PATIENT PARTICIPATION

**DES- REPORT**



**MARCH 2012**

**Key objectives**

The purpose of the Patient Participation DES is to ensure that patients are involved in decisions about the range and quality of services provided and, over time, commissioned by their practice. It aims to encourage and reward practices for routinely asking for and acting on the

Views of their patients. This includes patients being involved in decisions that lead to changes to the services their practice provides or commissions, either directly or in its capacity as gatekeeper to other services. The DES aims to promote the proactive engagement of patients

Through the use of effective Patient Reference Groups (PRGs) and to seek views from practice patients through the use of a local practice survey. The outcomes of the engagement and the views of patients are to be published on the practice website.

One aspect that practices may wish to focus on is excellent access into the practice, and also from the practice to other services in its role as coordinator of care, facilitating access to other health and social care providers.

Access has many dimensions; the relative importance of these will vary according to the specific needs of the registered population.

These dimensions include:

 **lists being open to all**

** hours of opening with the ability to be seen urgently when clinically necessary, as well as the ability to book ahead**

** continuity of care**

** range of skills available – access to different professionals**

** a choice of modes of contact, which currently includes face-to-face, phone and electronic contact but can be developed further as technology allows**

** geographical access, enabling care as close to home as possible.**

**Implementing the Patient Participation Directed Enhanced Service under the DES Directions**

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| **STEPS- & DETAILS** | **ACHIEVEMENTS OF** surgerylogo**Evidence and comments** |  |
| **Step 1: Develop a structure that gains the views of patients and enables the practice to obtain feedback from the practice population, e.g. a PRG**  The practice must develop a properly constituted structure that both reflects and gains the  views of its registered patients and enables the practice to obtain feedback from a cross section  Of the practice population which is as representative as possible.  Traditionally practices have developed a PPG through volunteers and regular meetings. Recently some practices have developed a virtual PPG (vPPG), an email community that they consult on a regular basis but which does not have regular face to face meetings. The practice should develop its PRG in the most appropriate way to most effectively reach the broadest cross section of its community. This may be a virtual or a face-to-face group or a combination of the two. Whichever approach is adopted by the practice, there must be a structure or process in place for regularly engaging with a representative sample of the population. Using a strict definition, no PRG will ever be truly representative. Many practices have incredibly diverse patient populations and all have patients of different ages and with a wide variety of different needs. Practices participating in this DES must strive to gain feedback from a representative cross section of the practice population. Practices should be able to outline the steps they have taken to do this and demonstrate that they have made an effort to engage with any underrepresented groups.  To do this the practice needs to have an understanding of its practice profile, beyond just age and sex, which could include social factors such as working patterns of patients, levels of unemployment, number of careers, black and minority ethnic groups. Local Involvement Networks (LINks), Local HealthWatch and voluntary organisations may be able to support  Practices engage with marginalised or vulnerable groups, such as elderly patients or patients with learning disabilities. Where a practice has been unable to encourage participation by a certain patient group, it must demonstrate what steps have been taken to try and engage that group. The practice will only qualify for any payment under this DES if it is able to clearly demonstrate that it has established a PRG comprising only of registered patients and used its best endeavors to ensure that the PRG is representative of its registered patients. There are steps that practices can take to ensure patient representation groups are as representative as possible. The starting point is to use the age and sex make up of their  Registered list. Practices should be collecting ethnicity routinely in order to be able to demonstrate that they meet the health needs of their registered population. It is important that the ethnic make up of the practice is reflected in the representative group, as far as possible.  The practice team will have also have local knowledge of specific care groups that the practice caters for, for instance it may look after a number of nursing homes, or a learning disability community, or it may have a high number of drug users. The practice should try to ensure that  Specific care groups are reflected in the representative group wherever possible. Practices should set up a PRG of a reasonable size which is representative of the practice population. Practices should particularly ensure that they comply with the Equality Act when developing a  PRG. Information on compliance can be found on the Equality and Human Rights Commission website3, in the Government Equalities Office guide4 and on the Advisory, Conciliation and Arbitration Service website.5  To engage patients, practices may find it useful to learn from the work the National Association of Patient Participation (NAPP) has done in developing PRGs. Best practice case studies and other resources can be found on the NAPP website.6 There is also a recent study available to  registered practice managers on the Practice Management Network website.7 While advertising in the surgery and in the practice leaflet will help, asking patients personally  To join a group (virtual or otherwise) has been shown to be very effective. Asking new patients at the point of registration as well as at routine surgery visits also helps to reach those people who attend infrequently.  