healthwatch
Leeds

What you need for meaningful engagement

Leeds Community Healthcare NHS Trust Review of Engagement
March 2019

About us
Your independent watchdog ensuring people's voices are at the heart of shaping health and care services in Leeds

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Background

It is being increasingly recognised that patient engagement is an essential way to ensure that services meet the needs of the person.

There are already several statutory requirements that NHS bodies must fulfil in terms of patient engagement including the Friends and Family test, national annual surveys and formal consultations when service redesign is taking place. However, good patient engagement is much wider than this and should be something that runs throughout the whole organisation.

Within Leeds, putting people at the centre of our health and care is a priority within the Leeds health and wellbeing strategy which states, "In our city wellbeing starts with people"[1]. As a health and care partnership, all partners have committed to "put people first... work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce.".

Health and care engagement leads in the city also come together as the People's Voices Group (PVG), with a collective ambition to work together as one health and care system to put people at the centre of health and care developments.

In late 2018, Leeds Community Healthcare NHS Trust (LCH) leaders recognised that they had a clear ambition to put people at the centre of LCH services but wanted an external perspective as to how the current practice was happening. They invited Healthwatch Leeds to undertake this external, independent review.

What we found

We found that there is excellent senior level commitment to developing engagement as well as good staff understanding of the benefits of engaging people. We found a variety of engagement activity happening across LCH, and pockets of good practice predominantly where resources have been allocated, however this was ad-hoc and not consistent across the Trust. A particular area of strength was involvement of people in their own care, which seems to be well on the way to becoming embedded in the Trust. There is some reliance in LCH on the Friends and Family Test which due to the nature of the question asked, only provides limited data, much of which once collected isn't systematically reviewed or acted on.

There has been a gap in the resourcing of engagement over the last couple of years, and this has resulted in a lack of good systems and co-ordination of engagement activity. There is also no formal strategy or plan in place around engagement which means that there is a risk of it dropping off the agenda. This is particularly relevant when the majority of the people 'doing' the engagement work are clinicians whose first priority will always be their caseload.

Two new Engagement posts including an Engagement Lead for the Trust have recently been created and there is a recognition amongst leaders that good engagement does require resource.

Staff had lots of good ideas around what they could do to improve how the Trust hears from people, however many mentioned time, resources and expertise as key barriers to putting these into action.

There was recognition that more could be done to engage with people from diverse groups. This included an identified need to make sure that engagement is accessible to all users of LCH services, and in particular those with disabilities, cognitive and communication impairments, those that are housebound and in receipt of end of life care and people whose first language isn't English.

Recommendations

1. Vision and leadership

1.1 A clear vision should be developed around putting people at the centre of LCH services that links in closely with the strong messages around the importance of hearing the staff voice.

1.2 Senior Leaders, Board directors and senior management team should live and breathe this approach in their daily activities.

1.3 Use the NHS Improvement Patient experience improvement framework self-assessment tool[5] (or similar) to agree areas for action and review which should inform the development of an overarching Engagement Strategy.

1.4 The Board should develop existing and new ways of ensuring that directors hear the voices of people using LCH services.

2. Culture of engagement

2.1 Look at ways of more explicitly linking engagement to the Trust's behaviours and making sure this is included in any campaign around engagement.

2.2 Explore ways that engagement can be made everybody's business within the Trust and not seen to be just the work of staff taking on dedicated roles.

2.3 Look at different ways that good practice in engagement can be more regularly and routinely shared and celebrated with staff.

2.4 Find ways of developing, sharing and promoting new messages around engagement into the already successful models of staff engagement within LCH.

3. Process, systems and infrastructure

3.1 Any Engagement strategy that is developed should include ways that the infrastructure and systems in LCH can enable all strands of patient experience to

tie up. This should include complaints and compliments, FFT, service level engagement work and public consultation around service change.

3.2 Establish a central engagement team whose primary role is one of co-ordination and strategy. In addition to this, there should be localised support in each of the business units with specialist knowledge to best advise the services in that unit.

3.3 Consider the possibility of resource being made available in the central team or within each business unit to support services with the collation, analysis and regular reporting back of patient feedback.

3.4 Explore the possibility of expanding on the FFT by adding more meaningful questions to the standard question with the aim of eliciting more useful responses from patients.

3.5 Continue the 'Involvement Champion' approach of there being key staff in each service whose role it is to champion engagement.

3.6 Make improvements to the website to make it more attractive, interactive and accessible for people to get involved.

4. Resources

4.1 Commit to long term funding of engagement activity. Continued adequate resourcing of a central team is integral to this.

4.2 As well as a central team, consideration should be given to ensuring that staff at service level, particularly those who are 'championing' engagement are given the time it needs to do meaningful engagement.

4.3 Ensure that there is an easily accessible budget allocated to engagement activities that services can tap into to cover things like travel expenses, refreshments and room hire.

4.4 LCH should explore the potential benefits of developing volunteers as an additional resource.

5. Skills and expertise

5.1 Dedicated staff should be available either within the central team or within each business unit to provide advice, support and resources to services, and look at how barriers to engagement can be overcome.

5.2 Consider developing a resource bank of good practice engagement tools that can be accessed by all staff to use and adapt for their services.

5.3 Ensure staff (and volunteers if appropriate) are provided with relevant training around engagement.

6. Diversity of voices

6.1 Staff involved in engagement should be systematically asking themselves questions about the needs and access requirements of their service users and carers and how engagement can be made accessible, attractive and meaningful.

6.2 Look at developing a core menu of ways that patients can share their feedback and ensure these are consistently publicised. This should include developing the patience experience section of the website so that it can act as a portal for people to share their views and ideas.

6.3 Services should be looking at which groups of people are currently underrepresented in accessing their services and thinking about the best way to hear their views.

7. Working with others

7.1 Do more to link with other local NHS trusts, community groups and relevant regional and national bodies to maximise patient voice.

7.2 Look at ways of pooling and sharing resources more within the Trust so that better use can be made of existing groups.

7.3 Where working with others seems to present challenges (e.g. in services such as Police Custody and Children's speech and language therapy), LCH should think more creatively about different ways, times and people to seek feedback from.

8. Monitoring and reporting outcomes

8.1 Develop more outcomes-based reporting mechanisms for services including questions which focus more on changes made as a result of engagement.

8.2 Consider the use of quality intelligence systems whereby data from any kind of engagement is collated and analysed regularly. This data could be fed back to relevant individual services, as well as used to drive quality improvement and learning.

Introduction

Healthwatch Leeds was commissioned by Leeds Community Healthcare NHS trust (LCH) with the aim of helping them to see where they are in terms of their current processes for engaging with people and areas where they could improve.

The key areas LCH wanted us to look at were:

- Establishing a baseline – where are LCH now as an organisation in relation to patient engagement?
- What is considered best practice in relation to patient engagement?
- What is currently working well in LCH in terms of engagement?
- What could LCH do better as an organisation?
- Develop recommendations that will feed into the LCH developed strategy for patient engagement.

"We want to know what we need to do to become an outstanding Trust in terms of how we engage with people." **(Thea Stein, Chief Executive)**

A note on language

It should be noted that throughout this report, we use the term 'people' to refer generally to patients, carers and the wider public. We also predominantly use the term 'engagement', although we are aware that the terms 'involvement', 'participation' and 'consultation' are commonly used interchangeably to describe different elements of the process, and therefore may appear in quotes.

Where we use staff quotes, we provide the name of the service that the member of staff works for to provide some level of anonymity. However, the view expressed in the quote should not be taken as the view of the service as a whole.

Methodology

In December 2018, LCH sent out a survey on our behalf to all services within the Trust. It was targeted at service leads or those who play a key role in engagement activity. Details of questions asked in the survey can be found in Appendix 1. The aim of the survey was to find out some basic information from services including:

- What engagement work they had done in the last 12 months
- Any plans for future engagement work
- Whether they felt that engagement made services better
- Whether there is a lead for engagement in their service
- What the challenges/barriers were to doing engagement
- What they felt the trust could do better in terms of engagement

We also asked them about the types of engagement they had done and whether it had been with patients, carers and/or the public. The types of engagement we asked about were:

- Designing services with people
- Working with people to make decisions about their care
- Evaluating services with people
- Seeking feedback about what works and what could be improved about services
- Involving people in proposed changes to services
- The option to give details of any other types of engagement

It should be noted that although we did ask whether patients were involved in their own care, the main focus of the work was around engagement in terms of how people were enabled to feedback about services and given opportunities to be involved in service design and evaluation.

60 staff members responded to the survey. There was a fairly even spread across the business units. 22 were from the Specialist Business Units, 25 were from the Adult Business Unit, 12 were from the Children's Business Unit and one wasn't specified (see Appendix 2 for breakdown of responses by service within each business unit). We received multiple responses from some services.

Following the survey, we arranged 13 semi-structured interviews with people from Board level, those with a key role in engagement and some service leads. The aim of these was to get a more in-depth picture of current engagement in the trust and what people wanted to see in the future. A full write up of all these interviews can be found in Appendix 6.

Name	Job role
Thea Stein	Chief Executive
Stephanie Lawrence	Acting Executive Director of Nursing
Ian Lewis	Non-executive Director
Heather McDonald	Patient Experience and Engagement Lead
Joanne Twigger	Patient Engagement, Experience and Participation Officer
Sam George	Communications and Engagement Manager
Chris Lake	Involvement Lead, Children's Business Unit (CBU)
Em Campbell	Neighbourhood Team Service Manager
Hana Haziem	Service Manager, Children's speech and language therapy
Amanda Jackson	Clinical Team Manager, 0-19 Public Health Integrated Nursing Service (PHINS) health visiting and school nursing
Jo Di Capua	Service Manager, Police Custody
Lynda Dexter	Advanced podiatrist in mental health and learning disabilities, Podiatry
Rebecca Kelly	Physiotherapist, Community Neurological Rehabilitation Service

Why engage with people?

It's useful to remember *why* engagement or involvement with people is so important, both generally and more specifically within health and care organisations. Below are some of the reasons given in the 4Pi National Involvement Standards.[2]

Spotlight on Good Practice: Why engage with people?

"The evidence tells us that good involvement can transform people's lives, improve services and develop the resilience of communities.

- Involvement in individual care and treatment can increase self-esteem, improve individual outcomes and increase people's satisfaction with services. The greatest benefits result when people agree with the purpose of their treatment, and when they have choice and control over it.
- Involvement in communities can build resilience, provide opportunities for peer support and mentoring and increase our social capital.
- Involvement in services can lead to enhanced quality of care, improved quality of life, a reduction in compulsory admissions, improved relationships between staff and service users, and improved outcomes for service users; it can also lead to improved outcomes for providers.
- Involvement in planning, commissioning and governance can improve information and access for service users and have positive effects on decision-making processes and staff attitudes and behaviour. It is vital that service users are involved in defining the outcomes of services for these benefits to be maximised"

There are many different ways in which people might be engaged in health settings. The 'Ladder of Engagement and Participation'[3] is a widely recognised model for understanding different forms and degrees of engagement with people. People's voices on every step of the ladder are valuable, although engagement becomes more meaningful at the top of the ladder.

The 'Ladder of Engagement and Participation'[3]

Level	Description
Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.

Spotlight on Good Practice: Incorporating people's voices throughout the entire process

"Whilst public and patient engagement is becoming increasingly pressing and, indeed, more prevalent, modern writing is now calling for more of a life-cycle approach to engagement, incorporating the patient voice and input throughout the entire process, and not just in a tokenistic fashion at the outset." [4]

In terms of our findings and recommendations in this report, we have structured them around some key elements that we consider to be core building blocks for good engagement (see diagram below).

Findings: Engagement activity in the last 12 months

54 (90%) of people who responded to the survey said they had done some engagement in the last 12 months. Two out of the six respondents who said they hadn't done any gave the following reasons – Police Custody said it was due to the 'nature of the service' and Health Case Management because it was a new service and they were planning to do some in the coming year. Less survey respondents (73%) said they had plans for future engagement with people.

