest frequency of choice and highest weighted score for the “top two” statements (highlighted in yellow on the above table) and a good correlation on a cluster of four statements following the top two (highlighted in green). After that there is a group of statements which are less important and a final group whose low frequency and low weighted scores indicate they are of least importance. This outcome allows the twenty statements to be grouped into a hierarchy ranging from “essential” to “least important” as follows:

Essential values	<p>“We can make a difference as a group better than as individuals”</p> <p>“I get to hear about local and national NHS developments and policies that affect us locally”</p>
Important values	<p>“It develops a more equal relationship between doctors and patients”</p> <p>“I get up-to-date surgery news”</p> <p>“It helps me learn how the practice operates”</p> <p>“Our group helps to build good relationships between patients and health professionals”</p>
Less important values	<p>“We encourage and support each other”</p> <p>“I know that at our surgery they are making the best of the many changes going on in the NHS”</p> <p>“It’s a chance to have discussions with other patients and with surgery staff”</p> <p>“What I learn helps me take decisions about my own health”</p> <p>“We help raise health awareness among other patients with our educational sessions”</p> <p>“I can meet all the staff, not just doctors”</p>
Least important values	<p>“I appreciate the type of complaints and compliments the surgery receives”</p> <p>“We can get to know patients in other practices who are interested in the same things as we are”</p> <p>“There is opportunity to discuss ways of improving liaison and record keeping between our surgery and hospitals so problems don’t arise”</p> <p>“I can appreciate the pressures the NHS copes with”</p> <p>“We can make good contacts with the Patients’ Forums at the PCT and the local Trusts”</p> <p>“It’s a chance to meet other patients who come to the Group and to realise they are ordinary people and not ‘experts’”</p> <p>“I have the confidence to ask more questions”</p> <p>“I don’t feel an outsider any more”</p>

Identified value of the Patient Participation Group to its practice

Balham Park Surgery staff who participated in this exercise (GP, primary care manager and reception manager) identified the following benefits to the practice of having BPSLG:

1. Testing out new ideas – e.g. access to patient electronic records
2. Helping to evaluate practice standards – e.g. telephone survey of waiting times for appointments
3. Discussing whole practice outcomes of the Improving Practice Questionnaire
4. Considering *anonymised* comments and complaints received by the practice
5. Developing new services – e.g. the group-funded yoga referral class which ran from May 2003 to end of March 2004.
6. Arranging educational sessions – e.g. repeated sessions on “what works in complementary and alternative therapies” to meet patient demand
7. Communicating with the wider practice population – e.g. 400 patients have opted in with their personal details to receive regular BPSLG newsletters which are also available through the surgery waiting room.

Identified value to the PCT and local health economy

The following points were made by BPSLG group members and practice staff.

1. Provides access to patients so PCT can set up focus groups, e.g. for comments on draft Annual Delivery Plan and the proposed content of staff training on customer care.
2. Gives opportunity for questions to be sorted out at the practice which might otherwise go to PALS or higher.
3. Creates additional ways to demonstrate compliance with “Section 11” requirements

Conclusions from the analysis

Testing the evaluation framework with one well-developed PPG was successful. The framework was easily understood and members enjoyed the brainstorming and prioritisation sessions. The results of the participation values ranking exercise produced a robust result and should be tried in the second PPG and the results compared. After that, the process should be offered to the Putney PCC patients and user group once it is independently established.

The outcomes from the personal values prioritisation of the group members related strongly to the PPG themes separately identified by Drs Greco and Fisher - namely increasing public confidence in the NHS and helping practices to learn from patients.

The governance, communications and networking information supplied by the test PPG matched five of the six criteria identified by Lewisham PCT (see Appendix 3) for a successful PPG, with the exception of fundraising as this is an activity which BPSLG has up to now decided not to pursue.

