

## Research

# The impact of Patient Participation Direct Enhanced Service on patient reference groups in primary care: a qualitative study

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### ABSTRACT

**Background** NHS policy documents continue to make a wide-ranging commitment to patient involvement. The Patient Participation Direct Enhanced Service (PP-DES), launched in 2011, aimed to ensure patients are involved in decisions about the range and quality of services provided and commissioned by their practice through patient reference groups (PRGs). The aim of this exploratory study is to review the impact of the PP-DES (2011–13) on a sample of PRGs and assess how far it has facilitated their involvement in decisions about the services of their general practices.

**Methods** A qualitative methods design, using semi-structured interviews and focus groups, was

employed to explore the experiences and views of GP practice staff ( $n = 24$ ), PRG members ( $n = 80$ ) at 12 GP practices, and other stakeholders ( $n = 4$ ).

**Results** Wide variation in the role and remit of the participating PRGs was found, which broadly ranged from activities to improve practice resources to supporting health promotion activities. The majority of PRG members were unfamiliar with the PP-DES scheme and its aims and purpose. Stakeholders and practice staff felt strongly that the main success of the PP-DES was that it had led to an increase in the number of PRGs being established in the locality.

**Conclusion** The PP-DES scheme has been a catalyst to establish PRGs. However, the picture was mixed in terms of the PRGs involvement in decisions about the services provided at their general practice as there was wide variation in the PRGs role and remit. The financial incentive alone, provided via the DES scheme, did not secure greater depth of PRG activity and power, however, as social factors were identified as playing an important role in PRGs'

level of participation in decision making. Many PRGs have to become more firmly established before they are involved as partners in commissioning decisions at their practice.

**Keywords:** general practice, patient involvement, Patient Reference Group (PRG), Patient Participation Group (PPG), primary care

### How this fits in with quality in primary care

#### What do we know?

Improving the quality of care is key to meeting the increasing demand of healthcare services and it is now widely accepted that patients have a central role and should be involved in the decision-making process in shaping the NHS services.

#### What does this paper add?

## Background

Over the last 25 years there has been an increase in policies reflecting commitment to patient involvement in the National Health Service (NHS).<sup>1,2</sup> The Department of Health<sup>3</sup> identified the need to involve and respond to patients and the public. The NHS Plan<sup>4</sup> committed the NHS to shaping its services around the needs of patients. Being accountable to patients, listening to patient views, and consulting patients on decisions about services have become defining features of NHS policy.<sup>5</sup> There has been increasing acknowledgement<sup>6</sup> that taking the patient perspective into account may lead to better targeted and more effective services. The Commission for Health Improvement proposed a model in which patients' experiences would be central to its reviews<sup>7</sup> and plans for the NHS contained in *Equity and excellence: Liberating the NHS*<sup>8</sup> aimed to place 'patients at the heart of everything the NHS does'. In addition, the Care Quality Commission (CQC)<sup>9</sup> highlighted their plan to involve the public, people using services, their families, and carers in their work. The Keogh Report<sup>10</sup> outlined an ambition to ensure patients, carers and members of the public feel valued, as partners in the design and assessment of local NHS services.

However, whilst there has been agreement on the importance of patient involvement, there had been little guidance from the Department of Health on how this might be achieved in general practice, until the launch of the Patient Participation Direct Enhanced

Service (PP-DES).<sup>11</sup> The PP-DES was introduced in 2011 to ensure that patients are involved in decisions about the range and quality of services provided, and over time, commissioned by their practice. Practices are encouraged and rewarded for routinely asking for, and acting on the views of their patients. The PP-DES scheme was launched during a period of major reform where primary care trusts (PCTs) were dissolved and commissioning groups were established. The six key requirements of the PP-DES are listed in Box 1.

Patient Reference Groups (PRGs) were first established in the UK over 40 years ago.<sup>12</sup> PRGs are based at a general practice and involve groups of volunteer patients and practice staff. Shortly after their introduction in 1978, the National Association for Patient Participation (NAPP) was established to promote PRGs and encourage their contribution to primary care. Today, NAPP continues to provide support to affiliated PRGs,<sup>13</sup> by providing support and guidance during their set-up and establishment.

