

A PATIENT PARTICIPATION CASE HISTORY
FROM PRIMARY CARE

written by

The Moore Adamson Craig Partnership

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Introduction

The Moore Adamson Craig Partnership (MAC) has been engaged by the Commissioning and System Management Directorate of the Department of Health to write a case history on the subject of patient participation at primary care level. The narrative can then be deployed in different inspirational and educational contexts to play its part in the implementation of the practice based commissioning which will, in the words of the Wandsworth Teaching Primary Care Trust's Practice Based Commissioning Governance Framework, "see practices, PCTs and patients working together to shape services and clinical pathways to improve services for patients." One critique of case histories about organisations is that the purportedly objective, truthful and hard-headedly factual case history can turn too easily into a work of celebratory fiction designed to support a thesis or pre-conception of the author.

No rush to judgement

The Partnership acknowledges this risk – we are not just specialists but believers in the idea that users must have a say in decisions that affect them. Two partners are members of the patient participation group described in the report that follows. To counter the risk of being too close to the material, the report was written by a partner who while sharing the specialised knowledge and the general commitment, is not registered with the practice and has played no part in the life of the patient group. We have adopted the role attributed in the report to the practice patient group – that of critical friend. Secondly where it seems appropriate, we have quoted directly from the documents of the groups and practice and have refrained from judgement and evaluation of the evidence presented. We have raised and begun to discuss some questions such as the question of 'representativeness' and 'replicability' of this participative model. These opinions are there to prompt further discussion and action to put more flesh on the body of evidence around the effectiveness of patient participation. They cannot be the final word.

Patient Participation – Vulnerable but Surviving

The approach takes the story of patient participation in one GP practice in SW London – the Patient Liaison Group of the Balham Park Surgery (BPSPLG) - and tells the story of what has been achieved by the patient liaison group by drawing on the files of both group and the practice supplemented by interviews with 4 people who have been involved with the group from its very earliest days and indeed one of the interviewees was the initial prime mover for the patient liaison initiative. We use the documents of the time – sometimes in their entirety; sometimes as extracts. Our story begins in the year 2000 and in citing the date, we make the first point of importance in the story – the fact that the group has survived to be alive and well eight years later. We court perhaps accusations of sentimentality but it has to be said – patient participation is based on the people who volunteer to take part and as such is a fragile organism that can come and go.

The Approach Taken

The narrative has a wider ambition than that of being a simple description. The account

does focus on one practice and on one Patient Participation Group but we look to see where lessons can be drawn that are capable of application elsewhere. What part of this experience is unique to the Balham Park Surgery? Where are the strengths and what are the weaknesses? What are the contrasts between national and local practice and learning? We have avoided where possible personalising our account but people do count. In any account that considers questions of survival, we have to look at processes that turn intention into action, are robust and resist erosion over time. The processes are considered in the classic circle of quality – analyse, plan, do, evaluate and start process again planning for improvement. Where external data exists such as those from the Client Focussed Evaluation System, that has been taken into account – not so much for the results – more for the processes set up to consider those findings.

We need to gain a better understanding of patient participation initiatives 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 and more recently, progress in practice based commissioning.

Understanding these factors helps develop a definition of 'added value'. "Value" has three dimensions:

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

To understand where and how such value can be added, we need now to understand what people mean when they talk about Patient Participation.

Patient Participation - some developmental definitions?

The definitions discussed here are a mixture of national and local and are taken from the 'middle' period of the BPSPLG's existence. They help give a sense of the development of the role over time. 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".

A 2004 definition of the BPSPLG

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
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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)

Wandsworth PCT’s “Get Switched On” PPI strategy launch event was held on 24 March 2004. Dr Michael Greco in his presentation, 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 paralleled another GP commentator’s - Lewisham GP and PEC member Dr Brian Fisher, then seconded to the Strategy Unit at the Department of Health. Speaking 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. At the time, the group thought this will be an important part of the answer to the question “how does patient participation make things better for the surgery?”

What Do Patients and Practice Think?

As part of the creation of an evaluative framework for patient groups in Wandsworth, Andrew Craig in his role as the Lay Member of the Professional Executive Committee (PEC) of Wandsworth PCT conducted an enquiry with members of the BPSPLG who set aside time in several of their meetings to discuss the project’s objectives 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 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:

Governance: 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?

Communications: What types of communications are used? How does the group reach the wider practice population? How is feedback from the wider practice population handled?

Networking with patient and public involvement activity: 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;

These three headings represent themes that recur regularly 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 in an Appendix). BPSLG was able to provide time for this to be worked through at a group meeting in February 2004. The results of the exercise are described in the following section.

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’	18	<10

		Forums at the PCT and the local Trusts”		
2	=10	“ I can appreciate the pressures the NHS copes with”	6	<10
11	2	<i>“Our group helps build good relationships between patients and health professionals”</i>	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	<i>“We can make a difference as a group better than as individuals”</i>	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 bold italics) and a good correlation on a cluster of four statements following the top two (shaded). 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	“We can make a difference as a group better than as individuals” “I get to hear about local and national NHS developments and policies that affect us locally”
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Important values	“It develops a more equal relationship between doctors and patients” “I get up-to-date surgery news” “It helps me learn how the practice operates” “Our group helps to build good relationships between patients and health professionals”
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Less important values	“We encourage and support each other” “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” “What I learn helps me take decisions about my own health” “We help raise health awareness among other patients with our educational sessions” “I can meet all the staff, not just doctors”
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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>
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Identified value of the PPG to the Balham Park Surgery

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 - eg access to patient electronic records
2. Helping to evaluate practice standards - eg 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 - eg the group-funded yoga referral class which ran from May 2003 to end of March 2004.
6. Arranging educational sessions - eg repeated sessions on “what works in complementary and alternative therapies” to meet patient demand
7. Communicating with the wider practice population - eg 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, eg 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 at the time

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.

In general terms, the exercise demonstrated that a methodology based on early involvement and discussion of the exercise and its goals with the patient group will give insights that can then be formalised as the basis for structured research amongst a group of patients.

Not said at the time

The frustration at the time and subsequently was the lack of data from other groups in the area. Another matching practice had been recruited for the survey but did not in the end provide any data and the patient participation group subsequently folded. The PCT could perhaps have done more to persuade other practices to let the PEC Lay Member conduct a similar exercise in their groups. GPs were worried that their patients might be 'professionalised' – which of course was part of the point of the exercise. The evaluation framework remains available to be used to study PPGs and compare and contrast models of participation out there. The evaluation on the basis of perceptions of added value could have given a useful extra dimension to the January 2007 report 'Patient Participation Groups in Primary Care: Moving beyond Them and Us' by N.A.P.P. (National Association for Patient Participation).

The Host Practice – Committed, Competent and Accountable

Organisations often find learning from users difficult to put into practice. Even for those organisations with the best of intentions, the process of aligning service strategy and delivery with the needs and expectations of customers is hard and the results imperfect. How did Balham Park Surgery a PMS practice manage the learning? Has the practice managed successfully to translate intention into achievement? If it has, why hasn't everybody?

Let us make the first same first point we made about the Patient Liaison Group – the ability to sustain the commitment to patient participation for eight years is already an achievement. The practice have been learning about learning from patients for many years.