Types of engagement

The most common type of engagement staff said they had done in the last 12 months was seeking feedback about what works and what could be improved about services (72% of survey respondents said they did this with patients, 35% with carers). On the 'ladder of engagement', this type of engagement would fall under 'consulting', the second 'rung' of the ladder.

Please tick the type of engagement you have done (tick all that apply)
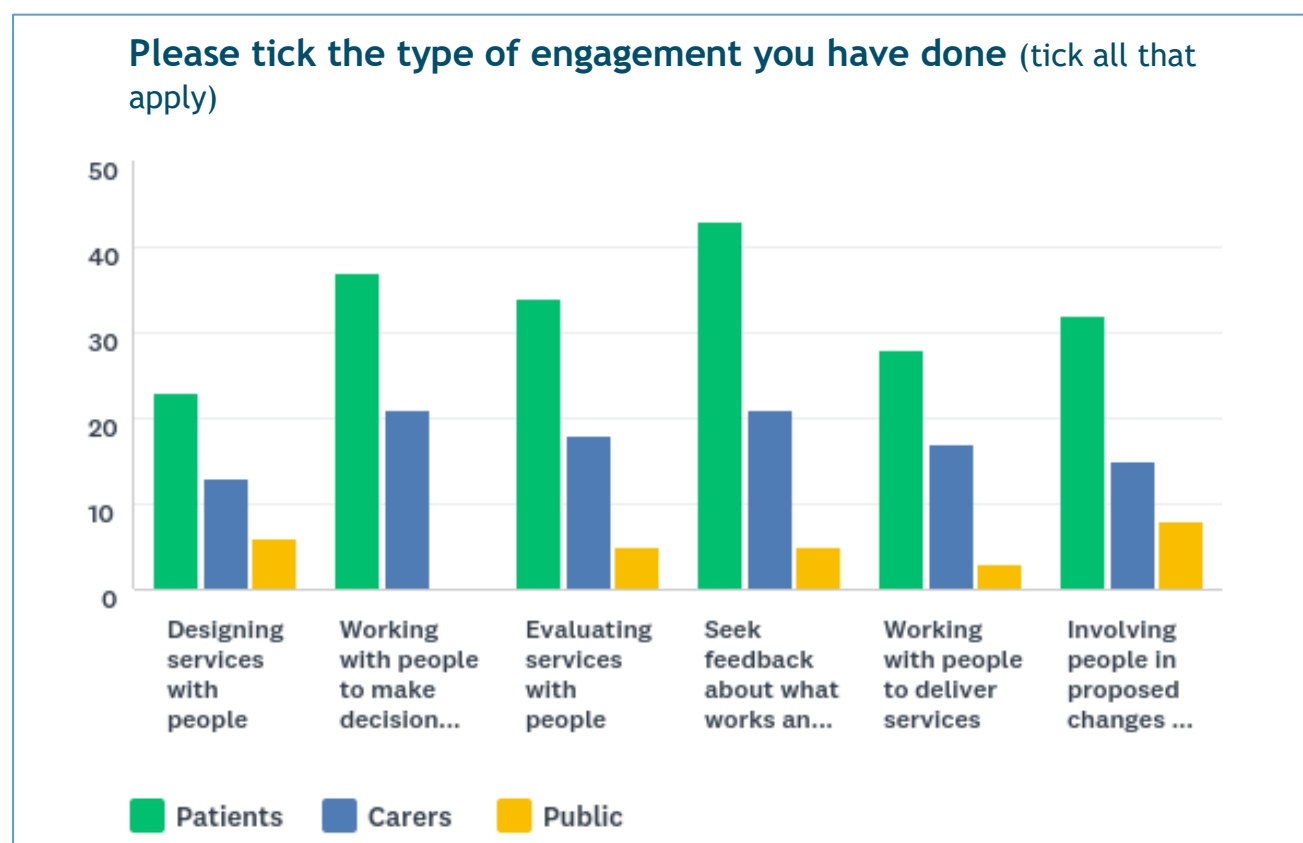
The second most common type of engagement was working with patients to make decisions about their care with 37 (62%) saying they had involved patients and 21 (35%) saying they had involved carers. The least common type of engagement was designing services with people, with 23 (38%) staff saying they had engaged patients in this kind of activity and only 13 (22%) engaging with carers.

Methods of engagement

The kinds of engagement people gave as examples via both the survey and the informal interviews included the more core requirements such as:

- Asking patients to fill in the Friends and Family Test (FFT) – most services said they use the standard test because they understood that to be the requirement, whilst others said they use the standard question but added in some more qualitative questions of their own.
- Responding to individual feedback, complaints or concerns, and involving patients in their care.
- Sending out surveys or patient feedback forms

There were also some examples of other kinds of engagement such as:

- Targeted questionnaires, focus groups or workshops about specific service changes or developments (0-19 PHINS, Community Dental Service, CAMHS, podiatry, Leeds Sexual Health, Musculoskeletal)
- Service user/carer fora (Community Neurological Rehabilitation Service, CAMHS and Children's Business Unit youth forum)
- Involving patients or carers in staff interviews (CAMHS and Children's speech and language therapy)
- Patients being involved in the development of leaflets or website (CAMHS, Podiatry, Wounds Prevention and Management Service, Community Neurological Rehabilitation Centre)
- Engagement through partner organisations such as third sector organisations and Healthwatch (Neighbourhood Team West, Palliative Care and Neighbourhood Night Service)
- Coffee hour for parents (CAMHS inpatients, Hannah House)
- Patient newsletter asking for views, sharing feedback and news about what's going on (Podiatry)

"We have podiatry assistants carrying out two sessions a month floor walking in a different clinic each month (they are out of uniform, at different clinics to where they work to try and make it more impartial). They ask the FFT question and a couple of other questions, e.g. what we do well, what we could do better, anything they'd like to see different in podiatry." **(Podiatry)**

"The service ran a new type of exercise rehabilitation course for lower functioning patients and because the process was a pilot there was a lot of patient consultation and evaluation of the programme." **(Long term conditions, Cardiac Service)**

"Service user visited the team to talk about their experience of Personal Health Budgets and how this has improved quality of life. The patient shared their own experience and what matters to them." **(Health Case Management)**

More detail about what people told us about their current and future engagement activities can be found in Appendices 3 and 6.

Findings and Recommendations in terms of core building blocks

01. Leadership
02. Culture of engagement
03. Process and systems
04 Resources
05. Skills and expertise
06. Diversity of voices
07. Working with others
08. Monitoring and reporting impact

What you need for meaningful engagement

1. Vision and leadership

Findings

"When engagement has happened well, it's happened as a consequence of good leadership." **(Ian Lewis, Non-executive director)**

Vision values and behaviours

Engagement and involvement of patients is certainly implicit in LCH's vision, values and behaviours. One of the ways the Trust says it will achieve the vision of "providing the best possible care in every community" is by "Working with children, adults and families to deliver high quality care".

The Trust's values certainly reflect patient centred care and a willingness to listen to, learn from and improve from people's feedback:

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously listening, learning and improving

The 'seven behaviours' do have some good elements in terms of engagement. For example, 'being open to others' ideas' and 'Looking at the way things are done now and suggesting new ways of working'. However, there is nothing explicitly in there about how people's voices feed into this.

Through our interviews with Board directors we know that there is a definite intention and will to embed people's voices into the work of LCH. Responses to the question, 'What would your vision be of what engagement within LCH would look like in the future?' included:

"It would feel that it would be impossible for anyone to realise that the patient was not at the heart of everything we do." **(Thea Stein, Chief Executive)**

"I want to see engagement at every opportunity – whenever there is a change, review or new pathway; when there is a serious incident or complaint as well as in general routine delivery of care." **(Steph Lawrence, Acting Executive Director of Nursing)**

However, there is acknowledgement that although the intention is there, work is needed to achieve this vision.

"It's not intrinsic within the organisation and doesn't feed through to board level... currently it is not clear that the strategic direction is driven by patient experience (not to say it doesn't influence it)." **(Ian Lewis, Non-executive director)**

"There needs to be a real focus on patient experience from board level to frontline and vice versa, and more patient voice is needed at the Quality Committee" **(Steph Lawrence, Acting Executive Director of Nursing)**

"If it's not being discussed at a very senior level, it won't be a priority, even with the best will in the world." **(Neighbourhood Team)**

Board level engagement

In terms of how people's experiences are currently heard at board level, this is mainly through patient stories at the start of each board meeting. The aim of this is to help to make sure that the board understand LCH services better and how it feels to receive care from the Trust. Patients are invited to attend and tell their story in person but at around half the board meetings, stories are told by clinicians because patients or their carers are unable to attend, which can detract from the impact of the story. We were told that the quality of these stories varies and that there is no flexibility about the timeslot which is always scheduled for 9am. This, along with health conditions and other life circumstances could be one of the possible reasons why patients are often unable to attend.

We were told that Board members are always in attendance at big consultation events relating to service change, and that board papers will include details of how patient voices have been heard during service development.

Part of a Board Director's role is also to visit services and talk to patients informally about their experiences. We were told that the majority of board members do this, but that some feel more confident in this role than others.

On a really positive note, there is clear support from the Chief Executive around being more creative in listening and understanding people's views.

"I want staff to feel free enough to respond to ideas for change and know that the Trust will have their back. In some ways, the culture is currently quite conventional. If demand for change is there from the public, we want staff to know that our culture is to listen to that and respond, and that's there with backing from Board." **(Thea Stein, Chief Executive)**

Recommendations

1.1 A clear vision should be developed around putting people at the centre of LCH services that links in closely with the strong messages around the importance of hearing the staff voice.

Listening to patients, carers and the public and listening to staff are equally important and should not be seen in isolation. There is a real opportunity for LCH to build on the good work they have done around hearing staff voice.

1.2 Senior Leaders, Board directors and senior management team should live and breathe this approach in their daily activities.

Leaders at all levels of the organisation should lead by example, listen to people throughout all their activities and clearly prioritise engagement and involvement of people. The Trust should consider a visible campaign of leaders promoting and celebrating engagement across the Trust and with the wider public. This could

include on social media, in blogs, presentations at staff events and on internal and external communications. Every opportunity should be taken to have conversations about engagement and what it means in practice. Included in this should be clarity around the difference between routinely involving people in their care and the wider engagement of patients and carers in service design, development and evaluation.

The message that senior leaders value, celebrate and encourage innovation to improve patient experience should be communicated and heard by staff. Staff need to know that they can do things differently if feedback shows that current systems aren't working.

1.3 Use the NHS Improvement Patient experience improvement framework self-assessment tool[5] (or similar) to agree areas for action and review which should inform the development of an overarching Engagement Strategy.

Spotlight on Good Practice: Patient experience improvement framework

The Patient experience improvement framework produced by NHS Improvement is an evidence-based framework centred around Care Quality Commission key themes to enable board and senior teams in providers to continuously improve the experience of patients. It brings together the characteristics of trusts that consistently improve patient experience and enables them to carry out an organisational diagnostic to establish how far patient experience is embedded in its leadership, culture and its operational processes.

https://improvement.nhs.uk/resources/patient-experience-improvement-framework/

1.4 The Board should develop existing and new ways of ensuring that directors hear the voices of people using LCH services.

The board could be more flexible in its approach to hearing patient stories in board meetings, taking into account individual circumstances and trying to make reasonable adjustments. For example, there could be more flexibility around the time slot available at meetings, and people could be offered different ways to share their stories, for example by video, audio recording or Skype. There could be more done to prepare people for these meetings, such as devising a set of guidelines so that people know what to expect and what they can get from sharing their story at a board meeting.

The Trust could also consider other ways for the Board to hear from patients, for example visiting and talking to existing forums or groups that exist within the Trust or having 'meet the board' sessions for patients and carers either in person or via social media. If some Board Directors are less confident in going out and about talking to patients, it could be that there is a buddying role for other Board Directors who are more comfortable in that role.

