

Establishing Critical Friends Groups in General Practice

Report to the North & East Devon Health Authority

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Contents	Page
1. Executive Summary.....	3
2. Introduction.....	5
3. Methods	7
4. Findings & Discussion.....	11
5. Conclusion	15
6. Recommendations for the Future.....	16
References.....	17
Acknowledgements.....	18
 Appendices	
1 Format for the preliminary session with CFG members (patients)	
2 Format for the first CFG meeting	
3 Format for interview with CFG members	

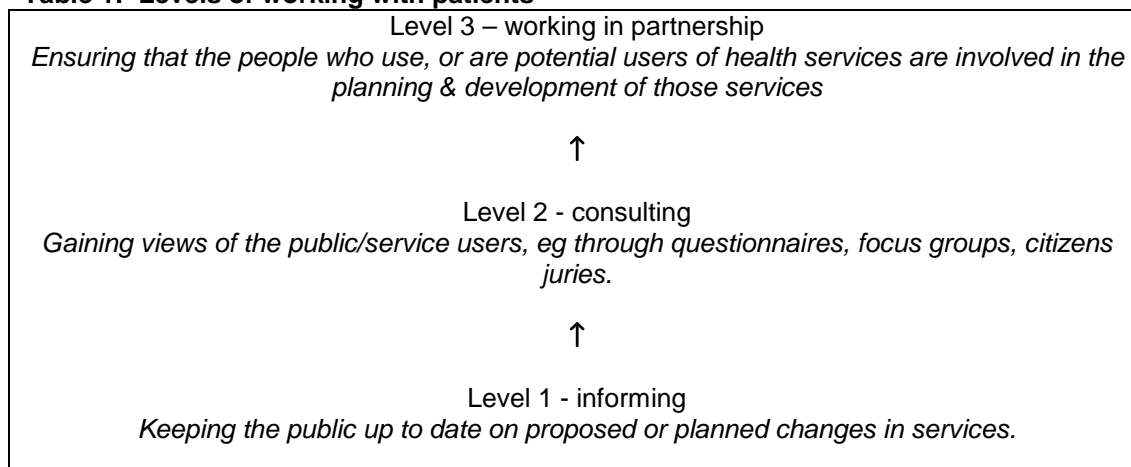
1. Executive summary

This study has centred on the establishment of joint patient/practitioner improvement (“critical friends”) groups attached to two general practices within the North & East Devon Health Authority, using the results of the Improving Practice Questionnaire (IPQ) as a basis for discussion. In addition to developing a template for rolling out this concept to other general practices throughout the Health Authority, discussions with participating patients and practitioners at various stages during the process have been analysed to inform future developments.

The NHS Plan (July 2000) acknowledges that “patients are the most important people in the health service”, but many of health care professionals and managers are unclear about how to involve patients in ongoing quality improvement planning and strategies, particularly within primary care. The IPQ Pilot Project, March – October 2000, (Greco et al, 2000) identified a need to continue the process of involving patients and maintaining a dialogue with those most affected by standards of service.

This project has researched the background context for this move towards involving patients in clinical governance activities, including current Government policies and their implementation at national, regional and health authority levels. It has progressed the public involvement agenda from “consulting” (via the IPQ) to the highest level, “working in partnership” (N & E Devon Health and Social Care Community, Public Involvement Strategy 2001) – see table 1:

Table 1: Levels of working with patients



A total of ten patients (5 at each practice) were involved in the Critical Friends Groups (CFGs), with equal numbers of practice staff taking part. Preliminary sessions for patients only, and discussions with the practice “contact” were held at the beginning of the process, at which participants were briefed about the background and aims of the project.

In both cases discussions centred on aspects in which the general practice had achieved a relatively low score in the IPQ (ie when compared with other scores recorded by the practice). For practice 1, several related issues were discussed: patient opportunity to see the doctor/nurse of choice, and the length of time waiting at the surgery to see the doctor/nurse. In practice 2, dialogue centred on one particular concern: waiting room times to see the doctor. In both cases, discussions in the first meeting of the CFG naturally led to suggestions for improvement strategies; the second meeting was used to review the effectiveness of these approaches. The meetings also provided an opportunity for participants to communicate information regarding the reality of working within the practice and the patient perspective of the health care provided. This exchange informed the development of practical approaches for improving the quality of health care.

