PPG Terms review

> *Written by Bob Davies for New Bank PPG*

A review of the updated PPG terms documentation, and discussion/exploration of PPG objectives and operations.

Its key conclusion is probably that making access harder, makes effective action less likely. A healthy PPG is one that can still fix problems even if every meeting has different participants.

Quick map

- What is the PPG for? what does success look like?
- Concerns about stricter onboarding causing exclusion - a shrinking/fragile group is an early warning sign
- Potential PPG goals - ownership, follow-through, drop-in participation, and confidentiality designed out
- Access basics, make it easy - predictable dates, multiple routes to contribute, no quiet expiry, better visibility
- Democratisation risks - interference and potential noise, well-meaning but unhelpful
- Support info in partner doc - ChatGPT impact, how PPGs respond, environmental notes and why staff should run meetings, resources.

Key questions

New Bank is already in a better position than the practice was under the previous operator. The presence of any PPG is better than no form of PPG. There are however some questions to ask as the process develops.

- How much admin burden is too much for patients?
  - Is this affected by deprivation and transience?
- What is the objective of the PPG?
  - Improve the practice by changing policy?
  - If for informing patients, this affects few patients.
- How well the system should tolerate noncompliance to satisfy access?
  - Should avoid over-formalising unknowns
- How maintainable are small/transient/disengaged PPGs long term?
- Does formalised but low-change process-theatre exclude real complaints/complainants?
  - Does "I told them they could signup for the PPG" replace or support per-issue/per-patient action?
  - How to avoid 'personal responsibility' cosplay that hides systemic failure?

Concerns

Stricter and more complex processes exclude by definition.

- It's worth interrogating the risks and opportunities that come with adding more paperwork to the process and considering some high risks:
  - A tiny opaque group who don't know each-others complex issues may have diffuse and complex/competing needs and trouble communicating those needs/goals

clearly/coherently
        - Every patient already has to overcome "is this just my fault?" placed on them by lots of other systems
    - Staff habituated to low-key friction might struggle to convert mixed quality feedback into action
    - Staff might feel like they've been seen to have listened, because some meetings happened, but with little real change

Is a PPG better than an effective and transparent complaints system with internal responsible fixers where every complaint has a guaranteed life-cycle?

- Is the PPG supposed to **replace** or **supplement** dedicated staff problem-solvers?
    - How to prove effectiveness in an environment of relatively high corpo/doublespeak, "that's just how it's done" resistance, with only low-responsibility and highly portable participants?
    - "You said / we did" is only effective if you add "...and here's the proof that it fixed the problem"
    - Who are our problem solvers? Who actually owns patient-actioned change within the practice?

A formal terms 'pack' might be better used to back-up the PPG, but without being mandatory reading/agreement for every member. Like a process manual, that can be standardised across all GTD practices

- The "How to run a PPG that works" internal 'binder'
    - A 'living' document that is
    - Open, readable by anybody
    - Mostly maintained by engaged staff, but revisable by PPG members
        - This lets staff update it to react to problems and integrate/share lessons learned
    - Members agree to a simple one-sheet unless a situation calls for guidance/rules from the binder
        - Most issues of protocol are rare, don't make it the front door
- A lot of people find it difficult to communicate effectively and reasonably.
    - eople 'expect' to engage with services in different ways.
    - Protecting staff and other patients is the highest priority
    - avoiding a culture where negativity is **expected**, can help prevent negativity
    - People treated with respect and care, tend to return the favour, even if they're not making the most perfect case.
    - Access should assume good faith,
        - but have tools prepared that can react sensibly to bad faith participants, patients or staff.
- Staff attendance has already declined (7 to 3) over 4 meetings over ~6 months.
    - Understandable for a small group that has shed patients too, but a minimum level of engagement expected from staff might improve confidence and attendance.
        - I'm thinking of a 'patient champion' at each practice who owns the interface with the PPG, and can ask other staff (and/or coordinate with champions from other practices) for information and for change as needed, and expect a response, or maybe even attendance.
    - Even if it's just a single practice rep who can action changes internally with some authority, the meeting schedule needs to be regular, stable, and the change process responsive
        - Any process manual should probably define what internal staff can and should do with patient feedback, so the role of primary PPG person gives them *some* internal