Resourcing future PPG development

In 2002, the Wandsworth Pilot Patients' Forum, using BPSLG's annual budget that year as a baseline (£3,000 in round figures), devised weighted bandings to calculate that if PPGs were up and running for a full 12 months in all practices covered by the three former PCGs (minus Furzedown), the expenditure would be some £96,000 not including reimbursement of practice staff time. While useful as an indicator of the scale of this potential activity, it is not realistic for Wandsworth PCT to provide this amount of funding. Indeed, how to resource future PPG development has been a growing issue locally. The implementation of a new contract in primary care focuses the need to resolve this issue.

A way forward for both existing and future PPGs which also addresses the legitimate question of practice staff costs identified in the PCT's *PPI Action Plan*, could be provided by the Quality and Outcomes Framework (QOF) of the new GMS (nGMS) contract. The feasibility of this approach was discussed briefly with Dr Michael Greco on 24th March and has been confirmed by personal discussions with Dr David Jenner of the NHS Alliance.

The QOF section on improving the patient experience (PE1-4) states: "A practice will be awarded quality payments on the basis of its achievement on the quality scorecard up to a maximum of 1,050 points". PE1-4 includes patient surveys and working with patient participation groups. It accounts for 100 points, just under 10% of the total 1050 available. This section of the QOF, of course, is voluntary, but could be recommended in local implementation guidance.

The national guidance to PCTs on implementing this section states: "Developing plans to support practices wishing to set up patient participation groups or forums" is one of the ways to "support practices to improve patient experience..."

(refs: NHS Confederation/NatPact "Quality and outcomes framework under the new GMS contract"
www.dh.gov.uk/assetRoot/04/03/51/08/04035108.pdf and "GMS statement of financial entitlements 2004/05"
www.dh.gov.uk/assetRoot/04/06/97/63/04069763.PDF both accessed March 2004)

Based on the above and applied to a large group practice such as Balham Park Surgery (approximately 12,000 patients) as an example, the per capita cost of supporting the PPG for 12 months would be only 25p per patient. If the surgery fulfilled QOF PE1-4 criteria and thus earned some 10% of its total quality payments from this source, the resulting revenue would appear to be more than sufficient to identify the resources needed to support the PPG. The funding implications of QOF points are explored further in the model in the Appendix 4 to this paper.

The ethics of doing this are clear, since without the PPG these resources would not be available to the practice in the first place. A small practice with some 4,000 patients operating to the same QOF PE1-4 standards would need the same level of per capita resourcing to funding a PPG budget of some £1,000 per year. This would satisfy the PCT's desire for equity in any PPG funding formula.

An added advantage of this approach to future PPG funding is that such groups would be a ready recruitment source for informed lay members to join QOF Visiting Teams for other practices. This is important because there are unlikely to be enough members from statutory Patients' Forums available, given their own obligations, to meet this demand once the nGMS is fully implemented.

(ref: DH *Guidance Gateway* ref 3038 www.dh.gov.uk/assetRoot/04/07/84/15/04078415.PDF Accessed March 2004)

An alternative or supplementary source of funding for PPGs is the charitable funds held by the PCT, though how this might be applied is outside the scope of this report. It should be recalled, however, that the former Wandsworth CHC obtained confirmation from the PCT Board that these resources, albeit limited, could be used for appropriate patient and public involvement purposes.

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Appendix 1

PPGs in Wandsworth PCT's a) Consultation Document (August 2001); b) PPI Strategy (May 2003); c) PPI Action Plan (March 2004) and d) Annual Delivery Plan 2004-05

a) Excerpt from *Wandsworth PCT Consultation Document* (August 2001) on linkage between participation at practice levels and higher levels:

9.3.2 “The PCT will need to consider how the structure of the Board, Professional Executive and Management structure of the PCT can ensure each locality is actively engaged with its patients, carers and the public as a conduit for information, exchange of views, and consultation; *lay input at PCT Board level is linked to patient participation at practice and “grass roots” service delivery level.*”

b) Excerpt from WPCT PPI Strategy (May 2003)

www.wandsworth-pct.nhs.uk/pdf/ppi/ppistrategy.doc accessed 3/04

(p 5) strategy acknowledges that users can be involved as individuals or collectively and that “Involvement can range from giving information, to getting feedback, to discussing problems and debating solutions, to empowering patients and the public to have full participation and influence.”