Participants have expressed a range of reactions to being asked to participate in CFGs. In most cases, these initial feelings have undergone some change during the process of establishing a CFG and the group identifying its role and becoming an effective entity.

The establishment of a CFG in both practices gave all participants an opportunity to share information and perspectives regarding health care. The groups have taken on an essential role of review and dissemination during times of fundamental change in both practices. These changes are predominantly to do with **access**, in particular developing a balance between systems which enable and improve access to health care professionals, and continuity of personal care.

2. Introduction

A previous pilot study, the Improving Practice Questionnaire (IPQ) Project, (Greco et al, 2000) has shown that in order for user involvement to make a real difference to quality in general practice, the level of patient involvement needs to progress from “consulting” to “working in partnership” (see table 1 on page 3). This can be achieved by providing an opportunity for general practice staff to meet with a small group of patients to discuss action plans for improving quality based on the findings of their patient survey. This agenda goes beyond the traditional role of patient groups (such as League of Friends, Patient Participation Groups), and draws together two important aspects of clinical governance: patient feedback and quality improvement.

This study has involved two general practices within the North & East Devon Health Authority, which each received feedback from patients via the IPQ. In each case a group of patients was brought together with practice staff to discuss ways of improving the quality of general practice services from a patient-centred perspective, based on areas identified in the practice IPQ results. The patient participants were selected by the practices.

The project incorporated the following research areas:

1. Establishment of patient participation in primary care, within the context of the NHS Plan (Chapter 10, Changes for Patients) and other current Government policies.
2. Development of a template for the establishment of critical friend groups at general practice level.

Sections 2.1 – 2.4 give some details about the contextual background to the CFG initiative.

2.1 *Previous initiatives*

The CFG concept builds on and enhances previous patient involvement initiatives, in particular “Patient Participation Groups” (PPGs). These groups arose during the late 1970s in response to increased attention to the role of the consumer within Social Services and commerce, as well as in health care. The theory was that PPGs, which integrated health care professionals with the populations they served, had a major role in providing improved information about health care services and thus in preventive health care. The movement was linked to Leagues of Friends, but spread to 3% of general practices only. PPGs became involved primarily with raising funds for equipment and improving health information booklets. A confusion about purpose, lack of finances and concerns about the representative-ness of PPGs have been blamed for the poor take-up of the initiative (Richardson & Bray, 1987).

2.2 *Improving Practice Questionnaire pilot project & report*

Forty two practices in North & East Devon Health Authority (8,600 patients & 206 practitioners) took part in a pilot project which introduced the IPQ as a tool and process for quality improvement in primary care. Following receipt of feedback by practices and individual practitioners, meetings were held with a sample of stake-holders, including PCG Board members, practice staff and patients, to elicit views on the process and discuss ways in which patients could continue their involvement in quality improvement strategies. (Greco et al., 2000). The key message from these discussions was that the dialogue must continue and that patient feedback must be seen as part of an ongoing quality improvement cycle. A favoured method for ensuring this ongoing dialogue was the establishment of Critical Friends Groups attached to general practices.

2.3 *NHS plan – chapter 10*

Chapter 10 of the NHS Plan, entitled “Changes for Patients”, includes the following requirement:

“All NHS trusts, primary care groups and primary care trusts will have to ask patients and carers for their views on the services they have received”.

Implementing the IPQ and establishing Critical Friends Groups will respond to the challenges of the NHS Plan at primary care level. Within North and East Devon Health Authority general practices are a key focus for the implementation of the new Patient Advocacy and Liaison Service (PALS) in primary care. The project team submitted an application (in collaboration with all four PCTs within the North and East Devon Health Authority) to use the CFG model as a key element in a PALS “Pathfinder” project funded by NHS Executive (South West). This model will be well placed to support the future implementation of Patient Forums.

At the Health Authority level, the project has contributed to the drafting of the North & East Devon HA Public Involvement Strategy (see diagram on page 3). The CFG concept clearly fits within level three (working in partnership), and builds on previous work at the consulting level (Improving Practice Questionnaire).

2.4 *Core Confidences*

The Report on the National Directions Workshop (2000) acknowledges that building public confidence in the NHS is a recognised and urgent concern. Several recent events have undermined public confidence, and there is a pressing need for feedback from patients about their experiences of all aspects of healthcare, in order to make targeted improvements in quality and engender confidence in the healthcare system. In order for patients and carers to feel confident about their care, they need to feel that their perspectives are seriously considered. These perspectives can be made known via a number of means, including responses to questionnaires which have been developed with patients, and which reflect the issues of care which are of paramount importance to them. The implementation of a patient questionnaire, however, is only the beginning of true dialogue with patients. Patients must be given the opportunity to build on their responses, share further information and explain in greater detail the nature of their concerns. Patients should be involved in an ongoing quality improvement process within primary care.