A commitment to patient participation cannot be realised without complementary management commitments to specific strategic goals and operational processes in areas such as service quality, staff development and business planning. (There is a useful analogy with empty proclamations about customer care unsupported by policy, process or people). These commitments have to be sustained and well-managed. One such proof of the commitment to people is that the practice has made partners of the practice manager and the practice nurse. Another is the undertakings provided in the Practice Charter setting out service standards on such matters as how quickly a patient will be seen by the doctor of their choice or any doctor.

The first manifestation of patient involvement was a series of patient information evenings set up within some two years of her arrival by Natalie Goldsmid-Whyte (NG-W) now the Managing Partner then the practice manager, with the support of the practice partners. The meetings were attended by a small group of mainly elderly patients who appeared to be more interested in the tea and biscuits, talking amongst themselves and occasionally making comments that are recollected as being less than helpful. The group had no

ambition nor the skills necessary to represent others.

Genesis of the Current PLG

Fortunately the disheartened practice manager found an alternative approach. The practice was a Beacon practice and it was at an open day for such practices to share best practice where NG-W heard about patient participation in a Surrey GP practice. Taking advantage of the annual “flu letter” mailout, she set out to recruit more and different people to come to a meeting with a representative from the Surrey patient participation group as a speaker. 20-25 people responded to the invitation and were invited to become members of the patient participation group and take charge of their own destiny with the help of £1000 from the practice. At the first meeting of some 7-9 people, a Treasurer was elected who remains in post to this day. No other posts were created. But some additional people were recruited including Andrew Craig on the basis of his knowledge of the local health economy. Valerie Moore joined later after Andrew recommended to her both to join the practice and the group. Andrew and Valerie were working together trying out the National Consumer Council training pack for consumer representatives Stronger Voice and adapting it for use in a health context. (Their partnership was later to be supplemented by Adamson and Millar) .

All those spoken to who were familiar with the history of what is now the Balham Park Surgery Patient Liaison Group (BPSPLG) acknowledge as a core element of the success of the group has been the commitment over time of NG-W. The practice manager or in NG-W's case Managing Partner is central to success and her profile follows, taken from the BPS Practice Professional Development Plan (PPDP) 2005-2009.

The Biggest Job in the World?

Natalie Goldsmid-Whyte – Managing Partner

Over the years Natalie has transformed the management style of our practice. She has made sure that we have sound business systems, which are responsive to the needs of our patients. At the same time she helps all our staff to reach their full potential by regular review and appraisals. It is through her energy that we have been able to achieve so many quality awards.

Natalie oversees the daily running of the surgery, manages all staff employed by the practice and is the main point of communications between GPs and staff. She is accountable for allocated budgets, finance, health and safety at work, complaints, compliments and suggestions and charter management. Natalie also oversees maintenance of the building, training, personnel matters and supports the Balham Park Surgery Liaison Group. (Patient Participation Group). She is a member of the Wandsworth South Locality's PCT Training and Education Support Team (TEST) and runs the local practice manager forum. She is a Quality Team Development (QTD) assessor for practices in the locality. She achieved the IHM Fellowship By Assessment (FBA) in July 2004. She takes the lead on strategy and development of the practice in all non-clinical or management related areas. She has worked as an Assessor for QPA on behalf of the Royal College of General Practitioners (RCGP) and has provided consultancy support to practices outside of the local trust and for the Kings Fund. Natalie writes management articles for Croner Publications on a monthly basis. In November 2005 she became a VTS

Trainer for a pilot funded by the Working In Partnership Programme and organised by the Institute of Healthcare Management to train Practice Managers using a model similar to that for GP Registrar's. She currently has a trainee based at another practice and provides weekly tutorial sessions. Natalie became a Partner in November 2005 and is the first non-clinical person to have been offered this position within the practice. This move acknowledges her commitment to and development of the practice. It also demonstrates the value that the practice places on its multi-disciplinary team.

Practice Quality Awards

The quality awards referred to are:

- Disability Symbol User - 1998
- Investors In People - 1998 (successfully reviewed November 2001 and 2004)
- House of Commons Early Day Motion for Achievements - 1999
- Centre of Assessment for City and Guilds NVQ's (Administration and IT) - 1999
- RCGP Quality Practice Award – 2000-2005
- Beacon site for Practice Management – 2000
- RCGP Quality Practice Award – 2005-2010

The Royal College of General Practitioners Quality Award is given to those practices meeting some 21 quality criteria. Practices have to produce evidence of achievement and are audited in an on-site visit by assessors to make sure that the claims of conformity are backed by process.

It seems right then to look to the practice for evidence that processes exist to take on board the learning available from the views of the BPSPLG.

This is most clearly seen in the process of strategic review that feeds in the patient view to that process. The PLG is not the only source of intelligence and data about patients – the Improving Practice Questionnaire is another important source of data. The process whereby the data from the latter exercise is absorbed into practice improvement with the active co-operation of the PLG is shown in the following extract from the current PPDP.

Action on CFEP/ IPQ Survey – A Quality and Participative Process

Annual patient survey 2006/7	900 patients took part in completing the CFEP questionnaire. GP's, Nurses and HCA's took part. Our overall score = 69%	Full team meeting held to review overall results. Overall survey results were taken to patient meeting. Action Plan and Priorities Set. Working party set up to review 5 arising issues (see Focus Groups). Consisted of representatives from each discipline in the practice and patient group volunteers.
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<p>Annual patient survey 2007/8</p>	<p><i>NB: The CFEP scoring system calculates as a % of the maximum score obtainable. Therefore, if all patients rated the practice as "good", our percentage score would be 30%</i></p> <p>983 patients took part in completing the CFEP questionnaire</p> <p>GP's, Nurses and HCA's took part</p> <p>Our overall score = 70%,</p> <p>This score was above the national practice mean of 64%, median of 61% and upper quartile of 68%</p>	<p>Recommendations and actions were taken back to the practice. The working party felt we had taken on too many priority areas. This weakened our ability to decide upon and implement changes. Whilst the practice acted on some of the key findings, some things were lost in the volume of issues raised.</p> <p>The group decided that for next year we should set up a similar group, but select just 3 priorities to work on in order to allow sufficient time.</p> <p>Full team meeting held to review overall results 25/01/08.</p> <p>Of our 5 priority areas, topics that we had not appeared to improve in / made little impact in were;</p> <p>Q1 Satisfaction with opening times (-1) Q2 Telephone access (-3) Q5. Seeing a practitioner of choice (-1)</p> <p>Of the 5 areas 2 showed some improvement;</p> <p>Q6. Speaking to a practitioner on the telephone (+2) Q8. Waiting times (+4)</p> <p>Three priorities set for 2007/8;</p> <ol style="list-style-type: none"> 1. Telephone Access – improve time spent on hold 2. Seeing practitioner of choice – further increasing continuity of care 3. Waiting times – to improve individual length of time patients are kept waiting after booked appointment – lowest average being 15 minutes.
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Focus Group Sub-Process

The Focus groups referred to above set up the process that they wanted to use and considered each of the issues in turn. The sub-process was documented as:-

1st Meeting – Agree Terms

Topic 1 – Telephone Access (Time being put on hold)

Topic 2 -Waiting Times (Time spent waiting past booked appointment)

Topic 3 – Seeing a Practitioner of Choice – Promoting continuity of care

Evaluation

and the terms of reference of the group were defined as:

Responsibilities are to review subjects in greater depth, and make recommendations for change / improvement to the wider practice.