Each PRG should have the freedom to choose their structure and issues of priority. National research has suggested that activity varies greatly across groups, with patients most frequently involved in 'advising the practice on the patient perspective'.<sup>14</sup> Their activities can also include health education (e.g. educational meetings and provision of information), supporting the practice (e.g. by providing services for other patients and fundraising) and providing voluntary services (e.g. as providing transport for others to the surgery).<sup>15</sup>

Two surveys<sup>14</sup> conducted found that 41% of English practices had a PRG and that they were more likely to

**Box 1 The Patient Participation Direct Enhanced Service (PP-DES) 2011–14**

The PP-DES was originally agreed by the British Medical Association (BMA) and NHS Employers in April 2011 to run for two years until April 2013.

- 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\*
- Step 2: Agree areas of priority with the PRG
- Step 3: Collate patient views through the use of survey
- Step 4: Provide PRG with opportunity to discuss survey findings and reach agreement with the PRG on changes to services
- Step 5: Agree action plan with the PRG and seek PRG agreement implementing changes
- Step 6: Publicise actions taken and subsequent achievement

Around £60m of released investment has been available to practices, provided that they successfully meet these requirements, which is equivalent in total to £1.10 per registered patient. A further one year of funding was agreed with NHS England, ending 31 March 2014.

\* The authors acknowledge patient groups preferred title is Patient Participation Groups. Throughout the paper the term Patient Participation Group is used interchangeably with Patient Reference Group, as this is referred to the DES.

exist in larger practices in semi-rural and rural environments.<sup>14</sup> Despite an increase in the number of PRGs being established, membership of the groups is often not representative of all patients registered at the practice, which could have implications for health and social care strategies and widen health inequalities between different groups of patients.<sup>16</sup> For example, of all the patients under the age of 65 years registered at one practice, only 45% were aware of the PRG and only 7% had attended a meeting. Attendees were more likely to be women, married and of a higher social status, measured by occupational class and educational attainment.<sup>14</sup>

PRGs may also suffer from unstable membership and disbandment, with early research suggesting that as many as 25% of PRGs registered with NAPP in 1983 ceased to exist two years later.<sup>12</sup> A study of general practitioners' (GPs') views suggested that a lack of patient interest was a common reason that led to PRGs no longer functioning.<sup>12</sup> In addition, GPs also suggested that the mobile population within inner-city areas contributes to lack of a sense of community and cohesion, which results in a lack of interest in PRG involvement.<sup>12</sup> An absence of planning and organisation was also identified as a reason for the cessation of a PRG. In a national survey in 2007,<sup>14</sup> practices that had not set up a PRG cited reasons of a lack of time and expertise in the practice, and a perceived deficiency of patient interest.

The existence and functioning of a PRG is also dependent on the support of their practice, meaning the cooperation of the GPs and practice managers to patient involvement and the PRGs is of crucial importance.<sup>17</sup> Visible support from a member of staff within the practice can help to maintain PRG morale.<sup>15</sup> Setting up a PRG can require several hours of

staff time, at least initially during the formation of the group,<sup>15</sup> but also requires continued support and a continuous effort after the initial 'settling in' period.<sup>12</sup> Research has suggested that within the first 12 to 18 months, the novelty of the PRG can wear off, and when this occurs the introduction of new members can generate new ideas and increased levels of enthusiasm.<sup>12,15</sup> In addition, national surveys carried out by NAPP from 2005 to 2009 found that obtaining more support for their PCT, now replaced by clinical commissioning groups, was one of the top three priorities identified across PRGs.<sup>14</sup>

Previously, although encouraged, there was no national requirement for practices to have a PRG.<sup>14</sup> It is unclear how practices and PRGs will respond to the PP-DES goal of partnership in decision making about practice services which appears to be a step on from their usual activities as outlined above. The PP-DES includes financial incentives to encourage practices to meet this goal and to publicly report on their progress by the end of the scheme. Despite a call for more research into the effectiveness of using PRGs as a model for patient participation,<sup>17</sup> so far there has been no formal evaluation of the PP-DES. The aim of this exploratory study is to review the impact of the PP-DES on a sample of PRGs and assess how far it met the aim of facilitating their involvement in decisions about the services of their general practices.