3. Methods

Dr Michael Greco, who co-ordinated the project, and Mrs Mary Carter, who managed the research activity, met on a regular basis for the resolution of issues raised by the project work. The project received approval from North & East Devon Local Research Ethics Committee in May 2000.

A brief description of the process by which patients were selected to participate in Critical Friends Groups is covered in section 3.1, and the schedule and purpose of the meetings in 3.2. The next section (3.3) contains details regarding discussions with individual participants about the experience of participating in the Critical Friends Group, and 3.4 describes the methodology adopted for the qualitative analysis of these discussions.

3.1 Selection of patients

Each practice was charged with selecting a small group of patients for participation in the critical friends group. Practitioners were encouraged to select patients with whom they felt comfortable, and who, they believed, would make a constructive contribution to quality improvement.

Practice 1 is a multi-site practice, and staff chose patients from each location, as well as a mix of male/female, ages and chronic/acute. The responsibility for selection was shared between several practitioners. Practice 2 has two sites, and the practice manager was responsible for choosing all participating patients, which included a mix of male/female, ages and chronic/acute.

3.2 Critical Friends Group meetings – schedule & purpose

Practice 1

Within practice 1 three meetings were held.

3.2.1 Patient-only meeting

Prior to meeting the patients, the researcher met with the practice manager to give her details regarding the aims and process involved in setting up the Critical Friends Group at practice 1. The practice manager welcomed the participating patients to the practice, and introduced herself and the researcher. The researcher then held a preliminary session with the five participating patients to provide background information about the project. Participants were given the opportunity to introduce themselves, and to describe their reactions to being invited to join the group. The researcher then provided details regarding the Improving Practice Questionnaire, and gave participants copies of the questionnaire, together with anonymised results to peruse. The group was made aware that the Critical Friends concept evolved from discussions with stake-holders following receipt of IPQ results within selected practices within the North and East Devon Health Authority. The researcher outlined the process, including the purpose of future meetings of the group (ie patients and practice staff).

The format of this preliminary session with patients is contained in Appendix 1.

3.2.2 *First CFG meeting*

A meeting of the whole group was held two weeks after the preliminary session, and was attended by 5 patients and 5 practice staff (2 GPs, Senior Practice Nurse, Practice Manager, Reception Manager). There was no agenda for this meeting, which was facilitated by the researcher. To begin the session, each member of the group was asked to introduce themselves, and to say what they thought they may bring to this new partnership between practice staff and patients. Members of practice staff took this opportunity to explain their individual roles within the practice. The group then used their practice IPQ results and a subsequent report on new initiatives (prepared by the practice manager) as a basis for a discussion about improvement strategies.

The format for the first meeting of the CFG is contained in Appendix 2.

3.2.3 *Second CFG meeting*

The next meeting was arranged for two months later. The group decided that it would review progress with two linked issues at that time (GP/nurse availability and length of time waiting at the surgery to see the doctor). Two group members, the Practice Manager and one of the patients (DC), were given joint responsibility of drawing up an agenda for the second meeting. Prior to the meeting DC contacted the researcher, requesting clarification on the status of the CFG – ie whether it is a “committee”, requiring a designated Chair, minute secretary etc., or whether the CFG is a “working party”, not requiring such a formal structure. The researcher wrote back to DC to express the opinion that an informal approach would probably be the best model for the CFG to adopt, but agreeing to the necessity of an agenda and minutes of each meeting.

The Practice Manager and DC drew up an agenda which was circulated to group members prior to the second meeting. This second meeting of the full CFG was attended by the same individuals as the first meeting. DC chaired the meeting, while the researcher offered to take notes and circulate them following the meeting. The agenda covered terms of reference for the group, confidentiality and the issues which had been discussed at the previous meeting (ie waiting times, opportunity to see the doctor of choice and dissemination of information). In addition, practice staff reported on various initiatives with which the practice had been involved, including Patient Access Conferences, Practice Business Planning Day and Doctor Time Management Study.

It was agreed that the next meeting will be held after three months, which will allow time for the new initiatives discussed at the second meeting to be put into practice. The group will then be able to evaluate their effectiveness.