(Nominees; Shirley Freeling, Catherine Kennington, Ajmal Qureshi)

The exercise brings together both practice staff and members of the PLG as a small sub-group to assess evidence, consider improvement and adopt the approach most likely to yield results. This process is reported on the PPDP which is available to all who ask to see a copy and is also reported in the PLG-produced newsletter.

The entire PPDP Appendix documenting the activities of the PLG is attached to this report.

The BPSPLG's Strategic Objectives 2006-2009

The group also owns the process of developing and ratifying its own strategic objectives. As described below in an extract from Newsletter 12 there are three meetings at the beginning of the year in January and February ending with the Group adopting the list and offering the objectives to be ratified at the public meeting later in the same year in June.

BPSPLG's Strategic Objectives for 2006 – 2009

The following list was developed in the Group's strategy discussions on January 19th and February 13th 2006, and revised and adopted at the 50th meeting on February 15th. It is to be ratified at the AGM on June 21st. The list includes objectives continued from the previous three years, plus new objectives (to be followed up with implementation plans).

- Ensure the Group has a wide and representative membership from the Surgery's diverse patient population, maintaining contact through seminars, the quarterly Newsletter, and information given in the waiting area and in Surgery mailings.
- Ensure that members who attend Group meetings are welcomed, brought up to date and enabled to make a contribution.

- Focus the Group's activity on learning about and keeping up to date with developments in clinical practice and current issues in health services locally and nationally.
- Participate in the procedures agreed with the Practice for implementing Practice-based Commissioning.
- Work collaboratively with Practice staff in handling ideas, comments, concerns and complaints (all in anonymised form) which are received from patients.
- Contribute to patient satisfaction/opinion surveys and to the monitoring and evaluation of performance and other targets set by the Practice.
- Continue to organise open meetings and education seminars for patients who are interested in specific aspects of the Surgery's operation (eg Practice-based Commissioning) or particular medical conditions/ treatments (eg diabetes, prevention of heart disease).
- Develop a joint approach with the Practice for special needs awareness training for staff and Group members.
- Continue to promote the value of patient liaison groups and to help other Surgeries develop their own groups, by being an example of good practice and by encouraging co-operation and networking.
- Develop our skills as individual Group members by sharing the functions of chairing meetings, taking notes, recording action points, organising special interest events and carrying out other administrative tasks.

The overall process is transparent and makes both practice and patient liaison group accountable.

How hard do people work?

Already by 2002, a summary of what the PLG had done and how they had set themselves up was looking like this summarised for a presentation on progress

Balham Park Surgery Liaison Group (BPSLG)

“How it works now”

An “Open committee”

- Monthly meetings (except August)
- Patients and practice staff together
- Aim is mutual benefit/share information/make improvements
- Formal paperwork and committee roles - use email where possible
- Bank account, Treasurer, annual budget
- Meetings chair (try to rotate this)
- Secretary/minutes (try to rotate this)

- PCT funding based on budget application
- Newsletter and editor
- Annual Meetings (audience = 100)
- Strategic objectives/facilitated session
- Keep broad focus: who the patients are; what the practice does; where we are going together
- Don't fundraise, but accept donations!

“Significant things we have done”

- Evening educational sessions (complementary therapy)
- 2002 RCGP Patient Participation Award
- Practice-based exercise class
- Outreach seminar for other practices
- Improving Practice Questionnaire: “critical friends”
- Examining our own health records
- Telephone appointment access times survey

The planned programme in the PPDP gives an outline of the annual programme now.:

Annual Programme of Activity Planned Now

14/05/08	Specific Topic Patient Meetings	Annual General Meeting
09/04/08 11/06/08 09/07/08 10/09/08 08/10/08 12/11/08 10/12/08 Dates for 2009 to be agreed by BPSPLG	Patient Group Meetings (2 meeting dates to be selected for Specific Topics)	BPSPLG Meetings take place monthly. There are currently 1,150 registered members. Practice representation: Managing Partner constant feature, GP representative on rotation, reception representative on rotation.

06/08 11/08 03/09 06/09	Newsletters	Minimum of 3 to be produced per annum by BPSPLG our patient group	Copies put onto our website. Sent to membership. Available in waiting room.
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11/09 03/10			BPSPLG fund printing
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The monthly meeting schedule is challenging especially when the multi-item agenda is taken into account. We reproduce the agenda for one meeting picked at random:

BALHAM PARK SURGERY PATIENT LIAISON GROUP

60th Meeting to be held Wednesday 12 September 2007 at 7pm

In the Education Room of Balham Park Surgery

236 Balham Park Road, London SW17

AGENDA

(Val Moore in the chair and Bridie Tobin taking notes)

- Introductions and welcome to any new people
 - Apologies for absence
 - Notes of previous meetings – 11 July 2007 – circulated by Andrew Craig
 - Hot topics for BPSLG and any local, regional or national NHS news including update on Local Involvement Networks (LINKs) which will replace PPI Forums in April 2008.
 - Surgery update including screen in waiting room
 - Newsletter – publication date and contents to be agreed
 - Practice based Commissioning –
 1. report back from Jeannette Lalla-Maharajh and Bridie Tobin on previous meeting
 2. note future meeting about patient involvement in PbC to be attended by Tom Pollack and Gwen Richards
 - GP Survey
 - Additional meeting proposed for Wednesday 19 September to discuss extended surgery hours.
 - Any other business
 - Date, chair and note taker for forth coming meetings:

10 October (plan meeting dates and programme for 2008)
14 November
12 December
- Meeting ends by 9 pm.

Note how the meeting schedule can alter to accommodate special issues of importance such as more debate on extended hours.

This meeting does not have an educational talk which is a frequent feature on health topics of interest to patients. As the following example shows these can be advertised separately in this case as a flyer in the flu' letter (the biggest surgery mass mailing)-

Balham Park Surgery Liaison Group (BPSLG)

Your surgery's patient participation group invites you to attend a meeting with Dr Patrick Bower, Senior Partner at Balham Park Surgery, to talk about

GETTING OUR PATIENTS INVOLVED IN PRACTICE-BASED COMMISSIONING: WHAT IT MEANS AND HOW WE CAN DO IT

What's this about? GP practices in this part of Wandsworth, including ours, are coming together to participate in "practice-based commissioning". This means there will be opportunities for local practices to do things better which really matter to patients. Examples include prescribing, diagnostic and investigation procedures (X-rays, blood tests), outpatient appointments and helping people manage long-term conditions. Any savings they make can be reinvested back in the practices to develop patient services. It's essential that we as patients have a say in how all of this happens at our practice. That's what we will talk about with Dr Bower at the meeting on

**Thursday 10 November 2005 : 7-9 pm
Education Room, 1st Floor, Balham Park Surgery**

Seating is limited in the Education Room, so please try to let us know if you want to attend. You can drop a note by the surgery, or email Natalie Goldsmid-Whyte (natalie.goldsmid-whyte@nhs.net) . We hope to see you on the 10th of November.