## Methods

General practices from three CCGs in the East Midlands were invited to participate. A total of 12 practices

were purposively recruited, with at least two from each CCG, to ensure representation of urban and rural practices. Data were collected over a four-month period from June to September 2013, two years after the PP-DES scheme was launched. Selection was determined by the practices' demographics, including the number of registered patients and location (Table 1).

## Design

A qualitative methods design was adopted to assess the impact of the PP-DES on PRG activities, by exploring the participants' views on the requirements of the PP-DES. Focus groups were conducted with PRG members and with the PRG chairs. These were audio-recorded and notes taken by a researcher. Interviews were carried out with practice staff involved with the PRG and key local stakeholders, including NAPP, Healthwatch, and engagement staff from the local

**Table 1** Demographics of the participating general practices

Practice	CCG area	Practice registered population size (in thousands)	Had a PRG before PP-DES 2010/11?	Indices of multiple deprivation scores 2010 (1 = most to 10 = least)	Number of patients who are a PRG	Gender of members present at focus groups	
						Females	Males
1	CCG 1 (Urban)	10 000 to 15 000	No	5	7	2	4
2	CCG 1 (Urban)	0 to 5000	Yes	6	10	4	2
3	CCG 1 (Urban)	10 000 to 15 000	No	1	13	4	0
4	CCG 1 (Urban)	5000 to 10 000	No	2	6	5	1
5	CCG 1 (Urban)	5000 to 10 000	No	2	7	7	0
6	CCG 1 (Urban)	10 000 to 15 000	Yes	3	63*	4	1
7	CCG 2 (Rural)	5000 to 10 000	No	9	12	5	3
8	CCG 3 (Rural)	10 000 to 15 000	No	9	7	4	1
9	CCG 2 (Rural)	20 000 to 25 000	No	10	13	7	6
10	CCG 2 (Rural)	10 000 to 15 000	No	9	37*	4	2
11	CCG 3 (Rural)	0 to 5000	No	7	9	4	2
12	CCG 3 (Rural)	10 000 to 15 000	No	7	13	6	2
<b>Total</b>						56	24

NB The number of members and attendance at groups is variable.

\* These practices have a virtual/discussion group.

CCG. These stakeholders were invited to participate because of their involvement in implementing the PP-DES and their role in supporting PRGs.

The schedules for the focus groups and interviews were developed by the research team and based on the six main components of the PP-DES (Table 2). All interviews were audio-recorded and transcribed. A member of Healthwatch Northamptonshire and a member of the general public were active members of the study's steering group, to ensure patient representation.

Approval for this study was granted by University of Leicester Ethics Committee and assurance given by the Clinical Commissioning Groups in Leicestershire and Rutland. All participants gave their consent.

## Data analysis

The transcribed data from the interviews and focus groups were analysed inductively using the 'framework' technique.<sup>18,19</sup> This approach develops a hierarchical thematic framework that is used to classify and organise data according to key themes, concepts and emergent categories. It was used to explore, compare and contrast key themes arising from the interview data, using the elements of the interview topic guide as a starting point. Analysis was undertaken by the research team who compared and contrasted themes and issues between interviews and focus groups. Data from the 28 interviews and 13 focus groups (total number of PRG members = 80 (males = 24 and females = 56) were read initially several times individually by each member of the research team and then by the team as a whole.

The varied backgrounds of the research team members enabled the issues to be discussed from a range of perspectives and avoided group polarisation, where decisions are reached which are more extreme than those that individuals would make.<sup>20</sup> Having a strict time limit was important to ensure that the discussions did not continue without a clear purpose or resolution.

Through majority consensus the key themes were identified, agreed on and mapped to the PP-DES components (Box 1). The research team agreed that there were emerging themes that influenced involvement in service change, which are outside the scope of the DES scheme, which the research team considered to be important to report (Box 2).