power to hold other staff responsible for contributions to the patient's group.
    - The existing docs put a lot of responsibility on the patient, very little on staff, and none on expectations for change by the practice.
- Reception lacking representation at the PPG might also suggest they're being treated as a significant power, but have no responsibility for their choices or mistakes (common complaints in reviews)
    - Reception have possibly the most impact on patient experience, they should probably be more directly involved in identifying the causes of complaints and good solutions that work for everyone
    - they have the most access/workflow related knowledge, and see more of real patient activity than anybody in management, or any patient
- The august and september meetings were pretty well attended
    - Mainly people checking in on their preferred doctors and changes at the practice since new management
- The november meeting being moved 2 weeks at the last minute, decimated attendance to 3 regulars and one person who was already in the waiting room, and started late
- Continued reduced attendance in february
- If there are no staff to listen and act, and no patients to speak, was there even a meeting?
- What is the outcome of 'nobody bothered to turn up?'
    - Is the lesson 'nobody cares' or 'everything is fine' or 'nobody thinks anything will change'?
    - How to measure 'hope' that the procedure is worth the results?
- If patients vanish from the PPG (because there is no incentive beyond practice improvement), how does the PPG expect to know if those people deregistered and went elsewhere (fleeing a sinking ship) rather than became satisfied/hopeless with changes and just stopped asking?
    - I'm not sure it's practical to depend on patients to reraise the concerns of other patients, so the workflow has to try and cover that somehow.
    - TODO: Shorten this section

> *[!IMPORTANT] TL;DR: The PPG terms ask a lot, promises little; risk of process-theatre; staff habituated to friction; attendance drop; nobody notices or checks, no problems get fixed*

The ask...

A PPG works if it leads to positive changes. So the terms should say not just the meeting protocol, but what the practice will do with feedback: how roles owns issues, what to expect, and some idea of timeline.

The PPG can only expect each patient to raise their own issue once, and often not very clearly. If that issue gets lost, that's a failure point.

Meetings should at some point review actions taken since the last meeting. Complex logging is probably an uneccesary burden, but staff should be responsible for understanding what is being asked of them, and patients should be able to expect that.

Practice staff with at least enough authority to action and chase change should be present at any PPG. If regular staff can’t show up or act, someone should still be able to run that meeting and coordinate with the primary as needed.

Keep a simple, one-page set of meeting ground rules in plain language (simple to translate a short stable doc), and let people drop in, speak, and submit items without having to “join” or

sign a pack first.

Keep personal and confidential details out of the room by design, and send anyone with an individual case to a named staff contact to help them fix it personally. Patients shouldn't have to sign a confidentiality document to complain to their doctor.

- If you need a way to deal with bad behaviour, keep it short and simple, not a front door blocker.
  - It's accusative and discouraging, bordering confrontational, when ~99% of the time everything is fine
- Make it apply to staff as well as patients: be respectful, don't blame others, try to understand shared issues, patients have to rely on 'me first' because that's all they see, and recognise that most people engaging with healthcare may not be in the best position to be compliant.

Make it easy to take part

Publish dates well in advance, don't move meetings at the last minute, and offer more than one way to get an item onto the agenda (paper at reception, short form, phone message, not just email and attendance). Right now, nobody beyond the room can see what's in the PPG, so there's no reason to attend, and very little to learn.

Don't expire people off contact lists just because they missed meetings; it picks the wrong kind of "representative" by filtering for free time and stable routines. Also create a quick route for small fixes so the PPG isn't the only way to get simple problems sorted, and send short updates after meetings so people who can't attend still see that something happened.

Even a simple suggestions box might be helpful (tho only catches patients once they're actually in the practice).

If the PPG is the main route to change, it HAS to be as accessible as possible, to have a chance at finding those excluded by other access issues or mistakes at the practice.

Democratisation Risks

Even in the best-case scenario (strong, consistent, high quality patient involvement, healthy cycles of feedback and action with staff, greater patient wellbeing, practice growth) a PPG carries some risks worth considering that fall outside the normal practice influences.

- Poltical extremism and intentional interference
  - Individual practices might/hopefully not see big direct problems, but there is a low-key wave of bureaucratic disruption which might show up in trends across all management company practices.
  - On trend in the US for the culture war to be fought at the smallest/localest meeting possible, as higher levels become less effective
  - ChatGPT effects are discussed in the support material

PPG-terms-support.md contains further exploration, mostly through lists of simple ideas. Contains some useful POVs, but is probably too noisy to keep in the overview.