Spotlight on Good Practice: Facebook meetings

Fort Belvoir Community Hospital in Virginia held quarterly Facebook "town hall" meetings where a group of senior people (including hospital commander and chief of staff) gathered for three hours to respond to questions and concerns via Facebook. Something like this could run as a virtual 'drop-in' and could be a way for people who may not be comfortable to attend board meetings to have their voice heard.

https://www.hfma.org/Leadership/Archives/2014/Spring/Engaging_Patients_in_Strategic_Planning/
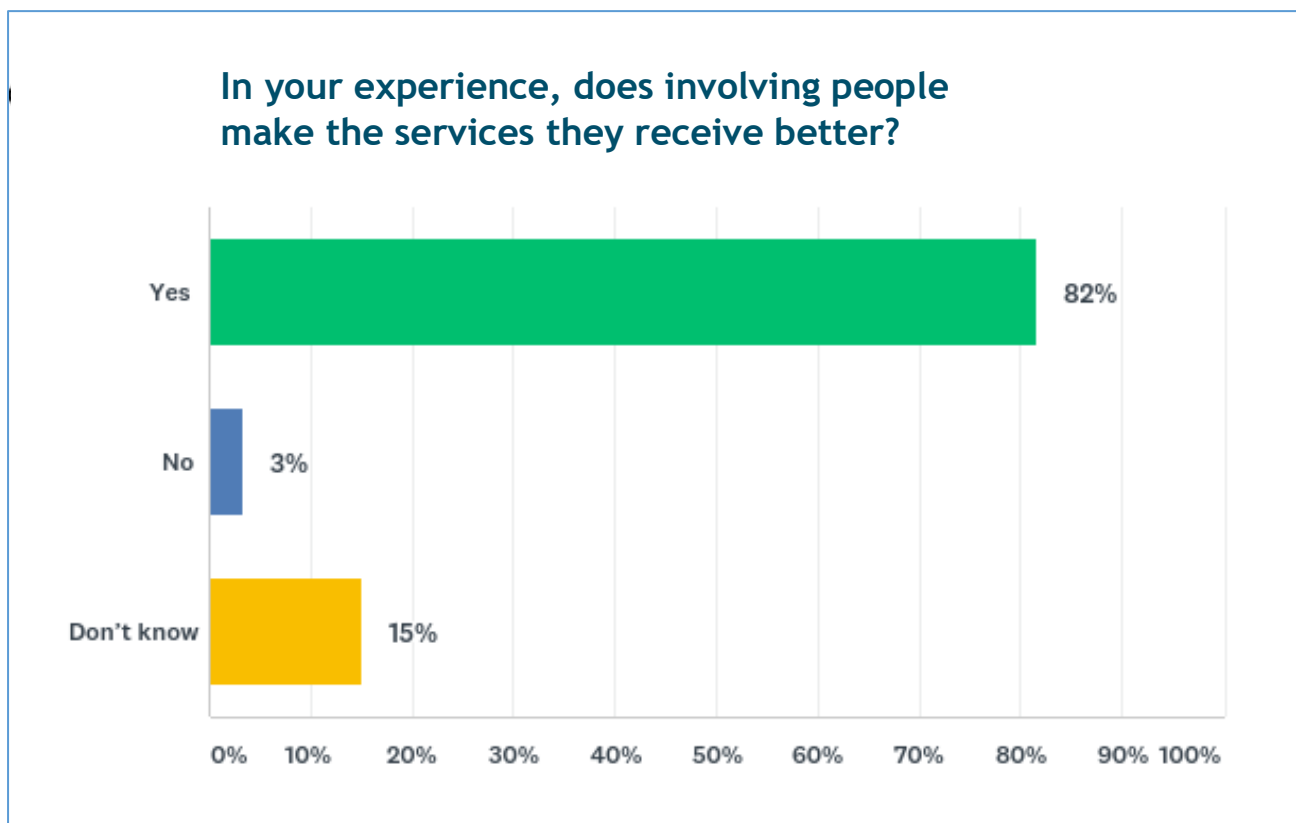
2. Culture of engagement

Findings

Having a culture of engagement running throughout an organisation is vital to ensure that engagement practices are meaningful and sustained. It's about creating an environment where the importance of listening to and learning from patients, carers and the public enters everyone's ways of thinking and becomes the norm rather than just assigned to specific activities.

Commitment from Staff

It is clear that there is commitment and recognition from leadership, and from individual services that engagement is important and should be prioritised. In the survey, the majority (82%) of staff indicated they could see a link between engaging people and improving services.

In your experience, does involving people make the services they receive better?

Response	Percentage
Yes	82%
No	3%
Don't know	15%

When asked what they thought was made better by engagement, staff cited improved patient-staff relationships, increased attendance rates, patients getting better outcomes and having a service that better meets patient needs. All the Engagement roles and service staff we interviewed were very clear on this, and could clearly articulate the reasons why they felt engagement was important.

> *"We can understand patient experience of our services revealing unexpected perceptions, beliefs and gaps."* **(CAMHS)**

> *"Patients are more engaged therefore getting better outcomes if they feel they have a part to play in the service"* **(Musculoskeletal)**

"It's important to improve things. It's alright thinking we're doing the right things, but how do we know if it's what patients want if we don't get their views. Often feedback can result in very small changes that we wouldn't have thought of. Being inside the service it's difficult sometimes to see it from the point of view of the patient." **(Police Custody)**

"People recognise that we are as good as we are because we get service users' opinions. We ask new starters (staff) to attend the user forum (they can share what their role is as well as learn about the forum)." **(Community Neurological Rehabilitation Centre)**

"Working with" people

Working with patients to involve them in decisions about their care is an area that seems to be well on the way to becoming embedded in LCH. As discussed on p.7 of this report, 62% staff surveyed said they were engaging with patients and 35% engaging with carers in this way. There has been a recent drive in this area within the Trust to promote health coaching, motivational interviewing and self-management, including a training programme for staff.

"At the Trust, we already have a strong focus on... health coaching which we are championing, where patients are put at the centre of their care." **(Thea Stein, Chief Executive)**

A few people we spoke to still felt there were bits of the old culture remaining, of 'clinicians know best', but this was the minority.

Other forms of engagement

In the survey results, it was clear that some respondents seemed to see engagement only in terms of involving patients in their care as opposed to the much wider agenda of involving people in designing, developing and evaluating services.

In terms of the culture of this much wider type of engagement, there was anecdotal evidence to suggest that it is not always present, and that engagement is not as much 'everybody's business' as it could be.

"Culture not there, staff don't hear about it. No-one is saying it's important how we improve services based on feedback. Sometimes because operational and clinical management are separate in this unit, involvement and feedback falls between the two, because the responsibilities lie with both sides of management." **(Neighbourhood Team)**

"If one Speech and Language Therapist is asking parents to be involved in a parent forum in one patch, it should be happening across the board." **(Children's speech and language therapy).**

Fear of engagement

There was a perception amongst some board directors that fear could be a barrier for some staff preventing them from engaging with patients. Fear that patient expectations

may not be realistic, and, within the complaints process, fear of asking what patients would like to see happen as a result of an incident in case it resulted in an action or a claim.

"We need to address fears by education, training and leading by example, show people it's okay to be open and honest, and share how things happened in practice." **(Steph Lawrence, Acting Executive Director of Nursing)**

Celebrating good practice

Senior staff acknowledge the importance of recognising and celebrating staff's involvement in good patient engagement, and that this is a good way of promoting a culture of engagement. There has been a recent review of the criteria of the annual staff 'Thank You' awards, to put more of an emphasis on involvement, which is really positive. The awards themselves seem quite popular with 89 nominations this year.

Staff mentioned several other ways that good engagement work is sometimes celebrated, for example through, Community Talk the weekly ebulletin, notice boards at Stockdale House, team newsletters and meetings and the intranet. Each business unit also has a celebration event, where good practice (not just about engagement but including it) is showcased. There were some people who felt that sharing and celebration of good practice was a bit 'ad hoc' and more could be done in this area; 6 people mentioned it as an area that LCH could do better in (see Appendix 5):

"There should be better ways of celebrating and sharing good practice to make it easy for staff to learn about it. Lessons learnt seem to be more widely broadcast when errors have been made rather than when people do things well" **(Children's speech and language therapy)**

Staff engagement

Although this piece of work wasn't specifically looking at staff engagement, several people mentioned that they had been involved positively in this kind of engagement, for example through 'Thea's 50 voices', the 'Ask Thea' initiative or being consulted about how a service had run. Good engagement with staff is really useful for helping to spread understanding of why engagement is important and contributes to a good culture of engagement.

"LCH has made massive improvements in engaging with staff in the last few years. Continue in this vein and the ethos will disseminate organically" **(anonymous)**

Recommendations

If the recommendations around leadership are implemented, this also serves to help develop a culture of engagement within the organisation. We would also like to make the following recommendations:

2.1 Look at ways of more explicitly linking engagement to the Trust's behaviours and making sure this is included in any campaign around engagement.

It would be particularly useful to look at how the importance of engagement and people's voices could be incorporated into in the last three behaviours: 'Adapting to change and delivering improvements', 'working together' and 'Finding solutions'.

2.2 Explore ways that engagement can be made everybody's business within the Trust and not seen to be just the work of staff taking on dedicated roles.

This should include considering how it can be incorporated into people's job descriptions, inductions, workplans and the appraisal system. As one member of staff suggested, people should

"talk about engagement at every meeting we have." **(Neighbourhood Team)**

2.3 Look at different ways that good practice in engagement can be more regularly and routinely shared and celebrated with staff.

This could be through a regular dedicated newsletter or ebulletin (such as the Involvement newsletter just started in the Children's Business Unit), or a slot in an existing e-bulletin such as Community Talk.

2.4 Find ways of developing, sharing and promoting new messages around engagement into the already successful models of staff engagement within LCH.

Link into the successful models of staff engagement within LCH by incorporating themes around engagement to raise awareness, get buy in from staff and share the message of why it is an integral way of how staff should be working.

Spotlight on Good Practice: Collaborative Practice

Collaborative Practice is an award-winning model pioneered by Altogether Better which helps health services (including community settings) and local people find new ways of working together – making a difference to people's lives, releasing resources, and improving services. Being from the community, local people transfer knowledge into the system and identify opportunities for redesign."

"Something magical happens when you bring local people into a health service and enable true collaboration. The culture of the organisation changes. And we create a fresh new space where change can happen and lives and services can be improved."[6] https://www.altogetherbetter.org.uk/what-is-collaborative-practice

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3. Process, systems and infrastructure

Findings

In order for engagement to work well in an organisation as large as LCH which provides such a wide range of services, it needs to be joined up. There need to be good, clear and accessible systems in place to enable staff to carry out engagement work and patients, carers and the public to participate.

"Engagement does happen at LCH some of which is excellent in particular services but it is patchy rather than across the board and there is no clear picture coming through." **(Ian Lewis, Non-executive Director)**

"I don't think that clinical staff don't think about engagement and how the public want to be involved in their care, and there's some outstanding work. What isn't embedded is a system and process for engagement so that good practice can be shared. There isn't a real framework there, or way for me to demonstrate that the engagement is happening." **(Thea Stein, Chief Executive)**

Resource gap

In the past couple of years, there has been no Engagement Manager in post at LCH, although more recently an Engagement Lead and an Engagement Officer have been recruited as a central resource for the Trust. It is apparent that this gap in resource has had an impact - staff and Board Directors identified a lack of consistency in engagement both within services, and across the Trust.

It is understood that the Complaints Team (currently separate) will be moving into the Patient Experience team. However, there are other key engagement roles which don't sit within this team, notably the Engagement lead for the Children's Business Unit which sits within that unit and the Communications and Engagement Manager which sits within Communications. There is a perceived lack of co-ordination which results in the Board, key engagement roles and individual services not knowing what other services are doing in terms of engagement, and what can be tapped into.

