REPORT OF THE PATIENT REFERENCE GROUP

The Patient Reference Group was drawn from people who had previously attended Patient Participation Groups here in the past. All these people were chosen by a random selection using a random number generator applied to their number in the Practice.

The patients were contacted by telephone, and messages left for people to contact the practice were they interested in attending a meeting.

Stage 1

1. Structure of Practice

Practice Population:	**Sex:**	Male 1278		Female 1054	
2332	**Age:**	**Under 16's**	312		
		17 - 25	179	**36 - 45** 488	**56 – 65** 201
		26 - 35	532	**46 – 55** 321	**66 +** 299
Ethnicity:		**Caribbean**	154	**Polish**	64
British, Mixed British	1038	**African**	63	**Pakistani**	37
English	126	**Mixed Black**	72	*other:*	31
Scottish	5	**Chinese**	10		
Welsh	4	**Japanese**	2		
Indian, British Indian	89	**White Irish**	21		

Are there any specific Minority Groups within the Practice Population?

We have 7 patients that prefer not to disclose their ethnicity & 627 patients with unrecorded ethnicity.

This practice has several large groups of different ethnic minorities, reflecting local population structures. It also reflects family and work-place structures. For example, there were only 6 Indian/British Indian patients when I joined the list in 1992, but since a lot of Indian software engineers sought career enhancements by bringing their skills to British multinational companies headquartered in Nottingham, the practice has seen a steady growth in numbers of patients from this ethnicity. This group's familiarity with the internet has made searching for a practice easy, and informal enquiry reveals that people have learned of this practice

by word of mouth in the workplace. The novelty of our open access system to GP consultations may also be a positive aspect of our practice that is recognized in conversation.

There are large groups of Caribbean, African and Mixed Black in the practice, many with strong family connections. Some patients chose to remain registered with the practice as they move around Nottingham, having had care from my predecessor Dr Darlaston, who had looked after their families since the early 1960s. Strong family ties can be one of the riches of our lives when loving and nourishing, and having a stable family doctor can play into that support that we all need as human beings. Families can go through difficulties too, and over the years people can say things to the doctor which will go no further, but which are a relief to say to at least someone else on the planet.

A lot of this sort of contact with the family doctor is never written down anywhere, but it becomes part of what we understand about each other. Most GPs will have developed enough of a sense of their own difficulties to be able to understand a bit of what is going on –we are all made of the same stuff, and our deepest and most private yearnings which can be felt tenderly and painfully are also universal. Naturally, this sought of encounter does not happen every day, but arises in the context of previous contacts about viruses and so on in the course of usual personal illnesses. When people move away, we do recommend that they re-register because there is evidence that having easy access to a primary care doctor increases life expectancy (we have actually only had evidence for this in the last few years!) – there is no point in having a doctor who knows you a bit if you cannot get in to see him when you are really ill.

The Polish community here is growing steadily, our Irish population steady (Dr Darlaston himself was Irish, and worshipped at the Catholic Church in Woodthorpe, another community structure within the practice that still has resonance).

The practice gained some Pakistani and Chinese patients from a local practice when it was dispersed. This practice had been cared for by an Asian couple.

Patient Representative Group Profile (PRG):

Ethnicity:		**Caribbean**	1	**Polish**	
British, Mixed British	10	**African**		**Pakistani**	1
English		**Mixed Black**	1	*other:*	1
Scottish		**Chinese**			
Welsh		**Japanese**			
Indian, British Indian		**White Irish**			

Age-Sex Profile of Patient Reference Group:

Age	Male	Female
>16	0	0
17-25	0	0
26-35	1	0
36-45	0	0
46-55	5	2
56-65	0	1
66+	3	4

2. What steps has the practice taken to recruit patients and to sure it is representative of the practice profile?

The Patient Reference Group was drawn from people who had previously attended Patient Participation Groups here in the past. All these people were chosen by a random selection using a random number generator applied to their number in the Practice.

The patients were contacted by telephone, and messages left for people to contact the practice if were they interested in attending a meeting.

The random method of inviting patients to join the group resulted in reasonable representation of the ethnic structure of the Practice. There are many other methods, but the virtue of randomly choosing people is that we have a group that has arisen purely from the fact that they have registered here, been randomly chosen, and then also willing to volunteer some of their time to the development of the practice. The problem we had is that not many people who had attended before wished to participate again. We continued contacting people until we had six available for the meeting. In the event, only five patients attended.

The people who were able to attend were white middle aged or older with four males and one female.

We discussed the way we had tried contacting and recontacting patients and felt that the methodology was reasonable and that there may be problems with the time (6.00pm may not be convenient for mothers with young children) and doubts in their minds from people from minority groups that attending a meeting at the practice would be likely to be of interest or real influence.

This discussion set the tone for concern about making communication with patients effective, particularly when trying to influence people's decisions about whether to go to hospital or see the doctor when they are faced with a potential medical emergency.

We felt that due process had been attended to and that no attempt had been made either to over – or under-represent any ethnic group. In a small practice with a majority of white patients, any group of five may consist largely of white people. We considered that for a natural representation of ethnic mix we would need a larger group of 18 or so patients. The quality of thinking of the group showed a real concern to make the practice as accessible to ethnic minorities as it can be.

Validating that the patient group is representative of the practices population base. ***Payment Component 1***

3. Compare the PRG with your practice profile and describe the differences between the practice population and membership of the PRG?

The ethnic mix of the pool of patients for our PRG reflected the ethnic mix of the Practice reasonably well., with 10 British or mixed British, and 4 minority ethnic group members. However, no-one from any of the ethnic minority groups were able to attend, though they had in the past. We were disappointed in this, and wondered whether the timing, 6 pm, was not good for families. This was discussed at some length in the group, as it was a concern. As mentioned above, this did not prevent us from thinking about ethnic issues. We wondered whether a direct approach to patients would be a good idea if random selection does not result in a wider ethnic mix in a larger group in future.

Validating that the patient group is representative of the practices population base. ***Payment Component 1***

4. Please explain any differences in section 3 above and the efforts of the practice to communicate with groups not represented? *(this is required even* ***If*** *the practice has chosen to use a pre-existing PRG)*

We explained the unexpected white bias in terms of people's availability at the time, the interest and perceived value of attending a meeting, and the difficulties of obtaining a selection of ethnicities when there are few individuals in the group. The practice has a large white British/mixed British portion, and this combination lead to the actual constitution of the group. In future we may have bigger groups to enable a natural ethnic representation. We had not envisaged this difficulty at the outset – the pool of available members of previous PPGs had a spread of 5 ethnicities, which we felt was a good basis for the PRG.