Balham Park Surgery Liaison Group

It is not an invitation from the doctors – it is from the/ 'your' patient group.

The Managing Partner has nurtured the group over the entire period of its existence and continues to manage the presence of the full range of practice staff to ensure familiarity with the PLG and its objectives. The question of a successor to whom this management task would be passed on has not yet appeared in any strategic or business planning document that we have seen. But our interview with NG-W did bring out a feeling of duty done in regard to PLG support and a wish to cut back on activities such as evening meetings.

So far we have focussed on the internally focussed activities of the group. It is now time to look at some issues that reached a wider audience than those attending BPSPLG meetings or seeing the newsletter

Achievements of the BPSPLG – External and Internal

The most quoted and most considerable achievement to date of the PLG came with their input to a consultation by Wandsworth PCT in 2005 about the arrangements for extended opening hours for GP surgeries. The argument was summarised in the Wandsworth PCT paper summarising the responses to the consultation as: “The consultation document proposed the ending of the Extended Hours Scheme in the Wandsworth South locality on the grounds that it:

- was not the best use of limited PCT resources;
- was not a consistently cost effective way to provide a service given the large variations in costs between practices; and
- benefited only a relatively small part of the PCT population and was therefore inequitable in its current form.”

BPS had already been offering a service of extended hours for some years and the proposal to end the service was not at all welcome. In order to reproduce both the flavour and feeling of the discussion, the BPSPLG response to the consultation is given in full:

The Exocet Letter that sank HMS Wandsworth PCT

I am writing to give the formal response to the above consultation from the Balham Park Surgery Liaison Group (BPSLG). This is a consensus view of our 300+ members.

We held three consultation meetings in December 2004 and April and May 2005, together attracting some 85 patients and surgery staff – far more than attended any PCT events. We also attended your two consultation meetings in March 2005, comprising most of the audience. The people most affected by the pending change are making their voices heard to the PCT strongly and must be listened to.

BPSLG is the oldest and largest patient participation group in Wandsworth, representing some 12,000 patients at the borough's only national beacon practice. Both the Balham Park Surgery and BPSLG are recognised by the Royal College of General Practitioners for their high standards and achievements. Comments from our patients, therefore, must be given due weight as evidence of the outstanding success achieved here by the innovative extended hours scheme. Instead of axing it,

the PCT should see it as a model for developing access to healthcare professionals in other suitable practices. It is concerning that the PCT showed no interest in involving us when you reviewed the scheme in 2004 or of learning from its success at our practice and applying those lessons elsewhere. This is a cavalier attitude and shows the PCT is failing in its legal duties to provide quality services and involve patients and users in service developments as required by the 2001 Health and Social Care Act.

We cannot stress too strongly that Balham Park Surgery patients are adamantly opposed to ending the arrangements for extended hours. Our practice is eager to continue offering them as long as they are appropriately funded because patient demand is overwhelming. As you know, these additional bookable appointments are virtually 100% utilised. This compares with a “did not attend” rate for “in hours” appointments of some 8% in this practice (a rate which is much lower than the PCT’s DNA rate because BPS already manages capacity and demand very well). It is important to point out, however, that this is not an overflow of people who cannot access doctors in usual times. It is people who choose appointments at these extended times because they fit in with life and work needs.

This clear signal of success cannot be ignored. For the year ended 30 April 2005, an additional 2054 patients were able to see a GP at our practice because this scheme exists. That is 17% of the total practice population. These patients would lose their opportunities to see a health professional they know and who has their records available if the extended hours service ceases. It is not an acceptable alternative to say that our patients could use the Tooting Walk in Centre. This is already running at 300% overcapacity by your own admission and has no bookable appointments that our patients could use. Most importantly, the GPs there have no patient records and there is no continuity of care. Even if distance were not a barrier, the WIC is a distinctly inferior quality of primary care compared with what these patients currently experience. The BMA’s national MORI survey in April 2005 confirmed that people value being able to see GPs and nurses at local surgeries. This survey found 75% of those questioned said accessing their local surgery was more important than impersonal walk-in services. Our local experience bears this out and the PCT should take note of it.

The PCT is very aware of the rapidly changing demographics of this borough and of the imperative to re-fashion primary care services accordingly. The extended hours service at Balham Park Surgery is doing just that already. Data that we have shared with the PCT shows that some 48% of our scheme users (990 patients) during the past 12 months who saw a GP came from the fastest growing part of our borough population – working people aged 25-34 – who cannot take time off at other times. One-third of these (301 patients) were younger men – a group notorious for under-accessing primary care. In addition, 139 children under age 16 used these appointments, generally because they were brought by a parent before or after work. All of these adults and children would have little or no alternative GP access if the scheme ends because our “in hours” appointments have no spare capacity. In addition to GP appointments, some 2,926 patients saw a nurse during extended hours last year. They too would lose this valuable access if the scheme ends. To end the services would be deliberate discrimination by the PCT against 4,980 of its own residents and blatantly contrary to the spirit of a patient-led NHS. It would also put additional pressures on already overburdened local A&E and WIC services and result in higher costs to the PCT which it cannot afford.

The PCT’s rationale for wishing to cease funding the extended hours scheme relies strongly on their

interpretation of “equity”. Their position ignores history and distorts logic. Balham Park Surgery has four years of successful experience of this scheme, yet the PCT’s appeal to “equity” is that this is unfair to other practices and people in more deprived wards. This argument is bogus. If no scheme existed and if the PCT proposed to give additional funds to BPS for increased access rather than, say, to a practice in Latchmere Ward, then yes, equity would be a powerful contrary argument. But four years of an established and successful service means this is not the case. You also admitted at our meeting on 11th May that the PCT has no alternative plans for applying the £50,000 it would “save” from ending the scheme at BPS towards improving health inequalities elsewhere. This trifling sum (<0.01% of the £60million the PCT spends on primary care annually, drugs excluded) would simply be lost in the PCT’s considerable deficit. Wasting money is poor stewardship of public funds. Penalising nearly 5,000 people to save a paltry £50,000 cannot be justified. Simple proportionality shows the fallacy of the PCT’s argument about equity.

The PCT’s position ignores strong signals coming from Government about the need for more choice in primary care. There will shortly be white paper about increasing capacity and widening patient choice in primary health care. Patricia Hewitt stressed the importance of bottom up reform to achieve this in her speech to the National Leadership Network on 19th May when she said “because we want the White Paper to be firmly based on the experience and expectations of patients as well as practitioners, I will be initiating a programme of public engagement in which we will invite people to help design the twenty-first century health service outside hospitals”. BPSLG welcomes this and we will actively participate in this initiative by inviting Ms Hewitt to visit our surgery to hear at first hand why the extended hours approach works and represents value for money and should be a model for developments elsewhere.