(p6) “Levels and Degrees of Patient and Public Involvement: *patient participation groups* identified as example of participating and influencing activity that “create opportunities and support and encourage patients to be involved in choices about their own care and treatment options.”

c) Excerpt from WPCT *Patient and Public Involvement Action Plan* (March 2004)

It notes (p 9) that the two *existing PPGs at BPS and Brocklebank constitute examples of “good practice”, but have cost implications for the PCT in terms of practice staff time.* The Action Plan does, however, commit the PCT as part of its core PPI activity “*to consider how best to develop further PPGs across Wandsworth*”.

d) Excerpt from WPCT *Annual Delivery Plan 2004-05* (May 2004)

“... Many groups have been established where local people have the opportunity to help shape their services. *Examples of these are the Brocklebank Patient Participation Forum and Balham Park Surgery Liaison Group where members of the public can raise issues or areas that they would like to see addressed or looked at within their local surgeries.*” (p 22)

Appendix 2

Prioritisation Questionnaire

What's most important to you about belonging to a patient participation group?

Here is a list of 20 statements which have come from discussions at Balham Park Surgery Liaison Group and the Brocklebank Group Practice Patient Participation Forum. People in these groups have said these things are important to them about belonging to their groups. The objective of this exercise is to choose your "personal top 10" from this list.

Read through all the statements first. Then go back and decide which ten are most important for you. Then rank these from 1 - 10, where 1 is the most important, 2 is a bit less important, 3 is a bit less still and so forth down to 10.

If there is anything in the complete list that you DON'T think is important about belonging to a patient participation group, then put a "X" in the box beside it.

This is a confidential exercise and only Andrew Craig will have the forms to analyse. Please say what you really think !

	"I can meet all the staff, not just doctors"
	"I get to hear about local and national NHS developments and policies that affect us locally"
	"I don't feel an outsider any more"
	"I have the confidence to ask more questions"
	"I get up-to-date surgery news"
	"What I learn helps me take decisions about my own health"
	"It helps me learn how the practice operates"
	"It's a chance to meet other patients who come to the Group and realise they are ordinary people and not 'experts'"
	"We help raise health awareness among other patients with our educational sessions"
	"I know that at our surgery they are making the best of the many changes going on in the NHS"
	"It's a chance to have discussions with other patients and with surgery staff"
	"We encourage and support each other"
	"It develops a more equal relationship between doctors and patients"
	"We can make good contacts with the Patients' Forums at the PCT and the local Trusts"
	"I can appreciate the pressures the NHS copes with"
	"Our group helps to build good relationships between patients and health professionals"
	"There is opportunity to discuss ways of improving liaison and record keeping between our surgery and hospitals so problems don't arise"
	"We can get to know patients in other practices who are interested in the same things as we are"
	"We can make a difference as a group better than as individuals"
	"I appreciate the type of complaints and compliments the surgery receives"

Appendix 3

The following excerpts illustrate how patient participation groups are part of user involvement strategies in other Primary Care Trusts:

Solihull PCT

www.solihull-pct.nhs.uk

PPGs exist in 16 practices across Solihull PCT and the PCT facilitates an association made up of chairs of PPGs which meets once a month to discuss matters arising and share good practice.

The PCT believes that PPGs “work with general practice and GPs to look at the way the service is provided. They give feedback on the quality of patient services, suggest and support changes and support health promotion work within their communities. They are about being constructive, supportive and innovative. They concentrate on identifying and discussing improvements and sharing ideas between the patients and the practice.”

Liz Nelson-Cooke, Primary Care Development Manager at Solihull PCT, described local PPGs as “very important to practice development. When the patients and the practice work together, listen to each other and have a strong partnership, patient care and satisfaction is always greater. It is all about the practice and patients working together to begin to understand each other’s needs and get the best service for both.”