## Results

### Component 1: Develop a PRG

Stakeholders and practice staff agreed that the main success of the PP-DES was that it had led to an increase in the number of PRGs being established where previously they did not exist. However, it was evident from the interviews that the majority of PRG members were unaware of the PP-DES. Practices with more established PRGs were less likely to attribute the growth of PRGs to the PP-DES, although some suggested that PRGs are fundamental and should not have needed the PP-DES to drive their existence:

'... I don't think the PP-DES has made any difference. Patient involvement should be done anyway' (Practice 12, staff member)

Meeting the PP-DES requirement of recruiting a representative PRG was cited as a common challenge. Difficulties were reported with recruiting younger members and mothers of young children, who were high service users, but largely absent in PRGs.

'It is difficult we are asking a "representative group" that are probably not representative because the group that are representative of our practice don't come to see us ... they don't see why they should give up their time for a service they don't need.' (Practice 6, staff member)

Most of the PRGs employed general advertising methods, aimed at the entire practice population, to recruit new members. Such measures included posters, practice website, noticeboards, newspaper advertising, newsletters, open days, community events and advertising messages on prescriptions and the telephone system.

The DES states that membership 'should take into account more than just age and sex' when seeking a representative group. In some practices, targeted recruitment was used to identify specific groups absent from their PRG. These included using other opportunities such as immunisation and flu clinics. In some PRGs healthcare staff approached known individuals or groups to join in an attempt to diversify membership. These included ex practice staff, local councillors, community representatives and visiting Sure Start Centres, Connexions, Women's Institute, tenants associations and school or college career services:

'We get involved with younger people by going into sixth form colleges ... Had it on her university application and her CV because it shows you get involved in your community.' (Practice 8, PRG member)

PRG representatives and practice staff emphasised the importance of maintaining membership. They suggested the following could be useful in retention: specific terms of reference for PRG roles and remit; future

**Table 2** The interview/focus group schedules linked to the main requirements of the PP-DES

Description of the key components to PP-DES	Focus group and interview schedules questions
<p><i>Component 1:</i> Develop a structure that gains the views of patients and enables the practice to obtain feedback from the practice population, e.g. via a patient reference group (PRG)</p> <ul style="list-style-type: none"> <li>• A structure that reflects and gains the views of and feedback from a cross-section of the practice population which is as representative as possible.</li> <li>• Outline the steps they have taken to do this and demonstrate efforts to engage with any under-represented group.</li> </ul>	<p>Are you aware of the PP-DES scheme?</p> <p>When was the PRG established? What are the main drivers behind setting up the PRG?</p> <p>Who are members of your PRG?</p> <p>How do you recruit people to and maintain membership of your PRG?</p>
<p><i>Component 2:</i> Agree areas of priority with the PRG Be agreed jointly based on key inputs, including the identification of:</p> <ul style="list-style-type: none"> <li>• practice and patients' priorities and issues including themes from complaints</li> <li>• planned practice changes</li> <li>• Care Quality Commission (CQC) related issues</li> <li>• National GP patient survey issues</li> </ul>	<p>What types of issues does your PRG usually discuss?</p> <p>Who is responsible for deciding what issues are on the agenda?</p>
<p><i>Component 3:</i> Collate patient views through a patient survey</p> <ul style="list-style-type: none"> <li>• The number of questions asked in the local practice annual 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.</li> <li>• Questions can be taken from existing validated patient surveys, or be developed locally.</li> </ul>	<p>As members of the PRG have you been involved in the patient survey and action plan? If so how?</p>
<p><i>Component 4:</i> Provide PRG with opportunity to discuss survey findings and reach agreement with the PRG on changes to services</p> <ul style="list-style-type: none"> <li>• Practices should respond to the outputs of the latest local practice survey by providing the PRG with an opportunity to comment on and discuss the findings of the survey, along with other relevant information.</li> </ul>	<p>Since the DES scheme has been introduced, have you noticed any changes to your group?</p> <p>Has the DES (survey) lead to any more time being spent on discussing the services that the practice provides?</p>
<p><i>Component 5:</i> Agree an action plan with the PRG and seek agreement to implementing changes</p> <ul style="list-style-type: none"> <li>• Following the discussions in Step 4, an action plan will be agreed with the PRG. The practice should then seek the agreement of the PRG in implementing the changes and where necessary inform the PCT.</li> </ul>	<p>Provide examples of important changes that the PRG has been involved in?</p> <p>To what extent do you feel the PP-DES has helped your PRG to become involved in decisions about practice? Can you explain why that was?</p>
<p><i>Component 6:</i> Publicise actions taken and subsequent achievement</p> <ul style="list-style-type: none"> <li>• Practices must publish a Local Patient Participation Report on their website.</li> </ul>	<p>How are non-PRG members informed about the changes/actions resulting from the survey at the practice?</p>