In every other aspect of life, innovative success and efficiency such as Balham Park Surgery exhibits through the extended hours scheme would be praised and learned from. Instead our PCT has shown it has already made up its mind to damn this innovation as selfish and inequitable and close it down in order to save an insignificant sum of money for which it has no alternative patient care plans to address health inequalities. That is an abuse of equity and abandons the PCT’s own Mission Statement commitments about “enabling people to get the health service they need, when and where they need them”; “listening and valuing the views of patient, carers and the public” and “involving and engaging local people in decisions about their health and health services”. If the PCT were serious about this statement of principle, it would retain the extended hours services at Balham Park Surgery and learn its lessons so they could be applied appropriately elsewhere.

We would leave the PCT with this final thought. In her first speech on the NHS (13 May 2005), the new Secretary of State Patricia Hewitt reflected on the lessons she had learned about successful organisations while at the Department of Trade and Industry. She said the NHS should learn that “the best organisations were the ones that understand how the world is changing; those that understand how they need to change to meet needs of people they serve.” She stressed that what matters to patients is being cared for as an individual and gave her definition of what creating a “patient led NHS” means. It should be “a service that is treating every patient the way that everyone working in the NHS would want themselves and their family to be treated.” We hope the PCT will reflect on this as it is an excellent description of the way our practice has implemented the extended hours scheme. We appeal once again to the PCT to understand the realities of this situation and not to continue dismissing our success from a distorted interpretation of equity issues.

Yours faithfully

BPSLG Committee Members

cc. Wandsworth Patients Forum
Wandsworth Health Overview and Scrutiny Committee

Strong Council Reinforcement

The view was backed up by the Wandsworth Patients Forum and by a very strong response from the Wandsworth Borough Council: Health Overview and Scrutiny Committee, quoted here:

Conclusion. *Whilst the PCT's wish to review the extended hours scheme reflects a legitimate concern to achieve value for money and ensure that access to GP advice is improved in all parts of its area, the case for change put forward in the consultation document issued by the PCT is seriously flawed and neither of the two alternatives suggested is acceptable. The weakness of the case put forward is reflected in the response to consultation, in which the PCT's arguments have been overwhelmingly rejected. This paper therefore recommends that the PCT maintain the scheme in its current form whilst taking a more measured approach to addressing questions over value for money and how to ensure that the benefits of extended hours provision are more widely distributed.*

So we have the view from the BPSPLG founded on patient opinion backed by elected members of the Borough Council. This foundation of legitimacy is backed by coherent argument developed through consultation and discussion including a presence at public meetings where as the letter noted, BPSPLG "comprised most of the audience". In the words of one person interviewed for this report, "we fought the PCT to a standstill". The PLG also attracted a measure of external publicity in local and national media. The Wandsworth Borough News wrote on 5 August 2005

Expensive commuter clinics saved from axe

Harassed parents and busy young professionals won a victory last week when health bosses agreed to save GPs' popular "commuter clinics".

Six surgeries in the south of Wandsworth borough have run early morning, evening and weekend surgeries so busy people can be seen at convenient times.

Wandsworth Primary Care Trust (PCT) tried to abolish the scheme because only a few areas were benefiting from what it said was a

costly pilot too expensive to spread to the whole borough. Balham Park Surgery alone accounted for half the £100,000 budget.

A furious Wandsworth Council health scrutiny committee forced the PCT to consult before deciding, and threatened to refer the decision to the Health Secretary.

The Balham Park Surgery Liaison Group, representing 12,000 patients, responded to the consultation by saying 2,054 extra patients were able to see a GP in one year because of the scheme. Forty-eight per cent were working people aged 25 to 34 who could not take time off work, and a third of those were young men, a group notorious for shunning doctors."

Some months later the scheme received more favourable publicity from a feature on the BBC Online site telling the tale of Mr Brogan who found the arrangements fitted his life much better.

"Mr Brogan moved south and registered with a surgery in Balham, the problems have been resolved.

Balham Park Surgery, situated in an area popular with commuters who work in central London, runs a late-night surgery on Wednesdays until 9pm, along with two 7am starts during the week.

Convenient

Mr Brogan, who was at the Wednesday night surgery for blood tests when the BBC News website spoke to him, said: "It is like a breath of fresh air. I ring up, make the booking and just pop in on my way home. It is so convenient. This is what the NHS should be like."

Come on Down, Secretary of State

The PLG took one further opportunistic step connected to the 'Health Outside Hospitals' consultation, to attract interest on a national level by inviting the then Secretary of State for Health to come down to Balham to see how a good, popular extended opening hours scheme is run. Sadly Patricia Hewitt was unable to accept the invitation.

Not all the achievements of the group are based on fighting to preserve services. The PLG has created public interest and support for particular services within the practice.

Patient Participation Award 2002

BPSPLG was also recognised by the Royal College of General Practitioners with the 2002 Patient Participation Award of £2000 to support a patient-led initiative for an exercise class targeted at particular groups of patients. The full proposal is attached as an Appendix to this report. For our purposes here, we note that the proposal emerged from a brainstorming meeting of the Group to consider strategic objectives for 2002/3 and these

proposals – to create and use an exercise space in the practice premises – were endorsed at the Open Meeting. There was therefore a patient mandate. This was allied to a clinical need identified by the practice and endorsed by the local PCT as part of a broader local initiative – the Health Improvement Programme. The programme was costed at £2000 to buy some mats and meet the costs of a yoga teacher over 50 sessions/ 12 months . All this was drawn together in the prize-winning proposal. The proposal made the point that the funds would be administered by the BPSPLG Treasurer and kept separate from practice funds.

As proof perhaps of the strength of the patient need, the class continues now on the basis of user contributions.

This then was an intervention by the group to enhance therapeutic services that met physical and psycho-social benefits

Service Enhancement Promotion and Familiarisation

We quote from the Newsletter no.12 which documents the direct involvement of BPSPLG members in a campaign to promote the use of the practice's online services.

Signing up for online appointments

The surgery had a week-long promotion at the end of January to encourage patients to sign-up to use online services (see the article in issue 11). Several BPSPLG members – with sweatshirts to match! – took a leading role in talking other patients through the process. Here are some of their personal reflections on the experience.

“Donavan and Natalie started the session. Eugene and Daksha from the IT department were helping with me. We asked all the incoming patients if they would like to sign-up. Twenty-one patients registered on that evening session (4-6pm). Some patients did not like the idea of going on line. Some people did not have any computers at home. A suggestion: I think it will be helpful if an eye-catching display stand/board is exhibited in the patients’ waiting room promoting the online services.”

Adjmal Qureshi

The idea to make the surgery more accessible to patients via using information technology/computers is a very positive step. This will enable patients to have a choice n how they contact/communicate with the surgery. I enjoyed it very much helping to introduce patients to this new system, which is my view was very well received by the patients. Let’s all hope this new initiative is a success for all.

Gwen Richards

Saturday 28 January found me behind the Reception in Balham Park Surgery, dressed in my distinctive blue t-shirt emblazoned with B P S P L G. I was there to tell patients about their ability to make (and cancel) appointments via the on line booking service, how to ask for repeat prescriptions and communicate

with the surgery by email if they wish to do so. For the majority of patients who had appointments that day, they left the surgery armed with their on line accreditation. For the minority of those who didn't sign up it was because they did not have any photo identity with them.

I hope that patients will sign up for the on line appointment service as soon as possible. It will benefit them and benefit the surgery. In the future it is intended that the service will extend to appointments with the nurses and other services.