'Involvement' initiatives

There was some mention of LCH's 'Involvement' initiatives that have been historically running in the Trust and comprised:

- Service led involvement plans which were reviewed on an annual basis.
- Each service was encouraged to have an Involvement Champion, a member of staff who was interested in engagement.
- Regular Involvement Champion meetings where Involvement Champions could act as 'critical friends' to review plans and share ideas.
- Based on involvement plans and levels of involvement during the year, each service could, in collaboration with other involvement champions, self-nominate and award themselves either bronze, silver or gold standard.

The thinking behind these initiatives was to enable knowledge about engagement within services to be collated centrally and create a network to share ideas and provide

challenge. The Involvement Standards linked closely to the LCH 'feedback cycle'. This can be found on the LCH website and is a good clear model of how good engagement should be carried out.

The LCH Feedback Cycle

We recognise that for us to achieve our vision of 'delivering the best possible care to every community in Leeds' we need to work with our patients, carers and public members. The feedback cycle is a tangible example of putting our values into practice:

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously listening, learning and improving

...what has happened as a result and if not, reasons why

Feed back changes

...using methods that suit individual needs

Gather views

Plan and implement change

...using feedback to influence decisions

"It was the first time that I felt I was making a difference and not just ticking a box."

Review what's been said

...on the same topic and from all sources

In a recent internal review of these initiatives, it was stated:

"Involvement initiatives have lost momentum amongst some teams. In 2016/17 35 plans were submitted, in 2017/2018 2 plans were submitted and in 2018/2019 1 plan was submitted. This doesn't mean plans are not being done and held locally by teams they are just not being submitted for an award or shared centrally."

Feedback from staff as part of this review indicated that linking the plans to the feedback cycle encouraged services to fully engage and share results with service users and the public, rather than just gathering feedback. But conversely, staff said they felt the

approach was corporate, and may have put people off being champions and getting involved in something that can be really interesting and creative.

Some services mentioned that they still have Involvement Champions, some of whom are more active than others. Involvement Champion meetings have recommenced in the Children's Business Unit (CBU) following the appointment of the CBU Engagement Lead, Chris Lake. Trust-wide Involvement lead meetings have also started up again after not running for some time and are now scheduled to happen regularly. Chris has also started an Involvement newsletter for the CBU to promote what his role can help with, share information and showcase engagement activities.

The internal review highlighted mixed feedback about Involvement Champion meetings - attendance was low because meetings were not a priority, junior team members were often sent who were not invested in being a champion and meetings often became a place to complain about the FFT requirement.

Regarding the involvement standards, the internal review indicated mixed feedback from staff which was echoed by some staff we spoke to through the interviews. Staff liked the sense of competition and incentive that the bronze, silver and gold awards provided. However, the question was raised whether Bronze level should be viewed as a minimum that all services should be doing rather than them being awarded for doing so.

> *"Involvement standards – it was self-assessment, and we provided evidence. Felt like it was a tick box exercise, just services assessing themselves, where's patients' views in that?"* **(Podiatry)**

> *"It needed more buy in from management – sometimes Champions said they felt powerless if managers didn't buy into it."* **(Neighbourhood Team)**

Some staff who are Involvement Champions told us they were facing barriers in accessing patient experience data on the IT systems where it is inputted.

Ways for people to give feedback

There is a positive and open message given in the 2017/18 LCH Quality accounts: "LCH and our staff welcome all feedback about the services we provide; whichever way people want to tell us. We can be contacted by phone, email, via the Friends and Family Test, social media, our website or even face to face!". The Patient Experience Team pages of the LCH website however, are very basic with no pictures. They could be made much more engaging and accessible. The link to patient satisfaction survey doesn't work and the link to the FFT just goes to an online description of it, rather than giving people the option to complete it online. The webpages are very focused on how to raise a concern or make a complaint rather than explaining the different ways people can share feedback (for example directly with the Trust or via Healthwatch or Care Opinion) and there is no obvious connection between the Patient Experience section and the 'Get Involved' section which talks about how to get involved and share views.

> *"We're good at reactive feedback but not so good at proactive feedback"* **(Neighbourhood Team)**

It was not clear whether or not services could use text to ask for patient views. Some services said they had been told that they could not use text because of information governance issues whilst others said they'd heard text could be used or were actually using a free text service to receive FFT comments from patients via text (Musculoskeletal).

Recommendations

3.1 Any Engagement strategy that is developed should include ways that the infrastructure and systems in LCH can enable all strands of patient experience to tie up. This should include complaints and compliments, FFT, service level engagement work and public consultation around service change.

Consideration should be given to how patient experience data is collated and accessed. Any systems should enable services to easily see all patient experience data relating to their service regardless of how it comes into the Trust. It should be made easy for any service staff involved in engagement to have easy access to this patient experience data.

"Consultation about big service change happens through the comms team. When a service change happens, it's important that public consultation (through comms) ties up with individual service user engagement." **(Neighbourhood Team, West)**

3.2 Establish a central engagement team whose primary role is one of co-ordination and strategy. In addition to this, there should be localised support in each of the business units with specialist knowledge to best advise the services in that unit.

3.3 Consider the possibility of resource being made available in the central team or within each business unit to support services with the collation, analysis and regular reporting back of patient feedback.

3.4 Explore the possibility of expanding on the FFT by adding more meaningful questions to the standard question, with the aim of eliciting more useful responses from patients.

For example, "What could we do to improve our service?" In all engagement, the question 'why are we asking the question?' needs to be asked and consideration given as to whether the information it will give you will be useful.

"I would like to see LCH capturing information better, explicitly and implicitly in the best way possible and in a meaningful way." **(Ian Lewis, Non-executive Director)**

3.5 Continue the 'Involvement Champion' approach of there being key staff in each service whose role it is to champion engagement

There is broad support for the Involvement Champions programme and a wish for it to be revived. However, it would be worth considering whether meetings are always the best way to do this considering time being such a barrier for clinicians. It would be worth considering having a virtual network (e.g. Email list, Facebook Workplace)

instead of or to complement meetings.

Spotlight on Good Practice: People's Voices Group

The People's Voices Group, co-ordinated by Healthwatch Leeds is a group of people from statutory and third sector organisations who lead on engagement in health and care across Leeds. The group meets quarterly but also uses Facebook Workplace between meetings to share good practice and develop a one team culture and approach.

3.6   Make improvements to the website to make it more attractive, interactive and accessible for people to get involved.

Bring together the patient experience pages with the 'how to get involved' pages to make it easier for patients and the public to navigate.

Spotlight on Good Practice: Northumbria Healthcare website
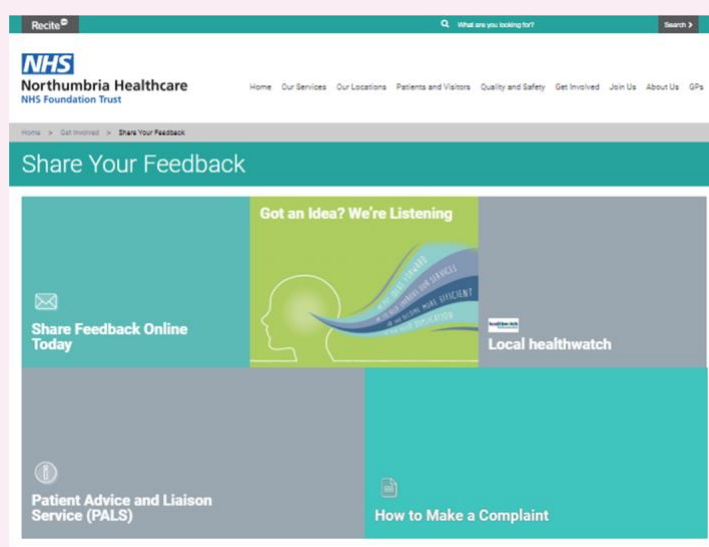
Northumbria Healthcare NHS Foundation Trust's website is a good example of clearly giving people different ways to feedback all in one place. As well as being clear and easy to navigate, they have online forms for sharing feedback as well as sharing ideas for how things can be improved.
https://www.northumbria.nhs.uk/get-involved/share-your-feedback/.

4. Resources

Findings

From our experience, meaningful and good quality engagement takes time and dedicated resources, and is not something that can be done well as an 'add on'.

It is apparent that there has been a gap in resourcing of patient engagement in the past 18 months, although this is now starting to be addressed with the recruitment of two new key engagement roles. There is recognition from the Board about time and resources being a key barrier.

> *"Regarding wider service engagement I think there is a capacity and headspace issue - If clinicians are trying to do clinical work, that will always be the priority and wider engagement needs more thought. So how do you get anything beyond a tick box survey for example?"* **(Thea Stein, Chief Executive)**

Time

Time was by far the biggest issue for staff when asked about barriers to engagement, it was mentioned by 25 people (See Appendix 4). A large number of people championing engagement in the Trust are in clinical roles, which means that it is often difficult for them to prioritise engagement work.

> *"Staff interested in engagement work often get lost in the day/clinical job."* **(Musculoskeletal)**

There was a recognition that good quality engagement and being able to do everything in the feedback cycle takes time. People mentioned that even if they had managed to collect feedback, having the time to collate, analyse, implement change and share any outcomes was often an issue. Some people talked about having some time allocated to engagement in their job role (for some this was as little as an hour a week), whilst for others, it was an add-on to their clinical role.

> *"This work really flourished when we had someone in a designated post. I am concerned that it will be hard for assistants to prioritise this"* **(CAMHS)**

> *"I am glad to be working for such a caring, forward thinking organisation, it is frustrating that staff shortages prevent achievement of our aspirations."* **(anonymous)**

Costs of engagement

Resources, including funding, budgets to run engagement activities and cover expenses was a barrier mentioned by 8 people (see Appendix 4 for more details). Some services had been able to get over this barrier by tapping into patient transport services to bring service users to forum meetings (Community Neurological Rehabilitation Centre), whilst others had tapped into third sector organisations to provide transport to the Otley Leg Club (Neighbourhood Team). However, another service told us that not being able to provide travel expenses had been a real barrier to engagement.

"Trying to get people to an area when we can't offer them travel expenses – it's difficult to get people there. Only 4 out of 15 who said they would come came to last focus group in Morley (they were all from Morley)" **(Podiatry)**

Nine staff, when asked what LCH could do better, said that more time and resources dedicated to engagement were needed (see Appendix 5). Suggestions included a central team, dedicated resource within each service or Business Unit as well as some resource to help doing the practical side of actually carrying out the engagement work, which staff recognised was time consuming.

Use of volunteers

Currently, the Trust does not seem to make regular use of volunteers which could be an avenue to explore in order to increase resource. Although the website talks about ways people can get involved (e.g. PLACE inspections), there is no dedicated volunteer management team, and there was little evidence of volunteers being involved on the ground. For example, there were mixed views as to whether the patient reader group still exists. Two services thought it was no longer available to support services, whilst another thought they could access it through the Communications Team.

Recommendations

"There needs to be a central resource which people can call in for support, for example that sits within each business unit." **(Thea Stein, Chief Executive)**

4.1 **Commit to long term funding of engagement activity. Continued adequate resourcing of a central team is integral to this.**

4.2 **As well as a central team, consideration should be given to ensuring that staff at service level, particularly those who are 'championing' engagement are given the time it needs to do meaningful engagement.**

This could be through giving staff protected time to do engagement, introducing dedicated roles, including engagement in the job description of new roles.