This can be done either at reception or at the end of a consultation by simply handing a leaflet to patients. For more information and tools on establishing a PRG see | 22/09/2011  all the staff were informed about the formation of a patient participation group  and all the details of the requirement of the DES were discussed in detail at our monthly meeting  all the doctors and staff agreed to publicize the concept and were encouraged to recruit patients who could agree to become members of the PRG  **EVIDENCE 1**  Discussion document prepared prior to the Engagement with our PPG  A LARGE LIST – REFLCTING THE DEMOGRAPHY OF OUR PRACTICE POPULATION was made as a result of this campaign.  **EVIDENCE 2**  Demography of our practice population and the distribution of PRG members  Consultation with them was conducted by the practice managers and doctors via a questionnaire on line  E mail and in paper  A comprehensive report was made – our proposal was shared with them which ended on 31/01/2012    We spoke to the TAMIL REFUGEE RESOURCE CENTRE, MEDICAL INSTITUTE OF TAMILS AND THE HINDU TEMPLE AUTHOTITIES BASED IN HIGH GATE. About how we could work together for the good of our TAMIL PATIENTS  We hope to do extensive discussions with TURKISH COMMUNITY GROUP next year. |  |
| **Step 2: Agree areas of priority with the PRG**  The PRG and the practice will shape the areas covered by the local practice survey.  The areas covered in the local practice survey will, therefore, be agreed jointly based on key  inputs, including the identification of:   patients’ priorities and issues   practice priorities and issues including themes from complaints   planned practice changes   Care Quality Commission (CQC) related issues   National GP patient survey issues.  It may be that a standard way or preformed of asking patients about their priorities is developed and agreed between the practice and the PPG. For example (and the words can be amended to suit the local circumstances of the practice):  We are planning our next annual survey and to ensure that we ask the right questions, we would like to know what you think should be our key priorities when it comes to looking at the services we provide to you and others in the practice. What do you think are the most important issues on which we should consult our patients? For example, which of the following do you think we should focus on:  Clinical care  Getting an appointment  Reception issues  Opening times  Parking and so on | |  |  | | --- | --- | | **PRG MEMBERS** | **Priorities** | | females | Wider choice in family planning,  choice of female doctor | | males | ‘viagra’ not available as before | | British white | Access, confidentiality | | Tamils | Access, language barrier with staff  A+E attendance – unhappy with  Alexandra surgery pressure not to  attend A+E- -car park | | Turkish | Access, language barrier with staff  A+E attendance – unhappy with  Alexandra surgery pressure not  to attend A+E | | Bengalis | Access, language barrier with staff | | Afro Caribbeans | Access | | Other Europeans | Access  Lack of Car park | | Other Asians | Access  Lack of Car park | | Somalians | Access | |  |  | | **Age distribution** |  | | **Under 12** | Parents suggest more emergency slots | | **Under 20** | Sexual health, confidentiality | | **20-35** | Sexual health, confidentiality  Access during non-working hours | | **35-50** |  | | **50-65** |  | | **65-85** | Some not happy with Cataract surgery referrals being reduced | | **Above 85** | **Social service support** |     **See EVIDENCE 3 for details** |  |
| **STEPS- & DETAILS** | **ACHIEVEMENTS OF** surgerylogo**Evidence and comments** |  |
| **Step 3: Collate patient views through the use of a survey**  The practice must undertake a local practice survey at least once a year. The number of questions asked in the local practice survey will be a matter for the practice and its PRG to agree. Questions should be based on the priorities identified by the PRG and the practice. Questions can be taken from existing validated patient surveys subject to the necessary copyright permissions, or be developed locally. A list of questions compiled from existing validated surveys is available on the NAPP website.8 Practices may find it useful to draw on these questions when creating their survey.  Guidance on conducting effective surveys can be found at: | The survey was conducted at Alexandra surgery between 5th January till February 27th 2012  **(1)A QUESIONNAIRE WAS DISTRIBUTED**  At the surgery  Sent out by e mail  Patients were asked to go to a secure website to answer them on line  **(2) a simple survey was carried out FACE TO FACE using a template with only two questions- in 4 different languages**  ENGLISH  TAMIL  TURKISH  BENGALI  Altogether 20 responses were obtained ,( to sample ‘free text’ views as a qualitative exercise)  this was found to be more valuable in getting an insight into how patients felt about our surgery  Survey report was produced and shared with our PRG  Results are tabulated to attribute views corresponding to the demography  Of our patient population      See EVIDENCE 4 -Survey report |  |
| **STEPS- & DETAILS** | **ACHIEVEMENTS OF** surgerylogo**Evidence and comments** |  |