Also, as it was a Saturday it was interesting to see that of the appointments on that day, none was a Did Not Attend. The PCT tried to close down the Extended Hours arrangements from which the Balham Park Surgery Saturday surgery was funded. The attendance on 28 January is just one piece of the evidence that these surgeries are wanted, needed and used and the PCT should take note accordingly.

The BPSPLG has donated a bottle of champagne for the 1,000th patient to sign up - there is some way to go as the system is still very new but we hope that it will not be long before we can present the lucky patient with the bubbly! Just ask at Reception and they will tell you all about it.

The new ingredient here is the patient group representatives dealing with patients face to face not in a meeting but in a practice environment. This is not a discussion about how to encourage sign-up but direct action to promote a service enhancement goal while raising the profile of the PLG.- note the supply of T-shirts.

A Variety of Goals and a Variety of Ways to Get There

The cases illustrate different goals for the group – the first to bring pressure to bear in public by lobbying decision-makers and engaging allies to advocate a particular case. The second enlists external support for an internal goal to provide additional services to a group of patients, using the reputation and history of the group to underpin and demonstrate its patient-led processes all wrapped up in a proposal that drew on professional competencies within the PLG to present a compelling case.

Finally, individual members of the group joined in in a practice-based promotion of a new services within BPS. This was an opportunity to engage members of the group with practice staff as well as patients to make a contribution in an operational setting. This is a public declaration of a commitment to common goals of patient satisfaction and service quality and would help dispel any concerns that patient representation is an activity that holds itself aloof from the day to day life of the surgery and is more interested in matters of high health policy.

Issues of Successful Representation

A particular issue of general concern arises from these achievements. The issue is whether the PLG is an adequate means of representing all those registered at the practice.

The profile of the practice is summarised in the PPDP as:-

Practice Population age profile taken on 18th March 2008

Age groups	0-4	5-16	17-24	25-34	35-44	45-54	55-64	65-74	75-84	85-89	90+
Males	447	585	314	1785	1328	707	376	200	119	25	10
Females	430	555	534	2325	1046	567	364	274	177	61	43
Totals	877	1140	848	4110	2374	1274	740	474	296	86	53
Total Population											12,272

The largest single group consists of those aged 25-34. None of them regularly attend the Practice Group meeting although a proportion will see the Newsletter which is now available on to new joiners on an 'opt-out' basis i.e. they will get it sent to them unless they say no. This group also rarely attend surgery and have little interest in forming a relationship with the practice – we can guess that they have other more interesting relationships to explore. Those that do use the services of BPS more regularly are those aged 55+ and that age group does account for most of the core membership – those who attend the PLG meetings most regularly. So the group represents a sample of 'heavier users' who value relationship and recognition as part of being reassured that they will be well-cared for. The next question is whether that group can take up issues that affect other patients with different needs? The extended hours passage of arms would suggest that they can – the issue was recognised and the arguments successfully made by the group on behalf of others. Equally the group marshalled a winning application for a service that was targeted at the older patient and won £2000 for the exercise class.

Empathy and Competence

Understanding the wishes and needs of people other than oneself is a basic user representative skill. What is lacking in terms of the empathic association with some one of the same age, social class, race or gender can be supplied in large part by an understanding of the rules of the game and some competencies in understanding research data or acquaintance with the rules, institutions and culture of the NHS.

Developing Value and Social Capital

None of this is to deny the need for the group to recruit and refresh its active membership base and this is a preoccupation reflected in its forward plans. Also in discussion with group members and practice partners for this report, there was a high awareness of the issue. The group has developed value and social capital in two ways – the first was by recruiting from amongst those registered with the practice, individuals active in the local and national health economy who knew both the rules and the players of the game. An example of this is the member who is a non-executive director of St Georges Healthcare NHS Trust which provides the local acute services..

The other means of developing the value of the group was by encouraging a person such as Bridie Tobin, the long-serving Treasurer with a business background to learn about the health service and apply this knowledge first with the BPSPLG and now with other health bodies such as the local Patients Forum and local practice-based commissioning cluster. The feeling of participants interviewed was that the group was what it was and as it stood, it added considerable value to the practice. It has within it a number of highly experienced

people with professional skills and knowledge of the health service and elsewhere. It has many of the characteristics then of an expert patient group tempered by the views of the larger number of attendees who attend for the educational sessions and the annual open meeting. NG-W did express a concern that the core group of activities and regular attendees could appear rather forbidding to a new attendee who was not up to the same speed on issues of high policy. Would the concerns of the group appear be too highfalutin' and off-putting to the new joiner? Not focused sufficiently on the more mundane, day to day issues of surgery life?

However the senior partner Dr Patrick Bower (PB) while uncertain at the outset of the value of the group has since been convinced of its value. In his view, once the group was reconstituted, it became clear that it had a valuable role to play, a role which has gradually increased over time. This includes their essential, formal role, in relation to various aspects of the GP contract as well as their advocacy for services which the practice wants to provide for its patients, exemplified by the consultation over extended access. It was this consultation process which convinced PB of the vital importance of the patient voice, both within the practice, and, ideally, in the wider NHS. Whilst it appears to him that the government routinely discounts the views of health professionals who disagree with government policy, it is much more difficult to ignore the voice of patients. The judgements made by the BPSPLG on the Darzi proposals, and the associated "consultation process" articulated a view very close to his own and that view had the advantage of being untainted by perceptions of doctors' self-interest. (The Newsletter item reporting on the views developed by 28 members of BPSPLG in February 2008 is attached as an Appendix entitled "Consultation – and more consultation".)

We have seen no reference in the files to a discussion about some of the other roles and tasks for patient groups such as patient transport or self-help groups. This is certainly not done by the BPSPLG. The PLG does pay an annual subscription to the National Association for Patient Participation and receives the newsletter and information about events but does not play an active role in that organisation. The N.A.P.P report mentioned earlier does not include the BPSPLG in its sample of PPG groups.

The details of the PPGs held by the N.A.P.P would form an excellent sample for any exercise to test out the evaluation system. The January 2007 report from this organisation is principally descriptive in tone with activities categorised under three headings – Health Promotion and Information Provision, Influencing and Communicating and Service Delivery.

Any Decent Rows?

There is no record or recollection of lasting disagreements with the practice. The BPSPLG is not confrontational in style. The individuals and the group would be ready to defend the BPS against unwarranted criticism and both practitioners and patients share a view that the worthwhile ideas for the improvement of the health service come from those who experience and give the service at the front line. Both parties point out that listening to patients and giving them time to respond to consultations has in the past been "a customer more honoured more in the breach than the observance". The relationship for the future was summed up by one interviewee who saw it in the new context of commissioning almost as the practice commissioning views from its patient group. The issue of

independence was seen within a context of shared interests both personal and professional.

On the whole the PLG membership is considered to be much more fun and more productive as well as being more social than the other bodies on which PLG members serve, according to the views expressed in interviews. It sees itself as being the critical but loyal friend ready to criticise but ready first to listen. The approach keeps the formalities to a minimum but some are inescapable.