4.3 **Ensure that there is an easily accessible budget allocated to engagement activities that services can tap into to cover things like travel expenses, refreshments and room hire.**

4.4 **LCH should explore the potential benefits of developing volunteers as an additional resource.**

In other NHS Trusts, volunteers are involved in roles such as volunteer reader to get patients' perspective on literature, administration, befrienders, meet and greet, Community Health Champions, Patient Champions activity helpers, rehabilitation volunteers, reception, helping with the inputting and analysis of data relating to patient feedback and assisting patients to give feedback. The introduction of a successful volunteer programme would in itself require a dedicated resource to oversee, co-ordinate and train volunteers, but it would lever additional resource in

terms of time, skills, a lay person perspective and involvement of a diverse range of people if done well.

Spotlight on Good Practice: Using volunteers as an additional resource

At Kent Community Health NHS Foundation Trust they offer many roles, one of which is a Health Centre 'Meet and Greet Volunteer' part of whose role is, "to oversee the patient satisfaction survey following the clinic appointment using and ipad or advising the patient as to other forms of accessing it"

https://www.kentcht.nhs.uk/about-us/ways-to-get-involved/volunteering/

Roles

There are hundreds of roles a volunteer can have in the NHS. For example, you could be a ward activity assistant, do some reception work, be a service volunteer or cardiac rehabilitation volunteer. Or maybe you would prefer to be administrative or clerical support, a ward visitor or helper with the chaplaincy, an arts and craft maker or an events helper. Volunteers get involved with baby clinics, tea shops, hospital shops, trolley services, dining companions, gardening and are often meet and greeters or help with PAT dogs.

Volunteer stories

Linda Hook - our volunteer of the year

Anthea Belsey, Ward Volunteer, Sevenoaks Community Hospital

5. Skills and expertise

Findings

Good engagement can never be a 'one size fits all' approach. Consideration always needs to be given to how different groups of people can best get their voice heard, and how LCH as an organisation can facilitate this process. This requires flexibility, creativity as well as skills and knowledge of different approaches that can be taken. Staff need to know the basics about meaningful engagement, including models such as the ladder of engagement and the importance of the feedback cycle.

"It's not easy and would require an element of training. Engagement is not necessarily an intuitive process – it needs thought and planning." **(Ian Lewis – Non-executive director)**

Good quality engagement is a skill and requires knowledge and expertise. There wasn't a shortage of ideas from staff around how they could engage, it was more the time, resources and expertise to put these ideas into practice that people said was the barrier. Some ideas people suggested for how LCH could better engage with people were:

- Digital/online solutions to facilitate better engagement (e.g. have online feedback and discussion forums, online surveys, service specific social media platforms, use of tablets)
- Arrange engagement events/focus groups/service drop-ins/roadshows, but not just with people who have a specific or vested interest
- Have patient experience forums or pool of people (either within service or centrally that service can tap into)
- More types of engagement including by phone and text and face to face
- More opportunities for service users to be on interview panels for frontline staff
- More involvement of patients and families in investigation of complaints and serious incidents
- Offer volunteer opportunities
- Opportunity for people to come and see what a service does and get a better understanding of how the service works. We get better feedback if people have a good understanding of the service.

(see Appendix 5 for full list of responses around 'What LCH could do better')

There is evidence at LCH that where there has been a dedicated participation post within a service (Chris Lake, CAMHS), there has been lots of good engagement work developed. Now that Chris's role has extended to cover the Children's Business Unit as a whole, services from within this unit have mentioned that the post was working well and that they were approaching Chris for support. At present there is no equivalent post in either the Adults or Specialist Business Unit.

"It can be a bit isolating for Involvement Champions and is important that they've got support or someone to go to. Sometimes the role is just about giving people the confidence to take things forward." **(Chris Lake, Children's Business Unit)**

"There needs to be a central resource… to be able to advise on how to do engagement practically and simply, and answer team's questions on what they can and can't do. A central team could come up with a menu of different ways teams can ask for feedback, how they can do things differently and help promote them, and help teams think about and remove barriers. How to use technology better, e.g. can we text them survey link?" **(Neighbourhood team)**

The Communications and Engagement Manager is also a source of advice and expertise for services looking to engage specifically around service change. She has developed templates for posters and leaflets that are available on Elsie for services to share outcomes of consultations in a 'you said, we did' format. She highlighted the need for a more consistent approach to sharing learning.

"It's a bit ad hoc at the moment. You can find examples of engagement in the Quality Account and Annual Report, but this is yearly and targeted at a particular audience." **(Communications and Engagement Manager)**

Other services also said they'd like a way that they could share ideas with others doing engagement as part of their role, as it would help if staff felt stuck and could give them the confidence to run with an idea if other services were already doing it.

Several services told us that they needed support to work out how to engage with groups for whom the 'one size fits all' approach doesn't work.

"We are a really specialist service and need some specialist support on how to come up with meaningful ways to engage with people. We need a different approach. It currently falls back on us because the central team doesn't have specialist resources to dedicate to helping us, or don't know how to do it." **(Police Custody)**

LCH works with some very vulnerable groups including those who are housebound, those with complex conditions, learning disabilities, or cognitive and communication impairments. To hear from these groups effectively requires individualised approaches and resources which would need time and expertise to develop.

Recommendations

5.1 Dedicated staff should be available either within the central team or within each business unit to provide advice, support and resources to services, and look at how barriers to engagement can be overcome.

They should also have a role in celebrating and sharing good practice and linking up services who may be able to learn from each other. There needs to be a good understanding from these staff of the particular challenges and barriers faced by specific services when seeking patient views and they need to have the skills to work creatively with these services to find different ways of engaging. It also needs to be recognised that engagement within particular services (e.g. Police custody) and with particular groups of people, will require more expertise, and potentially resource. These groups of people include those with communication or cognitive impairments,

learning disabilities, as well as those who are housebound or in receipt of end of life care.

5.2 Consider developing a resource bank of good practice engagement tools that can be accessed by all staff to use and adapt for their services.

This could be located somewhere accessible by all stuff such as the intranet and could include things like templates, 'how to' guides and training. It could be a place where the central team could share examples of good practice from both within and outside of the trust that could be accessed by all staff to use and adapt for their services.

around engagement.

This could include training around different levels of engagement ('ladder of engagement'), how to make engagement accessible, different ways of sharing outcomes with patients, carers and the public, and using digital technology to engage.

Spotlight on Good Practice: Volunteers bringing skills and expertise

Volunteering is another useful way of bringing in additional skills and expertise. Here at Healthwatch Leeds for example, we have a number of volunteers who are students or professionals skilled in data analysis and writing reports. https://healthwatchleeds.co.uk/about-us/volunteering/
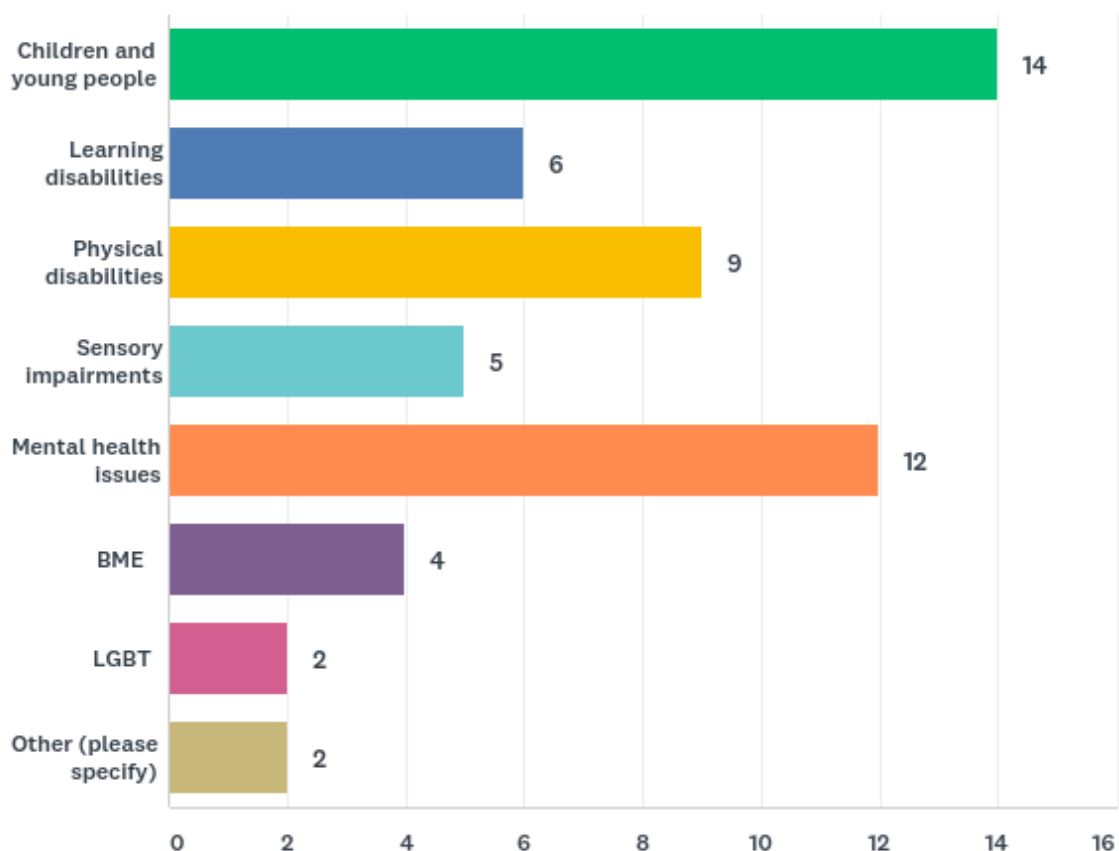
6. Diversity of voices

Spotlight on Good Practice: Considering who needs to be involved

"The population relevant to the involvement should be analysed at the start, in order to ensure that those involved reflect that population, and to identify which groups of people are particularly affected by the service or issues under consideration and who therefore need to be involved." 4Pi National involvement standards[7]

Public engagement strategy and evaluation needs to take account of diversity in the patient population... Failure to do so runs the risk of excluding those who are traditionally underrepresented and typically most in need and, in essence, reproducing existing health inequities."[8]

Findings

Have you done any targeted engagement work to hear the voices of groups of people with the following characteristics? (tick all that apply)

Characteristic	Value
Children and young people	14
Learning disabilities	6
Physical disabilities	9
Sensory impairments	5
Mental health issues	12
BME	4
LGBT	2
Other (please specify)	2

Only 26 (43%) of survey respondents answered the above question in the survey. Children and young people and mental health issues were the groups where respondents said the most targeted work had been done. This perhaps reflects the resource that has been invested in the previous dedicated CAMHS participation post (there were 7 survey responses from CAMHS), which has now extended to cover the wider Children's Business Unit.

'Other' groups mentioned were the traveller community (Musculoskeletal and 0-19 PHINS) and those with neurological disorders (community neurological rehabilitation centre).

The interviews highlighted some good practice, whilst also acknowledging that more needs to be done to ensure that a diverse range of people are reached in engagement work. Engagement around service change co-ordinated by the Communications and Engagement Manager showed some good practice around what needs to be done to reach diverse communities.

> *"We offer interpreters as standard at events and focus groups. We put on all our documents that if people need help to understand a document, they should get in touch. If there are language barriers or difficulties in communicating, the service would talk through changes face to face when patients are attending appointments. We make sure we communicate what changes are, how it affects people and which areas of the city are most affected."* **(Communications and Engagement Manager)**

This is likely to be in part because there is a clear process in place when the work is taken on which includes an Equality Impact Assessment. There was also some good practice in Podiatry where staff were doing regular 'clinic floor walks'.

> *"We get a lot of BAME people whose first language isn't English using the clinics so the clinic floor walk works really well to get views of these patients, as staff can fill in forms with them. We've been targeting inner city clinics for this activity. It also enables white British people with poor literacy and those with learning disabilities to share their views."* **(Podiatry)**

Accessible materials

Spotlight on Good Practice: Accessible Information Standard

All organisations that provide NHS care are legally required to follow the Accessible Information Standard. Part of this standard is to make sure that disabled people get information in an accessible way and communication support if they need it.
https://www.england.nhs.uk/ourwork/accessibleinfo/

Some services also mentioned they used the easy read and 'child friendly' FFT materials. They also talked however about the limitations of these materials. For example, people with learning disabilities could tick a smiley face about how they felt about a person treating them, but for those with poor literacy how was this meaningful feedback if they couldn't write anything in the comments section. CAMHS told us that they had produced

their own design of FFT, after feedback from young people that the monkey design was too childish for their age group.