**Box 2** Factors influencing PRG involvement in service change**Needing a clear role/remit purpose**

The GPs and practice managers interviewed expressed a need to expand and clarify the role and function of the PRGs in order to better support the practice and to ensure its members maintain interest in the future.

**Empowerment**

Some stakeholders suggested that as most PRGs are evolving, with experience they will gain empowerment, and their role will grow.

‘... the patients have realised that they can have influence ... I think a lot of this is about giving people the empowerment to challenge. And I think making decisions, being able to influence decisions only comes from the confidence to challenge.’ (Stakeholder 4)

**Social factors – personalities, leadership, skills, willingness, relationships**

It was evident in the narratives that PRG activity is contingent on local history, e.g. PRG formed before DES, personalities (both members and GP staff), skills and experience available to PRGs. GPs, practice managers and stakeholders observed that successful PRG maintenance is partly ‘volunteer spirit’. Having members that will not dominate the group with their own agenda and recruiting an efficient chairperson to lead the group effectively were seen as important factors.

‘It’s terribly personality dependent ... that’s my only problem, my issue with it. I keep bleating on about our Chairman, but he’s very good at facilitating.’ (Practice 9, staff member)

**Finances**

There were mixed experiences of practices’ use of the financial reimbursements associated with the PP-DES. Some practices spent the reimbursement on resources, e.g. air conditioning or seating in the waiting room. Others used it to cover the cost of staff time or administrative costs such as PRG recruitment campaigns. A small minority of PRGs had their own budget, allocated to them by the practice staff.

strategic direction and aims; topic-specific meetings to give purpose and avoid repetitiveness; a welcoming atmosphere; providing refreshments and reimbursing travel expenses. Groups that reported being successful in making changes at their practice believed that this resulted in a more stable membership over time. In addition, the introduction of new members resulted in fresh ideas and being involved in a variety of activities encouraged membership retention:

‘... there wasn’t any new developments coming to the practice and they were listening to the same old story.’ (Practice 4, staff member)

Online/virtual groups were used by many PRGs, to enhance participation; to communicate with younger members and those who are unable to attend meetings. Experiences of this were mixed, with some seeing them as an excellent resource to comment on matters arising. In contrast some people wanted to receive information without actively replying to emails.

Practice staff described the PP-DES as having ‘formalised’ PRGs and the nature of the activities they undertook. However, there were mixed views on whether a more formal approach to PRG activities was welcome. For example some PRG members were concerned about the group becoming too bureaucratic:

‘I think for a little while they were a little worried, they suddenly felt it was becoming more structured than they wanted’ (Practice 6, staff member)

In contrast some people felt the PP-DES made practices more accountable to PRG members:

‘If you take away the DES, then you don’t actually have a commitment to anyone, do we?’ (Practice 11, staff member)

**Component 2: Agree areas of priority with the PRG**

The PRG members and the GP practice staff jointly agreed on the areas of priority. Most groups reported that meeting agendas were agreed with the practice, often with the chair having the most influence. PRG members felt that they were able to bring patient’s priorities and key issues, which they had identified through consultation with other patients, complaints routes and ‘meet and greet days’:

‘... they will come to the surgeries and they will sit and talk to patients in the waiting room and ask them a number of questions as part of the conversation. They will then record the answers and that starts giving them feedback about what the issues are. And then once they’ve been running a question, say for four weeks it can then come up at the PRG.’ (Practice 9, staff member)

### Component 3: Collate patient views through the use of a survey

The PRGs reported that the PP-DES guidance on how to undertake the patient survey was helpful. All participating PRGs commented that it was possible to tailor the survey to reflect the priorities of their practice. Most PRGs had been consulted on the questions and had been engaged in the process. However, some groups reported greater involvement, having designed the questions, changed the scoring and/or analysed the data.