There is a culture of patient participation in Solihull. The Solihull Quality Initiative in General Practice stemming from the era of PCGs, included payment incentives to GP practices which committed to an active PPG with an agreed yearly plan of activity

Hertsmere PCT

www.hertsmere-pct.nhs.uk/community/local.htm

Excerpts from this Hertfordshire PCT’s implementation of its community involvement strategy:

“In Hertsmere we want to find people who are interested in getting involved with the NHS locally and want to help their GPs improve services and make good decisions about local health provision – people who want to get involved.

Locally people are being encouraged to get more involved in their own General Practices by setting up Patient Participation Groups to help local doctors improve their services.

We want to hear from anyone who is interested in getting involved in the NHS locally. Some people might want to join the Patients' Forum; some people might want to find out more about setting up a Patient Participation Group within their General Practice. Other people might be interested in joining a panel on just one or two health issues close to their heart, or maybe just want to come along to meetings and find out what is happening. “

Welwyn and Hatfield PCT

www.welwyn-hatfield-pct.nhs.uk

The PCT's website devotes a whole page to patient participation, singling out the PPG at Wrafton House Surgery as a model of good practice: “The group meets regularly with GPs and other practice staff and in this informal setting they are able to exchange ideas and information on the services provided by the practice and its day to day organisation. GPs are able to ‘sound out’ the group on any plans for change or service improvements, and the members can take suggestions and comments from their patients' perspective and experience. The group runs the patients library and produces information leaflets for patients at the request of the doctors, loan videos, audio tapes, books and booklets to support the leaflets. Members of the group also meet regularly with PCT staff and board members, to exchange views and information and arrange public meetings to inform local people about changes in healthcare. The work of this group is highly regarded by the practice they serve and the PCT.”

This PCT's PPI strategy includes the objective to “encourage and facilitate interested practices to establish patient participation/reference groups” which will be “included in the primary care investment plan.”

Fenland PCT

www.eastcambsandfenland-pct.nhs.uk

The PCT's CHI clinical governance review (July 2002) found: "it has also worked hard to include patients and the public in its work. This has included the establishment of a health forum and encouraging individual general practices to set up their own patient participation groups."

A neighbouring London PCT's view

Lewisham PCT defines a PPG as "A selection of patients and practice staff who meet at regular intervals to decide ways of making a positive contribution to the services and facilities offered by the practice to the patients." It has identified six main areas of PPG work

Providing Feedback from patients	Providing feedback from consumers e.g. appointment systems, consultation times, need for notice board
Health Promotion	e.g. Diabetes awareness day, first aid training
Voluntary activities	e.g. walking groups, providing transport, establishing carers group
Information	Practice leaflets Newsletters Local facilities Health care information
Representation	Acting as a representative group that can be called upon to influence the local provision of health and social care
Fundraising	To fund group costs For equipment e.g. patient wheelchair, refreshment machine.

(ref: *Patient Participation Groups: a brief guide to developing a patient participation group.*

Lewisham PCT, London: ?2003 Downloadable from www.lewishampct.nhs.uk)

Additional examples of patient participation groups which are integrated with and supported by PCTs' strategies for user involvement can be found in

Stockport PCT

www.stockporthealth.nwest.nhs.uk/pct/pgroups.asp

Newbury PCT

www.berkshire.nhs.uk/newbury/participation%20groups/newbury_etc_etc_etc.htm

Tameside and Glossop PCT

www.tamesideandglossop.nhs.uk/ppi.htm

And the **National Association for Patient Participation (NAPP)**

www.napp.org.uk (both Wandsworth PPGs are members of the NAPP)

Appendix 4

Example of Practice Earnings from “Patient Experience Domain” of Quality and Outcomes Framework (QOF)

The following model is a worked example showing what Balham Park Surgery is likely to earn from achieving the points in this domain. It compares this revenue against the “costs of achievement”.

This is only one practice’s expectation for one part of the QOF. If other practices undertook a similar calculation, there would be some basis for comparison. The PCT’s Board has been requested to ask other practices to undertake this exercise.