> *"How accessible is FFT? Interestingly we have high response rate from our stammering team who are generally not cognitively impaired."* **(Children's speech and language therapy)**

In contrast to the documents used in service change engagement, there was acknowledgement from one of the Neighbourhood Teams that the patient feedback form they send out to all patients is not as accessible as it could be. It is in small type with no pictures or anything to say that it is available in different formats or languages.

Both the survey results and interviews highlighted that one of the key challenges they faced was finding ways to ensure that people whose first language wasn't English and those with communication or cognitive impairments, learning disabilities or poor literacy were heard (see Appendices 4 and 6). This issue was mentioned by 11 staff members. In addition to this, 8 staff mentioned the difficulties around engaging people who are housebound, with complex health conditions or in receipt of end of life care (See Appendix 4).

> *"I think we could do more to ensure we hear a diverse range of voices. The majority of our service users will have communication needs. How can we make sure they have a voice? I think it's doable, but we need to find ways to do it."* **(Children's speech and language therapy)**

> *"Language is a massive issue. For example, with the FFT, when interpreters are in attendance at appointments, we sometimes leave and ask them to talk through FFT with patient when clinician isn't present, so that it's more impartial."* **(0-19 PHINS)**

> *"vulnerable/learning disability client group – often carers' voices not patient"* **(Community Dental)**

Several services said they would like to do more to involve more diverse communities. This included places where patient engagement is already well established such as the Neurology Rehabilitation Centre, who acknowledged that the majority of its Service User Carer Forum members are "white middle class".

Public engagement

The graph on page 11 of this report shows that there hasn't been a large amount of public engagement in the last year. Whilst talking to patients and carers about their experiences is key, engaging with the wider public is also vital to find out the views of people who aren't for whatever reason accessing services and highlight any potential barriers.

One example of good public engagement is the work that 0-19 PHINS have been involved with as part of the requirement of their new contract. They have commissioned Magpie, an external creative communications agency to find out people's understanding of health visiting and school nursing, what they would want from the service, information they'd like to receive, how they'd like to receive it, as well as any barriers to access. Magpie

have run insight groups with communities such as gypsy and travellers, asylum seekers as well as different geographic areas including culturally diverse, semi-rural and deprived areas.

Several of the staff we interviewed said that they recognise that it would be useful to do more engagement with wider communities other than those just accessing services.

Whilst the Trust does have around 600 'friends of LCH' who can be called upon get involved in things like PLACE inspections or judging staff awards, there is little else in the way of more formal volunteering. We also received feedback that the 'friends' (previously members) were not a particularly diverse group of people.

> *"We did use members in an interview process several years ago but the demographic (older men) wasn't really appropriate for our service."* **(Children's speech and language therapy)**

Recommendations

Ensuring that a diverse range of voices are heard should be a real priority at LCH, considering the wide range of services that the Trust provides, and the huge diversity of people who are its patients and carers. Many services are working with people who have disabilities, mental health issues, communication or cognitive impairments, or those who find it difficult to leave their home.

6.1 Staff involved in engagement should be systematically asking themselves questions about the needs and access requirements of their service users and carers and how engagement can be made accessible, attractive and meaningful.

Questions could include things like:

- Who are service user groups? Where do they live?
- Do they have any communication or language needs?
- Do they have any kind of disability or health condition that may require us to adapt how we do engagement?
- What is the best way of engaging with this group and how can we make it easy for them to have their say?
- Do our standard forms or methods of engagement work for all service user groups or do we need a range of approaches? For example, if the FFT question is really not appropriate (e.g. end of life care, police custody, young offenders etc) what questions can we ask that are more meaningful?
- How can we make our questions/engagement attractive (e.g. using more pictures) and easy for everyone to understand?
- How can we best hear from carers?

"Look to work with housebound patients as they still need to be engaged about our services, but it needs to be very different to our usual methods." **(Unnamed service, Adult Business Unit)**

Spotlight on Good Practice: Transgender health needs assessment

This was commissioned by Hertfordshire CCG to find out the health needs of the transgender community in order to influence local services. This piece of work was led by a transgender man and involved local Healthwatch, voluntary sector and the CCG. Key to this bit of work was that it was led by a transitioning man who gained the trust of the transgender community and was able to voice their concerns in their own language. https://youtu.be/3EZRr4J6_gk

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6.2   Look at developing a core menu of ways that patients can share their feedback and ensure these are consistently publicised. This should include developing the patient experience section of the website so that it can act as a portal for people to share their views and ideas.

Services, patients and the public should be clear what the options are and how they can access them. Ways of sharing feedback could include by text, online surveys, phone calls, comment cards, postal surveys, use of tablets in clinics, Apps etc.

"Could we have the conversation over a cuppa rather than a form, and ask how the service is going?" **(Neighbourhood team)**

"We could use smart phone links for carers who have the technology" **(Neighbourhood team)**

The patient experience section of the website should be developed so that it can act as a portal for people to share their views and ideas. It should be made attractive for patients, carers and the public and be in an easy to understand and accessible format. People should be able to look at the pages and understand why they should share their views and know what will happen with the information they submit. There should also be information and links to other ways people can share their experience if they don't want to do it directly with LCH. This could include links to other places they can leave feedback such as Care Opinion or Healthwatch.

6.3   Services should be looking at which groups of people are currently underrepresented in accessing their services and thinking about the best way to hear their views.

This should include asking about any potential barriers which could be addressed as well as asking for a totally fresh perspective on a service.

"Engage with diverse groups, who have no knowledge of how healthcare systems work. They may come up with new and alternative ideas". **(Musculoskeletal)**

Spotlight on Good Practice: Experience-based Codesign (EBCD)

This is an approach which uses the experiences of patients, carers and staff to redesign all or part of a particular health care process, to make it more efficient, safe and a better overall experience for both patients and staff. It has been used in many different settings and care pathways. The EBCD process starts by filming patients telling their stories and carrying out observations of routine care, to help staff to see the 'person in the patient'. Patients and staff then sit down and redesign services together, the focus being on designing the human experience and not just impersonal systems or processes.

Although filming patients is time consuming and resource intensive, experience shows that seeing and listening to patient experiences helps connect staff and is a persuasive starting point for change. The aim of the patient and staff interviews and observational work is to help patients and staff identify and jointly explore emotional "touchpoints" on the journey of care, with a view to improving these experiences. Touchpoints are interactions between staff and patients, both positive and negative, that both parties perceive as crucial to the overall experience of receiving or delivering care.

https://www.bmj.com/content/350/bmj.g7714

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7. Working with others

Findings

Working with other services both internal and external to LCH is key to developing good engagement practices. This is particularly important for people with complex or long-term conditions who have contact with multiple health professionals, as it helps to see the full patient journey. It is also a good way to share or pool resources and learn from how others engage with people, as well as potentially engaging with a much wider range of people. Working more with others was mentioned by 6 staff members as something that LCH could do to better engage with people (see Appendix 5).

"The CCG has involved a patient in some respiratory service development which has worked well. Perhaps [we need to be] working with partners to involve patients, as most pathways involve multiple services." **(Palliative Care and Neighbourhood Night Service)**

We found some pockets of good practice where this was happening already, for example with CAMHS who have been involved in things such as citywide crisis work and linking with young MindMate Ambassadors. Also, the Neurology User Carer Forum who are starting to do some work with the CCG on a piece of work to streamline neurology services across LCH and Leeds Teaching Hospitals NHS Trust. There was also mention of a citywide piece of work to seek views of end of life care.

"LCH is part of a citywide survey of bereaved carers seeking views on care delivered in the last days of life. This is being coordinated and led within the Leeds Palliative Care Network." **(Palliative Care and Neighbourhood Night Service)**

The Neighbourhood Team (West) told us about a partnership with the third sector and a GP practice which was enabling good informal conversations with service users and also enabling patients to tap into free transport.

"In Yeadon we have a good relationship with Otley leg club which is run by our staff in conjunction with Otley Action for Older People (OAOP) where it takes place, and Otley GP practice. There's a social and health promotion aspect to club, patients can come back as a member even after their leg healed, and it also has the benefit of transport from OAOP. We get some good feedback coming through there – if staff are hearing things through informal conversations (e.g. 'what's good about it? what could be improved?'), they will feed it back to us. It helps that patients don't have to feedback directly to our staff which I think would be a barrier for some." **(Neighbourhood Team, West)**

But there was also an expressed desire to do more of this kind of work both from this team and others, with some mentioning a key barrier being lack of time, as well as not having the necessary links or knowledge with both internal and external groups.

"Doesn't seem to be any central co-ordination of knowing what involvement is going on across the organisation. This makes it hard to know what's going on, to

link up involvement across existing groups. e.g. what groups do we have already in existence across trust that we can test an idea with." **(Communications and Engagement Manager)**

Within the Children's Business Unit, this is starting to happen with the development of a central youth forum which will be something that all services working with young people can tap into. There is a suggestion of having a parents' forum for children with complex needs which could give useful insights across multiple services.

"Parents of children with complex needs may have useful insights in terms of different services within LCH that their children use (e.g. school nurse, CAMHS, physiotherapy etc). A parents' forum within the Children's Business Unit could be a useful resource to capture those insights from those parents who have lots of different professionals for same or different children." **(Children's speech and language therapy)**

Challenges of working with others

Two services we interviewed told us about the challenges they were facing due to partnership working which is inherent in their services. Police custody, as well as having lots of challenges relating to the client group they are working with (patients often not in a good state of mind with varying levels of capacity and associated risk) are also required to fit into police guidelines. For example, they are often rushed by the 'police clock' as there is a 60-minute response time per person. There were also lots of restrictions around the environment and the fact that patients aren't allowed things like pens which could be used to harm themselves or others.

Children's speech and language therapy had a different set of challenges from working with schools where the majority of appointments for school age children take place. Because schools book appointments directly with the service for individual children, sometimes parents and carers are not notified about this, and they can than feel not engaged in the service that their child is receiving.

"Speech and language therapists tell schools to let parents know that we will be seeing their child in school, but this doesn't always happen. We have had phone calls before with parents upset because they haven't realised their child was being seen at school." **(Children's speech and language therapy)**

Another issue in this service was around FFT cards potentially not reaching parents or carers as they are sent home with the children and so are reliant on the child passing it on.

"We wondered whether school staff could do [FFT]... as teaching assistants work very closely with children. They attend therapy sessions with children and carry on working with them through the 12-week programme." **(Children's speech and language therapy)**

Recommendations

7.1 Do more to link with other local NHS trusts, community groups and relevant regional and national bodies to maximise patient voice.

It should prioritise being part of groups such as the Healthwatch People's Voices Group to ensure that LCH is linked in to what is going on citywide in terms of engagement, as well using it as an opportunity to learn from others and share good practice.

7.2 Look at ways of pooling and sharing resources more within the Trust so that better use can be made of existing groups.

The Patient Experience Team could develop a database of groups both internal and external that can be tapped into by services doing targeted engagement work.

7.3 Where working with others seems to present challenges (e.g. in services such as Police Custody and Children's speech and language therapy), LCH should think more creatively about different ways, times and people to seek feedback from.

For example, in police custody, it should be asking questions such as 'Is it the best time to seek feedback in this acute situation when someone has been taken into custody, or could we talk to patients retrospectively?'(e.g. people who have gone through the police custody system rather than those who are in it right now).

In Children's speech and language therapy, it could be that feedback from school staff working closely with children on their speech and language could provide useful insight and feedback, but also, are there simpler and more effective ways of engaging with parents, for example by text?