### Component 4: Provide PRG with opportunity to discuss survey findings and reach agreement with the PRG on changes to services

Many PRGs reported using the survey findings to shape the nature of their activities. Although the majority of the PRG groups are in their infancy, they have been involved in a wide variety of activities. The main types were:

- activities to improve the practice (e.g. phone system, car park, appointments, noticeboards, communications)
- supporting practice business (e.g. staff development, meetings)
- health promotion activities (e.g. health education days, awareness campaigns, guest speakers).

On the whole, PRGs have mostly been involved in changes to non-clinical care services, such as ordering prescriptions online and the peripheral aesthetic alterations. A minority of PRGs had experienced some involvement in consultation with clinical care services. However, some PRGs were uncomfortable about being involved in such decisions:

‘... I don’t think I would like to get involved on the medical side.’ (Practice 5, PRG member).

### Component 5: Agree action plan with the PRG and seek PRG agreement to implement changes

Following the results of the survey, the PP-DES requires PRGs to agree an action plan and implement changes. The action planning stage was viewed positively; ‘I think that it all has been a very good thing because that has got the PRGs and the Practices working together’ (Stakeholder 4). Most PRGs agreed the ‘PP-DES is good for setting a clear action plan to work on for the year’ (Practice 11 staff member) and this was echoed throughout the narratives.

The PRGs encountered barriers to change that were often beyond the practice’s control. For example, ‘changing (the) practice telephone system, this change couldn’t happen due to contractual arrangements’ (Practice 6, PRG member). This led PRG members to feeling frustrated at the lack of progress and to tackling ‘quick wins’ that could be evidenced more easily in order to achieve the PP-DES components, such as changing the noticeboard display.

### Component 6: Publicise actions to be taken and subsequent achievement

All PRGs are required to publicise survey results, with some groups also publicising copies of meeting minutes and their annual report. Stakeholders argued that although the PP-DES required publicising the action plan, it still lacks a crucial monitoring function which is necessary to ensure that genuine service improvement activities are carried out by PRGs:

‘The one thing you don’t do with the DES. You don’t ring the PRG Chair to say “Did you sign off?”’ (Stakeholder 3)

Other factors influencing involvement in service change were identified (see Box 2).

## Discussion

This exploratory study aimed to review the impact of the PP-DES on a sample of PRGs in primary care. The PP-DES has been successful in increasing the number of PRGs in existence, with over 80% ( $n = 10$ ) of practices participating in the study having established a PRG solely as a result of the PP-DES incentive. The PP-DES has also served to formalise new and existing PRGs. There were mixed views on the formalisation; some reported increased accountability to the PRG, while others were concerned about the bureaucracy that formalisation may entail.

All practices in the study fulfilled the six components outlined in the PP-DES guidance (see Box 1), and provided examples of making changes to their practice. However, the findings suggested that there was also variation in the level of involvement across PRGs. For example, the PP-DES required practices to collect and act on the views of their patients through an annual survey. Although all PRGs reported being involved in the annual patient survey, some PRGs had a small, consultative role, whereas others groups reported greater involvement; designing the questions, changing the scoring and analysing the data. Involving the PRG in clinical care services elicited mixed responses. Although a minority of PRGs were involved at a consultation level, practice staff and PRG mem-



bers from most practices were hesitant about being involved in decisions around commissioning and clinical care.

This could be attributed to enduring cultural issues and social factors. Historically, the patient–doctor relationship has placed power with the clinician, with the patient unwilling and lacking in knowledge to question the clinician’s judgement.<sup>16,17</sup> Consistent with previous research,<sup>15,17</sup> a further social factor affecting the functioning of the PRGs was the importance of the personalities of individuals within the group; both patients and practice staff. Further research could observe the decision-making process in action to gain a fuller understanding of the dynamics within the group.