A Particular Challenge

The BPSPLG has faced a particular challenge in improving access for blind and – to a lesser extent – deaf members. The practice now has a loop system that works in the meeting room used, but there was a long period when the system did not work at all. Improving access for the blind member of the Group means reproducing material like minutes in very large format in time to get it to the person concerned. The PLG does often fail on this and has to ask the practice for help with producing the paperwork, which is another demand on their time. In past, the blind member has complained with some justice that the service received is not good enough and does not meet statutory norms. A volunteer led group may be poorly resourced to meet these expectations but the BPSPLG acknowledges its need to be fully inclusive. How to do this consistently and well is not clear to the group at this time.

Questions of Constitutions and Budgets

Duly Constituted

The BPSPLG Constituion was drawn up in 2004 and reads:

Balham Park Surgery Liaison Group

Constitution

Name: The name of the group shall be 'THE BALHAM PARK SURGERY LIAISON GROUP' (the Group) based at the Balham Park Surgery, Balham High Road, London SW17.

Association: The Group shall be affiliated to the National Association for Patient Participation (N.A.P.P.) and be governed by the rules of the N.A.P.P.

Aims & Objectives: (1) To help Doctors and Surgery staff to provide, and patients to obtain, the best possible healthcare through discussions at regular meetings with surgery staff deliberating on local and national health issues. (2) Contribute to patient satisfaction through opinion surveys and other means, including the examination of complaints, as well as monitoring the performance and targets set by the Practice.

- (3) Produce three newsletters for Practice patients per annum which will contain appropriate information on local and national health matters.
- (4) Organise as required appropriate educational seminars on health matters suggested by patients which will be open to all patients of the Practice.
- (5) Monitor activities of Wandsworth Primary Care Trust and assess the effect any decisions or developments proposed by the Primary Care Trust may have on patients of the Practice.
- (6) Ensure that the Group has a wide and representative membership from the Balham Park Surgery patient population.

Membership: Membership shall be open to all patients and staff of the Practice regardless of ethnicity, disability, age or sexual orientation.

Committee The committee shall consist of three officers—a Chairman (revolving), Secretary and Treasurer—and at least six other Committee members nominated and elected annually. The Committee shall endeavour to meet at least six times in any period between two Annual Meetings. Four members plus one officer shall constitute a quorum. The Committee may co-opt up to two people. Co-opted members are not eligible to vote. All patients and staff of the Practice shall be entitled to attend all committee meetings.

Finance: All sums collected by the Group shall be handed to the Treasurer who shall pay the same into an account in the name of the Group at such bank or building society as the Committee may from time to time decide. All cheques must be signed by two members of the Committee of whom one must be the Treasurer.

Annual General Meeting: An AGM shall be held annually. Any item for the agenda shall be sent to the Secretary for consideration at least four weeks prior to the AGM date.

Election & Retirement of Committee Members: All officers and Committee members may offer themselves annually for re-election at the AGM. If more than one nomination for an Officer is received then a vote must take place. In the event of a tie the Chairman has the casting vote.

Report and Account: The Committee shall present at each Annual General Meeting a report of the activities of the Group and its own proceedings during the previous year, with a statement of accounts up to the end of its financial year.

Dissolution: If upon winding up or dissolution there remains, after the satisfaction of all its debts and liabilities, any property whatsoever, the same shall be given or transferred to the Practice or the parent charity or other similar charity.

Notice and Application of Rules: Any member of the Group shall upon request be supplied with a copy of these rules.

Alteration to the Rules: Any of these rules may be rescinded, amended or waived by a resolution passed at an AGM or a Special Meeting of which proper notice will have been given to all members, by a two thirds majority of the members present and voting. Provided that no alteration shall be made which would cause the Group to cease being affiliated to N.A.P.P. Reg. Charity No 222992157.

The legal status of the group is as an unincorporated voluntary organisation. No officers beyond Treasurer have been elected and it is the process of managing the two bank accounts of the group – current and deposit – with two approved signatories that make up the formal processes that satisfy the obligations of transparency and accountability. A Treasurer's report is submitted and discussed at the Annual Open Meeting. The governance arrangements in place facilitated the award from the Wandsworth Community Empowerment Network charitable status – an application made by the PLG in the period after the PCT funding was withdrawn. Indeed the PLG got a prize for the quality of its financial reporting.

Money and Budgets

Being starved of money can sour relations since adequate funding and other resources are part of the proof of the recognition of value. However at the time of writing, money is not an issue. It has been in the past when the PCT withdrew support and the PLG had to find its own sources of money such as a local grant giving source for one year. Now however the patient participation function has been identified as an activity worthy of being funded from savings generated as part of the pbc process. The happy event was reported in the March 2008 newsletter as:

We're in the Money

Certainly for this year anyway. The good news is that BPSPLG came up with a creative suggestion which the practice supported and the outcome was that £2,265 of so-called "freed-up resources" from practice-based commissioning has been approved for spending on BPSPLG's support for 12 months. The cheque is in our bank account. This reflects BPSPLG's budget proposals for 12 months of meetings, newsletter communications and educational events. Thanks to all concerned for getting this financial support agreed and we hope it sets a good example for how other patient participation groups in Wandsworth could be funded through practice based commissioning savings.

The Budget in Question

Balham Park Surgery Patient Liaison Group Budget for Year 2007/2008

Newsletters x 2.....	£680
Education Seminars x 2.....	£160
Publicity (posters/flyers).....	£120
Postage.....	£475
Annual Meeting Costs.....	£200
Monthly Meeting Costs.....	£ 75
Stationery.....	£ 30
NAPP Membership.....	£ 25

Total	£1765
Reserve for Miscellaneous Costs.....	£ 500

Total	£2265

Notes:

1. The above costs are based on a current membership of 650 patients approx..
2. The reserve is to anticipate increased costs related a further increase in membership as the Practice increases in size-for example, our postage costs will rise and to produce a third newsletter in the 12 month period (as we have done) would increase costs by at least £500.

BCT

10 July 2007

Questions of Purpose and Impact

The bulk of these funds will be earmarked to pay for the costs of printing and distributing the Newsletter which has a current print run of 1500. The new method of recruitment whereby interest is assumed, has raised the print run but there is no evidence that newsletter receipt raises the level of active involvement. The newsletter on its own is not a means of recruitment and indeed was not intended primarily to be one. Nevertheless the Newsletter gives the oxygen of publicity to PLG and BPS activities and in creating interest amongst readers may well play a role in promoting active participation. The debate will continue. As the minutes of the 61st meeting record "Agreed to talk about getting more people to meetings at next meeting. It was noted that postage to 600 members is expensive and does not seem to hit the mark." Now that membership is higher, the question of expense gains more prominence.

The Newsletter itself is written using volunteer resources including a journalist who acts as editor and sub-editor as well as copy taster. The small band of contributors seem to be having some difficulty in producing the three issues per year planned for in the BPS Development plan. The March 2008 issue is the first since the middle of 2007 and the PLG budget only commits to two newsletters.

The costs could be transformed if email was used as the means of distribution but this is not an option currently offered. The PLG is keen to extract email addresses from the surgery database. The process of permissions from addressees would be the same as that for postal addresses.

That section of the website that contains news of the BPSPLG is also intended to be maintained by the PLG who would pay the BPS webmaster. However this means of communication may be one task too many for the PLG. The title for the page misspells Liaison and the last newsletter featured on the site (as at 24/3/08) is issue 13 December 2006.