The patient experience domain consists of 4 indicators within 2 areas (consultation length and patient survey), worth up to 100 points to successful practices.

Practice/Process Characteristics	QOF Patient Domain Earnings	Costs of Attainment	Comment
Approx 11,500 registered patients; aspiration to attain all 100 available QOF points in patient experience domain; list size factor = 1.296	100% PE achievement would produce £4,850	Anticipated earnings, less costs associated with earning points in this domain	The practice has a well established patient participation group and several years experience of the IPQ approved patient survey
BPS will include all its medical, nursing and health care assistant staff in the IPQ for a whole practice assessment; this satisfies PE 2	£4850- £1200 = £3650	Procurement of IPQ for all GPs (11), Practice Nurses (4) and Health Care Assistants (1) £75 per person x 16 = £1200	Full cost of procurement of IPQ met <u>by practice</u> ; this includes standard analysis and feedback of results
Receptionist time required to oversee process, based on numbers of patients seen on average day and experience of previous years,	£3650 - £1050 = £2600	Administration of IPQ within the practice by receptionist @ £12/hr incl “on costs” over 2.5 weeks to complete required number of questionnaires = £1050	IPQ must be a managed process even though it is carried by patients into the consultation and completed afterwards.
Results come back to BPS on “named clinician” basis	£2600 - £1187 = £1413	1 hr reflection by each individual of results with peer. 1 hr salaried GP time + peer = £1012; Practice Nurse time = £155; HCA time = £20: TOTAL £1187	Reflection on individualized results with a peer is good practice to avoid personal misperceptions

Practice/Process Characteristics	QOF Patient Domain Earnings	Costs of Attainment	Comment
After individual reflection, practice team must consider general outcomes as a group This satisfies PE3	£1413 - £370 = £1043	Costs of 1 hr staff meeting comprising 50% of workforce + primary care manager = £370	Staff team reflection and consideration of implications for change must precede discussion with critical friends group of patients
Whole practice IPQ results must be formulated for group discussion; practice representatives must participate in the BPSLG meeting where these are discussed. This satisfies PE 4.	£1043 - £232 = £811	2 hrs management time to prepare whole practice results for discussion with critical friends group from BPSLG = £50; manager + GP + PN time to attend 2 hr BPSLG meeting = £182 TOTAL: £232; "participation time" of BPSLG members is "free good"	Patients group minutes must record outcome and patients views/priorities for action.
THE FOLLOWING MUST ALSO BE CONSIDERED IN THE CONTEXT OF THE COSTS OF PE 1-4 EARNINGS	Residual £811 potentially available, subject to other identifiable costs associated with achieving total points in the PE domain	Costs of achieving PE1 , length of routine booked appointments with doctors of not less than 10 minutes must be included. BPS estimates as more than £811.	High risk that "surplus" from PE2-4 could be wiped out by costs associated with achieving PE1.

Conclusion

For Balham Park Surgery, achieving all 100 QOF points in the PE domain would fully fund the staff time and other activity needed for the achievement of the points in PE 2-4. Against this, however, must be set any costs of achieving PE1. When these costs are included, it is felt likely by the practice that nothing would remain to support the activities of a patient participation group beyond the specific purpose of discussing the IPQ outcomes.

This practice's objective is to have a free-standing patient participation group whose activities are much more extensive than simply assisting the practice to achieve QOF earnings. On the above calculation the QOF patient experience domain earnings are not sufficient to support that objective. Four years' experience of running Balham Park Surgery Liaison Group (BPSLG), show that a budget in the neighbourhood of £3,000 per year is needed to cover operating costs of this group, primarily for printing and distribution of newsletters.

It should also be noted that the above analysis of PE2-4 earnings assumes that the “critical friends group” of patients was convened on a “no cost”, voluntary basis. This raises a moral issue because it ignores the value and opportunity costs of lay time.

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This document is available (free) to download in Microsoft Word or Adobe PDF format from

<http://www.publicinvolvement.co.uk/Articles/framework.html>

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