Practice 2

Within practice 2 three meetings were held.

3.2.4 *Patient-only meeting*

Prior to meeting the participating patients, the researcher spoke to the practice manager on the telephone to ensure she was aware of all details regarding setting up the group, and what was required from the practice. The researcher then held a preliminary meeting with 3 patients, at which they had an opportunity to peruse anonymised results and become familiar with the results format. Each participant introduced him/herself, describing his/her reactions to being asked to participate in the Critical Friends Group. The researcher explained the background to the project (as with Practice 1).

The format of this preliminary session with patients is contained in Appendix 1. Following this preliminary session, the researcher contacted the practice manager to invite her to chair the next session – ie the first meeting of the full critical friends group (patients and practice staff). The practice manager agreed to this. There was some difficulty in arranging a mutually convenient date for the first meeting, and 2 further patients were contacted and invited to join the group. The researcher spoke to each on the telephone to give background information, and sent each a set of anonymised results, so that they could become familiar with the format.

3.2.5 First CFG meeting

The first meeting of the group was arranged, and was attended by 5 patients and 5 practice staff (2 GPs, Practice Nurse, Practice Manager, Receptionist/Secretary). All were given the opportunity to look at the surgery's own practice results and identify areas and strategies for possible improvement. The main area of discussion was waiting room times to see the doctor. It was agreed that a further meeting to review the effectiveness of several strategies addressing the problem of waiting room times would take place after a couple of months. The researcher distributed notes of the meeting to all participants.

The format for the first meeting of the CFG is contained in Appendix 2.

3.2.6 Second CFG meeting

The second meeting took place three months after the first, and was attended by the 4 patients and 4 practice staff (1 GP, Practice Nurse, Practice Manager, Receptionist/Secretary). The Practice Manager chaired the session. Discussions covered the issues raised at the previous meeting, and placed them within the context of the practice's (and other local) responses to Government initiatives and requirements. The group agreed that their role was dual:

- Dissemination of information to other patients, including explanation of changes and new schemes.
- Provision of information and the patient perspective to the practice.

The group agreed to meet quarterly in future to review changes at the practice.

Table 2 summarises the stages in setting up a Critical Friends Group:

Table 2: Stages in establishing a Critical Friends Group

Task	Who	Objective	Timescale
Identification of 5 patient participants	Practice staff	Cross section based on age, gender, chronic/acute	Week 1
Identification of 5 practice participants	Self selected practice staff	Cross section of practice roles	Week 1
Briefing session with patients	Researcher	To inform patients Patients can air concerns. Patients become familiar with IPQ results format.	Week 3
Briefing session with practice staff	Researcher	To inform practice staff. Staff can air concerns.	Week 3
Meeting 1	All participants + Researcher	Introduction of all participants. Explanation of practice roles. Examination of practice IPQ results. Identification of areas for attention. Identification of improvement strategies.	Week 5
Meeting 2	All participants (+ Researcher)	Agreement of CFG's terms of reference. Review of effectiveness of improvement strategies suggested at previous meeting.	Week 13

3.3 Discussion with individual participants

Following meeting 2 of the full CFG (ie patients and practice staff), the researcher telephoned individual participants to ask them some questions regarding their attitudes to participation. These questions are contained in Appendix 3.

3.4 Analysis

Analyses were conducted in a number of ways. Firstly, the researcher interviewed CFG participants to ascertain their experience of involvement in the project.

The format for these interviews is contained in Appendix 3.

Secondly, CFG meetings at each pilot practice were observed, and field notes were undertaken regarding the group dynamics and the ways in which improvement strategies evolved.

4. Findings & discussion

Critical Friend Groups add value to a process of dialogue which commences by eliciting systematic feedback from patients about their experiences of primary health care. Although useful, this feedback is incomplete without further communication between patients and health care professionals. CFGs give both patients and professionals an opportunity to exchange and share information, and to work together to devise quality improvement strategies and review the effectiveness of these joint initiatives. This section deals with the findings of this pilot project, under various headings – 4.1 covers the evolving attitudes of group members to participation, 4.2 explores the agreed role of the group, 4.3 the “mechanics” of the group, and 4.4 the role of the researcher.

4.1 *Evolving attitudes of group members*

Participants’ attitudes were assessed throughout the pilot project, both during meetings and in conversation before and after “formal” sessions. In addition a sample of participants (n=8) was contacted by telephone following the process and interviewed individually; these included 3 patients, 2 reception staff, 2 GPs and 1 practice nurse.