The Most Precious Resource

The financial accounts omit all reference to the most precious resource of all – that of people's time. Only the time of practice staff presenting at educational events are charged back to the group (£160 in the budget above) – otherwise the time of all those attending at the PLG's meetings is not costed and freely given. The investment is considerable – 10 meetings a year lasting two hours and involving up to 18 people (recorded as attending the October 2007 meeting to take one at random) represent some 360 person hours a year for actual 'time in the room', discounting the larger audiences attracted to educational events. It would not be too fanciful to double that figure to account for the time taken before and after meetings for preparation, minute taking, special purpose working groups and the other administrative and content-related tasks involved. We have no data on the costs per hour of practice staff. Volunteers' time is considered to be 'free'.

Why So Few? - the absence of other patient participation groups

There have been investments of time and energy in proselytising and spreading the word about the benefits of patient participation. Following the big Wandsworth PPI strategy launch in 2004, there is a The Practice Based Commissioning (PBC) Toolkit to assist in involving and engaging with Wandsworth Patients (<http://www.wandsworth-pct.nhs.uk/pdf/PBC/ppi%20toolkit%20version%205%20Sept%2006.pdf>) and there are now about half a dozen groups around the Borough at various stages of development. We have no details on them at this time.

Why take up should be so tentative is beyond the scope of this case history. But we can at least suggest that it is a question of leadership at partner level giving sustained and adequately resourced support to a committed practice manager. As the agenda below proves the BPSPLG was ready back in 2002 to help spread the word.

Balham Park Surgery Liaison Group (BPSLG)

Balham Park Surgery, 236 Balham High Road, London SW17

Patient Participation Outreach Meeting for Wandsworth GP Practices

4 December 2002 12.30 – 15.30

12.00 Sandwich lunch available

12.30 –13.00 ***Introductions*** – Rowena Davis, patient & member of BPSLG

13.00 – 13.20 ***“How it all began”***

“What we’ve learnt/what we would do differently if starting now”

Natalie Goldsmid-Whyte, Practice Manager; Andy Morgan, GP; Bridie Tobin, patient & member of BPSLG

13.20 – 13.30 ***“How it works now/ Significant things we have done”***

Andrew Craig, patient & member of BPSLG

13.30 – 13:50 ***Question time***

13:50 – 14:30 ***Breakout session for small group work*** –audience divides into groups with members of one practice working together on these questions: A BPSLG member will join each group as a “resource”.

What would be the advantages/disadvantages of setting up a Patient Liaison Group in our practice?
How would we do it in our practice?

What would we have to do to get it started?

14:30 – 15.15 ***Feedback from small groups***

Rowena Davis and Valerie Moore, patients & members of BPSLG

15:15 – 15:30 ***Review of meeting.*** Satisfactions/dissatisfactions/learning
Andrew Craig

The group also developed a template to share good practice – attached in the Appendix.

Research done by the still extant Community Health Council prior to the December 2002 meeting had come up with the following estimates of intention to do more on patient representation at that time. 35 responses had been received from local surgeries and 17 wish to set up a group (less 2 already set up), with a further 7 considering the idea. 11 had no intention of doing so. In the event we are left with one..

Optimistic times and why not? More public discussion and promotion was to come. The official launch of the Wandsworth PPI strategy in March 2004 was attended by over 150 people.

However given the pressure on people's time and energy, it is unlikely that the BPSPLG will set aside time for promotional purposes. Information and support are available nationally and locally and all that remains is for independent practices to take it up. There is the PPI web-based toolkit – link above – as well as the expertise of the National Centre for Involvement. They can step in and be the flag wavers for patient engagement in other practices and take the burden off a hard-pressed group of volunteers, the managing

partner and others in one particular practice.

What has this Account told us?

Patient Participation needs:

- a committed practice – by this we mean personal commitments from partners that may involve financial support. If not direct financial support, then indirect costs in the shape of a part of a practice manager's time and other administrative resources
- simple administrative points – a room that does not cost anything to hire and is accessible for disabled people and has such facilities as induction loops. Support to assist the PPG make its proceedings fully accessible.
- Clarity around the budget; who pays for what and where the money is coming from. Continuity of a level of guaranteed funding helps advance planning and underpins a regular service such as a newsletter. The funding must reflect the costs of communicating with patients and involving more in the activities of the group.
- Good organisational processes that can integrate inputs from different sources in the process of development of strategic objectives within a time line that takes account of the extended process of discussion and validation needed by a PPG which does not meet more than once a month and needs to submit proposals to an annual meeting.
- Practices that are good at running their business and want to improve in a way that meets the needs of those registered with them will also be good at patient participation which is not considered a process apart but one essential way to incorporate the patient viewpoint into the practice's mission and objectives
- that the people who come forward as patient participants may not be representative of the overall demographic make-up of the practice list. They represent the more regular and heavier user of the practice's services. However this does not mean that they cannot represent the views of others.
- Professional skills amongst the participants are very valuable and can add a great deal of value to the group. Such professional skills may not be available at all times given that they may be in demand by others
- It is difficult to recruit more active and regular participants who do more than read a newsletter. Participation is linked to need or perceived future need. The strong driver is recognition by practice staff of the individual.
- Activities can range from direct involvement with surgery services in a promotional or educational context, through gaining support from external bodies for such initiatives as service extension to full-blown public campaigning for or against proposals that affect the service offered to them.
- The patient voice is recognised as having an authority and status that is distinct from that of the medical profession and gains such authority not so much from declarations of formal constitutional independence but from the ability to demonstrate that the views propounded have been gathered from patients by patients.
- The BPSPLG cannot be replicated exactly but we can say that a PPG gains a great

deal from accessing people with a knowledge of the Health Service locally and nationally. The group is strengthened if it can draw on skills and competencies in the area of communications and the mechanics of running meetings and understanding consumer/ user research data. It has to work hard to provide access and support to those with disabilities. It must not be afraid of having fun and acknowledging that it meets social needs of participants as well as meeting their desire to make a contribution.

Looking to the Future – Plans and Prospects

The principal elements can be summed up as:-

- stable funding if the current approach which takes advantage of practice based commissioning arrangements is continued
- review channels of recruitment and look to internet based e-communications instead of paper
- look to expand involvement by targeted recruitment perhaps for specific areas of activity with short-term involvement connected to that activity.
- consider the BPS management role and start planning for a successor to take over from the Practice Managing Partner
- consider expanding the role of the PLG e.g to do more in the area of complaint handling
- understand the role of the new LINKs Network and develop an appropriate relationship
- lessen the burden on the practice and the group by making the BPSPLG experience available to national and local bodies who can take this experience to stimulate others to take part in patient participation schemes without making further calls on the limited resources of practice and PPG
- offer the evaluation methodology for an exercise involving a wider group of practices working in conjunction with the N.A.P.P

The Content of the Appendices

- A. Evaluation Questionnaire
- B. Balham Park Surgery Business Plan BPSPLG Appendix
- C. Patient Participation Award Application
- D. Sharing Good Practice Template
- E. Newsletter article- Consultation-- and more consultation

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