| **Step 6: Publicise actions taken – and subsequent achievement**  Practices must publish a Local Patient Participation Report on their website. As a minimum this must include:   1. a description of the profile of the members of the PRG 2. the steps taken by the contractor to ensure that the PRG is representative of its registered patients and where a category of patients is not represented, the steps the contractor took in an attempt to engage that category 3. details of the steps taken to determine and reach agreement on the issues which had priority and were included in the local practice survey 4. the manner in which the contractor sought to obtain the views of its registered patients 5. details of the steps taken by the contractor to provide an opportunity for the PRG to discuss the contents of the action plan 6. details of the action plan setting out how the finding or proposals arising out of the local practice survey can be implemented and, if appropriate, reasons why any such findings or proposals should not be implemented 7. a summary of the evidence including any statistical evidence relating to the findings or basis of proposals arising out of the local practice survey 8. details of the action which the contractor, 9. And, if relevant, the PCT, intend to take as 10. A consequence of discussions with the PRG in respect of   the results, findings and proposals arising out of the local  practice survey  iii. where it has participated in the Scheme for the year, or any  part thereof, ending 31 March 2012, has taken on issues and  priorities as set out in the Local Patient Participation Report  I The opening hours of the practice premises and the  method of obtaining access to services throughout the core  hours   1. Where the contractor has entered into arrangements under 2. an extended hours access scheme, the times at which individual healthcare professionals are accessible to registered patients.       A copy of this report must also be  supplied to the PCT. | **Patient Participation Report**  ALEXANDRA SURGERY worked with a PATIENT REPRESENTATIVE GROUP (PRG), duly formed, closely representing the ETHNIC AND AGE mix of the practice.  We consulted them through written, verbal and emails and collated all views over a period of 4 months FROM September to December 2011.  We were able to obtain clear PRIORITIES identified by the PRG.  Our primary care team at ALEXANDRA SURGERY discussed the  PRG- PRIORITIES,  SURGERY- PRIORITIES  NHS- PRIORITIES  And made a proposal and discussed with the PRG beginning 12th January 2012.  Our consultations with the PRG group members was concluded on 28th January 2012  A patient survey questionnaire was designed with questions addressing the PRIORITIES identified by all.  The survey was conducted over two week ending on 17th February 2012 involving 60 patients randomly selected by the staff at reception roughly reflecting the ethnic and age mix of the practice.  WE CONSULTED widely with community group associated with TAMIL  Patients and vulnerable patients especially patients with learning disabilities living in HARINGEY AND ENFIELD.  All the data collected were analysed .    key findings are as follows  Access via telephone to the surgery was of prime concern.  Lack of ‘slots’ for consultation especially female doctor and nurse were noted  Many of the responders were concerned that ALEXANDRA SURGERY STAFF were continuously pressurising some of the patients who were  attending ACCIDENT AND EMERGENCY services in hospitals, to not go there but to use HARMONI, our out of hours GP service.  They stated that they find it difficult to communicate with staff at HARMONI switchboard in ENGLISH, hence, choose to go to A&E during out of hours.  Restrictions on medication prescribing like Sleeping tablets including diazepam, antibiotics, Viagra, were highlighted in the survey and in PRG group discussions.  We explained to them, the need for evidence based medicine and cost effective prescribing.  Plan of action was presented to the PRG GROUP in March 2012  This has resulted in the following  changes in the practice    Access to the practice for advice has been increased By introducing  EXTRA TELEPHONE LINES from 2 to 6 where 4 mobiles phones are now used by the practice to allow patients to access the surgery easily.  ‘Telephone call back’ service was created in order to respond to telephone messages received by our reception staff from patients on a daily basis.    **See EVIDENCE 5 : Telephone consultation protocol and Plan**  More Telephone consultations have been introduced in response to the survey and PRG group regarding access. The daily telephone consultations have increased by 80%.    A doctor and Nurse working on Saturdays have been introduced to enable working population to access services.  We have recruited extra staff who speak the following languages- TAMIL, TURKISH. BENGALI . NEPALI AND POLISH to enable culturally sensitive dialogue  To take place with Relevant ethnic groups in our practice- we are training them as health officers to promote health and to monitor chronic diseases and support them  In the language of their individual choices  Car park- TWO SPACES to be used only by patients  We have updated the leaflet to reflect the changes that we have put in place  WE HAVE AGREED TO THE FOLLOWING TO BE IMPLEMENTD IN FUTURE  our new doctor with special interest in palliative care to  take care on a day to day basis the welfare of terminally ill patients  our new lady doctor with FAMILY PLANNING CERTIFICATE from the faculty of family planning of the ROYAL COLLEGE OF OBSTRETICS AND GYNAECOLOGY will in future expand the services to meet the wider choice in family planning as requested by women needing contraceptive services  .  We will regularly engage with our practice population in order to improve our services to meet the needs of the population we serve. In addition to written comments that can be put in our suggestion box the internet will also be used to allow our patients to voice their concerns and needs by registering online on a secure website ,  We hope to meet with the TURKISH COMMUNITY GROUPS next year to enable wider participation of this population with greater needs.  We plan to engage with Alexandra primary and secondary school near our Surgery to provide health education and support. Also allowing parents, children, teachers and school nurses in our neighborhood to share their concerns and to work in partnership with Alexandra surgery to provide solutions together.  Our experience so far has been largely positive and there have been suggestions from the patients to set up a permanent patient participation group which they would like to call ‘Friends of Alexandra Surgery’.  We would like to explore this idea and help this group to make this concept a reality. |  |

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