Patients

Most patients agreed that the process of dialogue which had begun with the IPQ should be followed up with further communication and clarification. They also felt that such partnerships are beneficial, particularly as they allow for people from all walks of life to inform the debate and exchange their experiences. Patients were confident that their surgery and practice staff were responsive to suggestions made via the CFG. Participating patients recognised that there are some potential barriers to change within a practice, such as financial and physical (ie building) considerations, and discussions within the group had clarified these circumstances further for participants.

Some patients expressed surprise at being asked to participate in such a group, citing reasons such as not being regular visitors to the surgery or not being sure about the skills they could contribute to the group. Others were flattered, and welcomed the invitation as a boost to their self esteem. Many participants could identify their own particular area of expertise and experience, for example, working with Age Concern and involvement with Devon Doctors out-of-hours scheme.

Most patients believed the patients-only briefing session had been beneficial, in explaining or clarifying the background to the pilot project, and the objectives of the CFG. Most patients were not anxious about meeting with practice staff for the first time, although one patient said that she had been a little apprehensive knowing that she would:

“have to return to the surgery as a patient, whatever happened”.

On the whole, patients agreed that progress, albeit slow, in terms of quality improvement was being made, and that things had moved on between meeting 1 and meeting 2.

Patients were confident that practice staff had taken their views on board, although one participant felt that they were “*ahead of the patients*”, and knew about the problems and areas for improvement without being told. The group therefore would fulfil a “*chivvying*” rather than informing role. Patients were pleased that their general practice had set up a CFG, and that staff were keen to improve the service. They acknowledged that any improvement initiatives would take time to come to fruition, although some felt that they could perceive some differences at this early stage.

When asked if patients would recommend participation in a CFG to friends and colleagues, most said that they would. One patient said that potential participants would have to be:

“prepared to recognise that it (ie CFG) wasn’t there to solve personal problems, but for the good of the whole community and practice”.

Patients had enjoyed the interaction between CFG members, and were encouraged that their practice had recognised the need for changes and improvement. A patient in practice 1 commented on the disadvantages of holding CFG meetings in the waiting area, which he felt was not sufficiently private.

Having attended two group meetings, patients were keen that the CFG should continue, in particular to allow time for changes and new initiatives to have effect. One patient, commenting on the role of the CFG, saw it as a “*midpoint*” between the majority of patients and the practice, and she stressed the differences between the CFG as an instrument for quality improvement and a “*complaints bureau*”, which she saw as a very limited and negative development.

PATIENTS are encouraged by the establishment of a CFG at their practice, which demonstrates a willingness to listen and work in partnership. The CFG can be a vital communications tool for the patients and the practice, allowing the patient perspective to be incorporated into change and quality improvement, and forming a link to clinical governance.

Practice staff

The initial practice contact in practice 1 was with one of the senior partners; in practice 2 it was the practice manager. As the group was set up, the role of the practice manager became increasingly important, as a co-ordinator and communicator within the practice. Project staff had anticipated that patients may have anxieties about participating in the CFG, but it was also apparent that practice staff too needed a supportive induction to the initiative, in particular the practice manager as key contact. It was important to spend some time explaining the concept and its objectives to the practice manager, and to other participating members of staff. Communication among practice staff about the IPQ and resulting initiatives was found to be essential in ensuring that individuals felt comfortable with sharing information with their patients. In order to communicate effectively with its patients, a practice needs to be sure of the effectiveness of its own internal communications.

Practice staff were positive about the possibilities of quality improvement offered by having a CFG. They believed that changes and improvement would be small-scale “*no mega changes*”, and that progress was likely to be gradual. They welcomed the opportunity to explain to patients first-hand any restrictions or problems faced by the practice, and believed that CFG participants were beginning to understand the situation better. One member of practice staff was very positive about participating in the group, as it gave her valuable “*patient contact*” time. CFG members were also seen as a useful way of monitoring the effects of changes within the practice.

Practice staff were concerned about identifying mechanisms for promoting the work of the CFG to a broader patient audience, and viewed dissemination as one of the CFG’s key roles. They suggested various vehicles for publicising the CFG, including articles in local magazines which would be read by a majority of practice patients.