8. Monitoring and reporting impact

Findings

For engagement to be meaningful, it should make a difference and lead to the improvement of services. What happens as a result of engagement should be shared internally with service staff and leaders, and externally with people who have been involved in the engagement and the wider public. Where things haven't been changed as a result of engagement this should also be shared, and reasons given as to why.

> *"The focus should be on celebrating what's changed as a result of engagement – sharing the difference it makes to staff as well as patients is important."* (Neighbourhood Team)

Identifying outcomes

Only 31 (57%) out of the 54 staff who said they'd done some engagement in the last 12 months could clearly state what had happened as a result of the engagement. The remaining respondents either left this field blank or said that feedback was shared with their team or management but couldn't say what if anything had happened as a result. Four staff mentioned that one of the challenges they faced was that they felt that the public may feel that their voice doesn't make any difference (See Appendix 4).

> *"Service users don't often see what the outcome of feedback is. They often don't see what the point is and where there's any benefit to them."* **(0-19 PHINS)**

There were some good examples of reporting impact, particularly when engagement about service change had happened. Information about feedback patients had provided and what has happened as a result was published and made available through different media (e.g. social media, website, targeted mailings, quality accounts etc).

> *"With the Child Development Centre, we held two events once we had received all the feedback and invited everyone on the caseload so that we could share what was happening as a result. The invitation letter to this event included a link that had information about 'you said, we did' relating to the move, and what the next steps were. We held one event at St James (old site) and one at Reginald Centre (new site), and also took them on a bit of a tour around the Reginald Centre. We had interpreters there on the day. We also supported the team around communicating the move itself to all referrers, partners, and the public"* **(Communications and Engagement Manager)**

Some services we spoke to said they put up 'You said, we did' information in waiting rooms (Health visiting, Podiatry, Continence, Urology and Colorectal Service) or made online posters to be shared in Facebook parents' group (CAMHS). Others said they reported changes back through a service user newsletter (Podiatry), service user meetings (Community Neurological Forum, CAMHS) or directly to focus group participants (Podiatry) or individuals if appropriate (Neighbourhood Team). However, reporting outcomes wasn't routine or consistent across services.

Effectiveness of Friends and Family Test

Regarding monitoring and reporting of FFT, the focus is very much around response and recommendation rates rather than any of the more qualitative feedback given by patients in the comments boxes. The response and recommendation rates are what is reported in the Quality Accounts and what services told us is fed back to them. Lots of staff told us that any comments just sit on the MES system and/or are difficult to access once on there because their clinical staff role means they are not given access. Others also felt that the way the FFT is structured is quite restrictive and doesn't really allow much meaningful feedback to be gathered.

"At the moment we get feedback from patients, but a lot of it just sits there on the system and we don't do anything with it. We deal with it if we have an issue, but don't have the time it takes to analyses data/collate info, themes and trends and feedback." **(Podiatry)**

"At the moment I'm photocopying all the forms (patient satisfaction and FFT) before I send to the Complaints Claims and Patience Experience Manager, as once they're gone, we don't have access to the comments section (the useful bit), only the FFT statistics." **(Community Neurological Rehabilitation Centre)**

"FFT doesn't give us much feedback that is tangible or that can be acted on." **(Children's speech and language therapy)**

Sharing with staff

Most services said that any feedback and actions taken as a result was shared with staff at team meetings. Some staff said that compliments were inputted on Datix, others mentioned inputting them into ESR, System 1 or Elsie. Podiatry mentioned that compliments were shared in a 'shout out' section of their weekly staff bulletin, and one of the Neighbourhood Teams mentioned a notice board in the staff room where they could be shared.

System for capturing engagement work.

Five staff members we spoke to said that they wanted a clearer and more systematic way of capturing the engagement work that is going on. One person suggested that if different reporting requirements were in place, then there could be more focus on monitoring outcomes and impact.

"Are we reporting on the right things? In each business unit, there is a performance meeting that feeds up to board. There's only one question about people's views asking for FFT numbers and recommendations. No question like "what was the last thing that changed as a result of feedback?" – something like this would be a prompt for people to prioritise it and could be used as an opportunity to share good practice within the business unit." **(Neighbourhood Team, West)**

Recommendations

8.1 Develop more outcomes-based reporting mechanisms for services including questions which focus more on changes made as a result of engagement.

These could be things like:

- Give one example of how patients, carers or the public have had their voices heard and influenced change in your service in the last 6 months
- What plans do you have for the next 6 months to enable patients, carers or the public to have their voices heard and influence change in your service?
- How have you fed back what you found out and any changes that were or weren't made to the people involved in the engagement and/or the wider public?

Services could also be asked for photos or images that complement this reporting and could be used to share and celebrate any good practice that is happening. Reporting should be made easy for staff and incorporated into existing mandatory reporting mechanisms. This data could then be collated into regular updates to be shared with both the Board and all services.

Spotlight on Good Practice: Leeds City Council Children's Services

A successful model of monitoring and reporting is employed by Leeds City Council Children's Service's Voice and Influence team who produce bi-annual summary reports of all the children and young people's voice and influence activities happening in both public and third sector organisations in Leeds. This is then shared with Children and Families Trust Board and with all individual organisations who are part of their network of services working with children and young people across the city. An example of one of their repots can be seen here: https://breezeleeds.org/haveyoursay/Documents/Citywide%20VIC%20CYP%20Report%20April%20to%20September%202018.pdf

8.2 Consider the use of quality intelligence systems whereby data from any kind of engagement is collated and analysed regularly. This data could be fed back to relevant individual services, as well as used to drive quality improvement and learning.

It should include all patient feedback, whether from complaints, concerns, ongoing engagement activities, engagement about service change, FFT, or from external organisations such as Care Opinion rather than different types of engagement data being considered in isolation.

"They [central team] could proactively encourage people but encouragement needs to come from both central team and management performance – they need to dovetail." **(Neighbourhood Team)**

Next Steps

Following our report, we would like to hear from LCH about any steps they hope to take to develop engagement with people and would be happy to support them do this where we can. We have already agreed to attend their 'Patient safety experience and governance' group and would also be happy to meet up with key engagement roles to review how things are going.

Thank you

This report has been written by Harriet Wright, Community Project Worker at Healthwatch Leeds.

Thank you to Steph Lawrence for helping us co-ordinate this piece of work within LCH. Also thank you to all the staff within LCH who took the time to share their views and experiences via both our survey and the face to face interviews.

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Appendix 1- Online survey questions

Healthwatch Leeds has been commissioned by Leeds Community Healthcare NHS Trust (LCH) to find out how it is involving and engaging with people (patients, carers and the wider public)* who use or have an interest in this service. This questionnaire is for service leads or staff who have a key role in engagement to complete to help us build a picture of what is working and what can be improved. Any information you share with us may be used in a report which will be used to help shape engagement across LCH.

*for the purposes of this survey we will use the term 'people' to refer to patients, carers and the public.

(1) In the last 12 months have you done any engagement with people?

Yes/No/don't know

If no, what would you say the reasons for this are? (go to question 10)

(2) If yes, please tick the type of engagement you have done (tick all that apply)

	Who you engaged with		
	Patients	Carers	Public
Designing services with people			
Working with people to make decisions about their care			
Evaluating services with people			
Seek feedback about what works and what could be improved about your service			
Working with people to deliver services			
Involving people in proposed changes to your service			
Other (please state)			

(3) Have you done any targeted engagement work to hear the voices of groups of people with the following characteristics (tick all that apply)?

- Children and young people
- Learning disabilities
- Physical disabilities
- Sensory impairments
- Mental health issues
- BME groups
- LGBT
- Other (please specify)

(4) Can you give one example of how you have enabled people to have a voice and influence your service in the last 12 months?

(5) What happened (if anything), as a result of this?

(6) Do you have any plans for future engagement with people? Yes/no

If yes, please give details

(7) In your experience, does involving people make the services they receive better? Yes/no/don't know

If yes, what do you think is made better?

(8) Within your service, do you have a lead person whose responsibility it is to lead on engagement?

Yes/No

If Yes, please give details give their job title and how engagement is part of their role

(9) Please tell us about any other resources to carry out engagement work?

(10) What, if any do you see as the challenges/barriers to good engagement with people?

(11) What do you think LCH could do better to engage with people?

(12) Please use this space to tell us anything else about how LCH engages with people.

(13) As part of this work, we will be arranging a time to meet/talk with some service leads for about half an hour during February 2019 to get a more in depth picture of how LCH engages with people. Please provide us with your contact details to enable us to do this.

Name:

Service:

Job title

Tel:

Email:

Best days/times to contact you:

Appendix 2- Survey responses by service and business unit

Business Unit	Service:	Number of responses
Children's	Children's business unit (service not specified)	1
	0-19 PHINS health visiting and school nursing	2
	CAMHS	7
	Children's speech and language therapy Service	1
	School Immunisation Team	1
	Total	**12**
Adults	Adult business unit (service not specified)	3
	City wide services	1
	Clinical Education Team (Neighbourhood Team)	1
	Continence, Urology and Colorectal Service	1
	Health Case Management Service	5
	Neighbourhood Teams	9
	Palliative care and neighbourhood night service	1
	Pharmacy technician	3
	Wounds Prevention and Management Service	1
	Total	**25**
Specialist	Community Dental Service	2
	Community Diabetes Team	2
	Community Neurological Rehabilitation Service	1
	Dental/ TB/ Gynae / Homeless Admissions Leeds Pathway (HALP)	1
	HMPYOI Wetherby	1
	IAPT	1
	Leeds Sexual Health	1
	Long Term Conditions	2
	Musculoskeletal	3
	Podiatry	2
	Police Custody Suites	5
	Spinefit Musculoskeletal	1
	Total	**22**
Service or Business Unit not specified		1

Appendix 3 – Survey data: Current examples of engagement and plans for the future

Service Name	Please give ONE example of how you have enabled people to have a voice and influence your service in the last 12 months?	What happened (if anything), as a result of this?	Plans for future engagement
0-19 PHINS health visiting and school nursing	Face to face anonymous questionnaires in public settings as part of NHS 70		New 0-19 service involves marketing research and engagement with service users.
0-19	Focus group with young Fathers.	Changes to practice, pathway development	young parents, Learning Disability Get me Better group, more young fathers, young carers
Adult Business Unit	Working with a carer and the formal complaint process enabled clear feedback to be received by the service	A comprehensive improvement/action plan was completed making changes to clinical practice and processes	Gaining more feedback during visits of what is going well and what can be improved
Adult Business Unit (service not specified)	Otley leg club volunteers	They are part of the steering group	
CAMHS	Recruitment of staff	Influenced who was appointed for the job	Crisis service design and review; input into new build, learning disability intervention plan, continue with looking at chi-experience of service questionnaires and Friends and Family Test, outcomes in clinical practice
CAMHS	Involvement in interviews for staff		Service development, recruitment.
CAMHS	Reviewing feedback from parents and young people with groups of parents and young people to determine what action can be taken in	We improved information on letterheads and website and are developing clearer displays of how we respond to feedback	To continue reviewing feedback to improve services. This one example, but there are many others.

	response to improve services		
CAMHS	Patient participation group/parents' group	Feedback sent to management and care team / then nothing,	
CAMHS (inpatients)	Organised workshops regarding new build	young people attending and shared ideas	
CAMHS Outreach Service	Qualitative patient feedback forms for young people to complete, share experiences and make comments about how service could improve.	Themes from feedback fed back to team manager and action taken (e.g. to improve leaflets)	Updating team leaflets to include issues raised by young people, involving young people directly in formulation of their needs.
CAMHS Little Woodhouse hall	I meet up with young people on a regular basis to talk about service improvement. I meet with parents once a month.	I feedback young people's feedback to management and our team. To be honest I struggle with getting feedback from management so I can't always action change.	Care plan changes, young people would like to do a video of the unit, make the website more young people friendly
Children's Business Unit	Young people from CAMHS designed a guide around a service they accessed.	Published, now in use and available on the Leeds CAMHS website	Trust youth board due to start, first meeting of steering group Jan 2019
Children's speech and language therapy Service	Interview participation - young person and parent, plus other professionals outside of the service.		Engagement of parents/carers with appointment booking in schools/settings; designing leaflets, further interviews
City wide services	Always event		Awareness day
Clinical Education Team	By tailoring a service to a patient following specific feedback.	Service to patient was changed	Continuing development of service
Community Dental	Questionnaire, focus groups	The assessment centres from two areas went ahead and no complaints came in	focus groups around closing two sites
Community Dental	Patient feedback forms	This work fed into the estates review	Further patient consultations in line with the estates review