PRGs have been involved in a wide range of activities beyond the mandatory requirement of the PP-DES; from improving practices’ aesthetics to organising health promotion schemes. These findings are in keeping with previous literature,<sup>14,15</sup> however, the breadth of activity has led to confusion over the purpose and role of PPGs. Although previous literature had pointed to lack of patient interest<sup>12</sup> to explain why some PRGs stop functioning, the current study suggests that even where patient interest is high, groups can become less productive if they are unclear about their role and purpose and findings even highlighted the effectiveness of sharing examples of good practice between PRGs. Networks and patient forums were suggested as an effective strategy to coordinate and support PRGs at a local level.

In the current study, the size of PRGs ranged from approximately four to 25 participants, equating to less than 1% of the practice population, and predominantly white females. Although there has been an increase in the number of PRGs, there has been little improvement in their representativeness. Concern has been expressed in previous research<sup>16</sup> about patient representativeness which may have implications on health services and strategies. PRGs acknowledged the need to improve recruitment, since young people and mothers were noted as two under-represented groups, and although they have tried a combination of strategies outlined earlier in this paper, these have been largely unsuccessful. Perhaps a local recruitment campaign, in conjunction with wider national and local advertising could raise the profile of PRGs.

Participants also discussed the need to maintain group membership. Due to the voluntary nature of PRGs, both members and practice staff were unsure about how much commitment they should expect to contribute and receive. Many PRGs had experienced a high level of turnover, however, most appeared to be made up of a core number of individuals who had been with the group for some time. Results found that PRG members felt they would generate more ideas

and demonstrate increased impact if there were more people in the group. This is consistent with earlier literature<sup>15</sup> suggesting PRGs require both continuous effort and the introduction of new members to provide fresh ideas.

It is evident from the interviews that the majority of the PRG members were unaware of the scheme. The timing of this study may have been a contributing factor to that, as the study took place two years after the introduction of the scheme in 2011 and the average length of membership is 12 to 18 months<sup>12,15</sup> so the introduction of new members may be an explanation of the lack of awareness.

The financial incentive of the PP-DES scheme encouraged some GP practices to establish PRGs. However, the financial incentive alone did not secure greater depth of PRG activity and power. The PP-DES is currently funded on an annual basis and it will continue until 2014/15, although somewhat altered;<sup>21</sup> beyond that the future of the scheme is currently uncertain. PRGs require support from their practice and without the financial incentive it may be unrealistic for some practices to provide the same level of support to their PRG which they are currently receiving. If sustainable funding was secured then PRGs might need a robust strategy in order to maintain growth and development, as although the concept of PRGs has been developing for almost three decades, there are still outstanding areas for future research. This could include supporting PRGs to help their general practice to tackle specific issues (e.g. to reduce unplanned admissions), costs and benefits associated with PRGs, and the future role of PRGs.

## Strengths and limitations of the study

The main strength of this study is the attempt to explore a topic that is currently under-researched, as well as assessing the impact of the PP-DES from a number of different perspectives, including PRG members, practice staff and relevant stakeholders. The current study recruited a range of practices, varying in size, locality and deprivation. However, the small sample may not be representative of all PRGs and therefore results may not be generalisable. It is also possible that practices that participated in this study were more likely to have an interest in patient participation and the PP-DES scheme; this bias could also result in the findings not being representative of GPs and PRGs. However, to reduce this potential bias, the researchers aimed to foster an environment that allowed participants to express both negative and positive views and experiences towards the PP-DES scheme.

## Conclusion

The PP-DES scheme has been a catalyst to the establishment of PRGs. However in terms of how far the PP-DES has facilitated PRGs involvement in decisions about the services provided at their general practice, the picture was mixed, with wide variation in the PRGs' role and remit. The financial incentive alone, provided via the PP-DES scheme, did not secure greater depth of PRG activity or power, however, social factors were identified as playing an important role in PRGs' level of participation in decision making. PRGs will require additional support if they are to be routinely involved in decisions about the services of their general practices.

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None.

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