Although practice staff were positive about the constructive nature of the dialogue between CFG participants, they believed that the original basis for discussion, that is the practice’s IPQ results, should continue to be reiterated and emphasised, as they feared potential dominance by individuals with their own personal axe to grind.

PRACTICE STAFF welcome the opportunity to build on their IPQ results by engaging in further dialogue with patients. They particularly value the role of the group in disseminating information to the broader mass of patients, and recognise the value of good internal and external communications.

4.2 *Role of the group*

Participants agreed that CFGs perform an important 2-way communications role – from the practice to other patients, and from a wide population of patients to the practice. This function is linked to the publicising of quality improvement initiatives to a wider constituency, and ensuring that these are linked to the establishment of the CFG and the continuing partnership between practice and patients instigated by implementation of systematic patient feedback (IPQ).

The CFG has a key role to play in reviewing progress within the practice. Participants also generally believed that the terms of reference of the CFG should not be “set in stone”, but should be revisited periodically and adjusted, if necessary, to respond to changing circumstances.

Some participants felt that although the practice may have been aware of their problem areas prior to the establishment of the CFG, the group had an important role to play in monitoring and reviewing improvement activities at the practice.

CFGs have 3 key roles:

EXCHANGE of information & perspective
REVIEW of quality improvement strategies
DISSEMINATION to wider patient population

4.3 *Mechanics of the group*

It is important that an agenda is agreed by both patients and practice staff, and, in practice 1, a representative of each party was jointly charged with the responsibility of drawing up the agenda for meeting 2. The joint responsibilities of the partnership should also be reflected in the choice of Chair for meetings, and this should alternate between patients and practice staff. Similarly, since minute-taking effectively precludes the individual from participating effectively in discussions, this responsibility should “rotate” around the group from meeting to meeting. The importance of allowing each participant a fair opportunity to contribute to discussions was recognised in most instances, although some occasions demanded a disproportionate input from practice staff (for example, explaining systems and reporting back from other practice meetings).

4.4 *Role of the researcher*

During the pilot study the researcher gradually withdrew her involvement with the group by handing over the chair and facilitation role to the CFG itself. In the early stages, the group looked to the researcher for a degree of leadership and as the source of information, although in practice 1 the responsibility for drawing up an agenda, determining terms of reference and chairing were quickly transferred to the group members. Practice 1 was keen to continue with the CFG and agree dates for future meetings, while practice 2 required prompting from the researcher to agree a date for the second full meeting of the CFG.

5. Conclusion

Evidence from the process of establishing CFGs at two general practices in North and East Devon Health Authority suggests that these groups have an important contribution to make to quality improvement in primary health care.

Firstly they provide a forum for an exchange of information – from the patients, providing a view of the practice from the service user perspective, and from the practice, to explain the various imperatives and difficulties faced by the service provider.

Secondly, the group has a crucial role to play in bringing about and monitoring the effectiveness of change within the general practice. The CFG will be able to provide input to planning and implementing efforts to achieve a balance between the varying needs of patients, and to reviewing thoroughly the success of such initiatives.

Thirdly the group provides a communications hub, from and to which information can flow from the practice and its wider constituency of patients. There will also be close links between CFGs and those working within the new NHS Patient Advocacy and Liaison Service (PALS).

Finally, members of the CFGs from the pilot study will be contributing to two national initiatives in the coming months. One will be presenting in a workshop session entitled “Empowering the public: active patient involvement within the GP practice” at the Annual NHS Alliance conference in October 2001. Another CFG member is joining the National Primary Care Collaborative Expert Reference Panel to assist with the Smart Pathways project.

6. Recommendations

- **That a funding mechanism is established to rigorously evaluate the effectiveness of CFGs.**

It is clear that Critical Friends Groups have a role to play in addressing the clinical governance and quality improvement agenda in a primary care setting. The significance and effectiveness of this role need to be carefully evaluated.

To date, funding has been secured to establish CFGs at 20 practices within North and East Devon Health Authority, as part of a Patient Advocacy and Liaison Service (PALS) path-finding project. These CFGs will be closely linked with the work of appointed PALS officers within Exeter and East Devon Primary Care Trusts (PCTs), and will provide them with valuable information about patient participation in quality improvement initiatives at a general practice level. The next stage will be to rigorously evaluate the effectiveness of CFGs in bringing about quality improvement. As yet, no funding has been identified for this important work.

- **That the role of Non Executive Directors in establishing CFGs be further explored.**

This pilot study has demonstrated that there is a need for an informed facilitator who has responsibility for briefing both patients and practice staff, and possibly for chairing early meetings. In the future roll-out of the CFG concept, the PCT Non Executive Director may be best placed to fulfil this role.

- **That a forum be established for CFG members to network and share ideas.**

There has been some discussion, during both the pilot study and later visits to practices for the purposes of recruiting to the PALS path-finding project, about the potential benefit of bringing together representatives from different practice CFGs. This would be an ideal opportunity for representatives to share experiences, common themes and good practice.

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Web sites

National Association for Patient Participation website, <http://www.napp.org.uk>

8. Acknowledgements

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Appendix 1 – Format for preliminary session with CFG members (patients)

**CRITICAL FRIENDS GROUP
FORMAT & TIMINGS FOR MEETING 1 (PATIENTS ONLY)**

<i>Time</i>	Activity	Outcome
1.00 – 1.05	Introductions (facilitator & participants). A	All introduced & comfortable.
1.05 – 1.10	Brief details & background about IPQ (including approximate number of practices which have undertaken it). F	All know background & context.
1.10 – 1.15	Brief details re IPQ pilot project & findings (ie critical friends) F	All know origin of critical friends project.
1.15 – 1.25	Details about critical friends pilot project, including: <ul style="list-style-type: none"> • number of practices taking part • how many meetings • what the meetings will cover F	All aware of context & future commitment.
1.25 – 1.35	Circulation of anonymous set of results & opportunity to peruse. A	All aware of format (& possible impact) of results.
1.35 – 1.55	Discussion about partnership with practice staff, including: <ul style="list-style-type: none"> • role of patients • potential for change • possible barriers to change A	All aware of role, agenda & possible barriers/boundaries of critical friend groups.
1.55 – 2.00	Summing up. F	All reminded of background, future & role of critical friend groups.

- A** ALL present participate.
F Task for FACILITATOR.

Appendix 2 – Format for first CFG meeting

**CRITICAL FRIENDS GROUP
FORMAT & TIMINGS FOR CFG MEETING (PATIENTS & PRACTITIONERS)**

<i>Time</i>	Activity	Outcome
1.00 – 1.05	Introductions (facilitator & participants), A	All introduced & comfortable.
	Explanation of purpose of meeting (<i>What is the meaning of this set of results & what are the implications?</i>) F	All aware of purpose of meeting.
1.05 – 1.10	Circulation of practice results & opportunity to peruse. A	All have opportunity to read & interpret results.
1.10 – 1.40	Identification of areas in which practice may need to improve; discussion about possible strategies. A	All agreed on interpretation of results & areas for improvement.
1.40 – 1.45	Explanation of purpose of next meeting (<i>How can we respond to these results?</i>) & agreement on date. F/A	All aware of purpose of next meeting & agreed on date.

- A** ALL present participate.
F Task for FACILITATOR.

Appendix 3 – Format for interviews with CFG members

Name:

Surgery:

Questions for telephone interview	
1. What was your first reaction when asked to participate in the CFG?	
2. (<i>Patients</i>) How did you feel before the patients-only briefing session - were you apprehensive, confident etc?	
3. (<i>Patients</i>) How did you feel after the patients-only briefing session - were you clear about the role and background to the group?	
4. (<i>Patients</i>) How did you feel before the first CFG meeting? Were you more or less nervous/confident than you were before the patients-only briefing?	
6. (<i>Practice staff</i>) Would a briefing session for practice staff only have been helpful?	

7. How would you compare the two CFG meetings - do you feel that progress is being made?	
8. <i>(Patients)</i> Do you think the practice staff have taken your opinions seriously?	
9. <i>(Patients)</i> Do you have a better understanding of the problems/restrictions faced by practice staff as a result of CFG discussions?	
10. <i>(Practice staff)</i> Were you surprised by any of the patients' views expressed at the CFG?	
11. <i>(Practice staff)</i> Do you think the patients have a better understanding of the problems/restrictions faced by practice staff as a result of CFG discussions?	
12. Do you think the CFG initiative will make a difference to healthcare at your practice? Will your surgery's IPQ results improve?	

13. Would you recommend your friends/colleagues to participate in a CFG at their own surgery?	
14. <i>What have you enjoyed most about participating in the CFG?</i>	
15. <i>What have you enjoyed least about participating in the CFG?</i>	
16. <i>Do you think the CFG should continue at your surgery?</i>	