Community Diabetes Team	Developed a reasonable adjustments programme for people with Learning disabilities.	This is to be trialled this quarter	We plan to run more focus groups
Community Neurological Rehabilitation Service	We have a Neurology User Carer Forum meeting every 3 months where staff, patients and carers are invited to attend for training and news on updates within the service and the trust	Patients are asked to give their feedback at the planning stage rather than when changes have been implemented	Continue with Neurology User Carer Forum
Continence, Urology and Colorectal Service	Patient awareness day held Always event, and involved with questionnaire to understand level of rectal stump dysfunction. We also complete patient survey and action you said we did from feedback	Ongoing you said we did, Rectal stump has resulted in research being started and article in GI. Newsletter from service	With research to refine questionnaire, Patient feedback via staff survey. Newsletter and ask patients to write articles for it
Dental/ TB/ Gynae / Homeless Admissions Leeds Pathway (HALP)	Patient questionnaires	Changed clinic sessions	Public consultation r.e. Estates
Diabetes	Feedback forms		
Health Case Management			planning stage
Health Case Management	Feedback form		
Health Case Management	Service user visited the team to talk about their experience of Personal Health Budgets and how this has improved quality of life. The patient shared their own experience and what matters to them.		Recently identified engagement champions, looking at how we can increase patient/care feedback

HMP Young Offenders Institution Wetherby	Getting young people involved in the development of the Healthcare Induction, by the use of Peer Mentors to deliver the session.	Better engagement from patients during the session.	I will be conducting Patient Forums working in connection with other services (Camhs)
IAPT	Attended service user group to seek views on proposed new approach to patient safety	Incorporated feedback and made some amendments	Seek volunteers to co-produce new service model
Leeds Sexual Health	Survey around opening times on a Saturday	Trialling a change to opening times on a Saturday	From responses to a survey carried out in September
Long Term Conditions	Provide choices, feedback on questionnaires	Changes to service	
Long term conditions, Cardiac Service	The service ran a new type of exercise rehabilitation course for lower functioning patients and because the process was a pilot there was a lot of patient consultation and evaluation of the programme.	Small revisions and then a full roll out of the new programme	
Musculoskeletal	Via concern/complaint/incident route	Change in process as a result of investigation	No firm plans - service looking for new involvement lead/team for 2019
Musculoskeletal	Would people be willing to pay for acupuncture treatment.	Not persuaded.	First Contact Practitioners evaluation in conjunction with Keele University. National research project.
Musculoskeletal	Using the patients and friends questionnaire		In the process of taking on the Patient Involvement Lead for Musculoskeletal
Neighbourhood Team	We only send out the surveys to patients	The comments are sometimes shared with the team, but nothing is changed due to this.	Set up a group to decide what we need to do to engage people
Neighbourhood Team	I took part in Thea's 50 voices Group		

Neighbourhood team	I refer them to our enablement team	they assess the patient and if appropriate teach them how to look after their own care	As a Neighbourhood Clinical Assistant it is part of my role
Neighbourhood team	Patient sitting for a long time, supplied a Harvest cushion and checked they are using it to prevent further damage	further deterioration to skin	
Neighbourhood team	Visiting and listening to a patient after a verbal concern raised	Review service delivery to meet the needs of patient and family	Review outcomes of patients through patient feedback
Neighbourhood Teams (West 2)	Responding to feedback - informal concerns as well as formal complaints	Feedback to staff, training, reassessment of care, further communication/explanation to family	Engagement with people via Neighbourhood Networks to broaden feedback from what is received through FFT.
Neighbourhood team	Encourage people to complete feedback forms on our service.		Face to face patient care
Neighbourhood team (Kippax).	Help facilitate Friends and Family Tests to be sent out	Feedback given to senior management team	Commencement of Linsey leg club.
Palliative care and neighbourhood night service	LCH is part of a citywide survey of bereaved carers seeking views on care delivered in the last days of life. This is being coordinated and lead within the Leeds Palliative Care Network.	Awaiting results	
Pharmacy Technicians	Not consulted patients and carers, but other pharm techs have been consulted as to how the service should be run	Adapted mobile working to be appropriate for pharmacy technicians	
Podiatry	Focus group for developing website	Patients' views recorded and fed into the website development group	
Podiatry	Diabetic foot workshops	Reinforced the notion of lack of	

		awareness that staff perceived, and began to address this.	
Police custody			Process being set up
Police custody	Difficult to engage with patients within the custody setting		
Police Custody Suites/ Specialist Services	I always document views and opinions expressed in clinical notes, and what I have explained about ongoing care. This has helped quickly resolve a complaint made	The complaint was quickly responded to and resolved	
Police custody - Custody Nurse	Supplying patient complaint forms and changing systems that were not delivering care	Systems changed to meet patient needs	
School Immunisation Team	Meet and greet sessions in schools	Adapted the way the sessions are run to meet the needs of the service and the school. This ultimately improves the experience for the young people	Gaining feedback regarding the new E-consent programme
Spinefit Musculoskeletal	Friends and Family Test	shared with team and individuals	
Wounds Prevention and Management Service	New patient leaflet feedback from focus group	Feedback contributed to the design of the leaflet	
(Service name not given)	Discussed options for care		
(Service name not given)	Palliative care provision	Good feedback	Frontline care

Appendix 4 – What do you see as the challenges/barriers to good engagement with people?

Issue	Number of respondents mentioning this
Time (clinical workload, waiting list pressures, difficult to make it a priority, external pressures from police service in Police Custody)	25
Making engagement accessible regardless of language spoken, communication needs, cognitive impairments, literacy levels, learning disability etc.	11 (see table below for breakdown of this number)
People's complex health conditions including end of life and being housebound	8
Resources (including funding, budget for expenses/refreshments, resources to run focus groups etc)	8
Expertise, training or more support to share best practice needed	6
Public may feel that their voice doesn't make any difference, lack of clarity on how feedback is being used	4
Nature of the service means people don't want to engage (Police custody, Wetherby YOI, IAPT)	3
Friends and Family Test (too much focus on response rates and doesn't ask the right questions)	3
IT/can't access systems where feedback is held	3
Lack of consistency across service/Trust	3
Getting other staff on board / lack of support from management	3
Restrictions due to working with partner agencies (Speech and language therapy working with schools, Police Custody working with police service, HMP Wetherby YOI working with the prison)	3
Information governance (unable to send text messages to ask for feedback)	2
Not knowing what to do with feedback, or being able to take action in response to what people say they want	2
Some of the feedback isn't constructive enough to allow changes	2
Having to ask patients to fill in a lot of forms at once	2
Levels of capacity due to intoxication, withdrawing or mental health and state of mind of patient and associated risk to staff (police custody)	1
Culture of engagement not there in LCH	1

Making engagement accessible: break down of numbers	
Literacy levels	1
Cultural/language barriers	3
Cognitive issues	2
Communication or hearing impairments	4
Vulnerable or learning disability voices often not heard	1
Total	11

Appendix 5 – What do you think LCH could do better to engage with people?

What LCH could do better	Number of respondents mentioning this
More staff time and resources dedicated to engagement (e.g. budget to run focus groups, pay travel expenses, staff time to analyse, collate and display patient feedback data)	9
Digital/online solutions to facilitate better engagement (e.g. have online feedback and discussion forums, online surveys, service specific social media platforms, use of tablets)	8
Dedicated staff available Trust-wide to provide advice, support and resources around engagement, and look at how barriers to engagement can be overcome. Also, to raise awareness and celebrate what's gone well.	7
Working together better across the trust and externally with partners groups and services outside the trust (e.g. other NHS Trusts, Healthwatch, community groups etc). Help to capture whole of patient journey not just one aspect of it	6
Arrange engagement events/focus groups/service drop-ins/roadshows, but not just with people who have a specific or vested interest	6
Make engagement a focus across the organisation so all staff know it's a priority and a routine part of services. All management should take it more seriously and help with changes.	6
Share and raise profile of good work that is happening regarding engagement.	6
Have patient experience fora or pool of people (either within service or centrally that service can tap into)	6
A clearer and more systematic way of capturing the work that is going on	5
More types of engagement including by phone and text and face to face	5
Look at increased presence in community venues and inner-city areas	4
Let services change the satisfaction survey questions or expand on FFT to suit their patients/better forms	3
Think patient engagement is very good/we're doing all we can	3
More opportunities for service users to be on interview panels for frontline staff	3
Listen to what patients and carers have to say about what that patient really wants	3
Make it more service related (e.g. housebound patients)	3
Have more focus on changes made as a result of feedback combined, rather than separating it into complaints, FFT, engagement. People need to be kept informed about what changes as a result of their feedback.	2

More involvement of patients and families in investigation of complaints and serious incidents	2
Re-establish Involvement Champions in all services and hold Involvement Champion forums	2
Have an easy to use framework to measure ourselves against	2
At every service change/development ask patient what they think.	2
Offer volunteer opportunities	2
More awareness of the difficulties faced by some services to engage with particular client groups	1
Correct shortfalls of staff	1
Be more open to shaping/changing service delivery	1
Talk about engagement at every meeting we have	1
Look externally into how other businesses engage with the public.	1
Be creative with engagement	1
Make forums open to all staff to attend at some point in the year - staff view can be relevant	1
Improve communication techniques of staff	1
Give patients more responsibility for their care	1
Staff should be accessible to patients and carers	1
Opportunity for people to come and see what a service does and get a better understanding of how the service works. We get better feedback if people have a good understanding of the service.	1
Don't know	6

Appendix 6 – Interview write ups

Name of person:	Thea Stein
Job role:	Chief Executive
Contact details/ best way to contact you:	Email: theastein@nhs.net Tel: Bridget (PA) 0113 220 8503

Do you feel that engagement with people is currently embedded within LCH? If yes, how? If not, why not?
Yes and no. Yes, I don't think that clinical staff don't think about engagement and how the public want to be involved in their care, and there's some outstanding work. What isn't embedded is a system and process for engagement so that good practice can be shared. There isn't a real framework there, or way for me to demonstrate that the engagement is happening.

Do you have any written plans/policies around engagement with people?
No, there's bits and pieces. Our Vision, Values and Behaviour are all about that. We always listen and learn. There are two types of engagement – involvement of the patient in their care and wider service involvement around shaping how services work. At the Trust, we already have a strong focus on the first type - health coaching which we are championing, where patients are put at the centre of their care. It's about having a different kind of conversation and changing the way that staff interact in with patients to involve them in their care. Regarding wider service involvement, we're also doing lots of good work but it's more difficult to find out what a particular service is doing in this area.

What do you see as the existing challenges/barriers to good engagement with people?
I don't think there are any barriers to how clinicians interact with individual patients and involve them in their care. Regarding wider service engagement I think there is a capacity and headspace issue - If clinicians are trying to do clinical work, that will always be the priority and wider engagement needs more thought. So how do you get anything beyond a tick box survey for example? There needs to be a central resource which people can call in for support, for example, that sits within each business unit. One of the reasons why children's services do better regarding engagement at LCH is because they've got Chris Lake, whose job is to co-ordinate it.

Can you give any examples of how people's voices have been shared at board level?

We always have a patient or carer story at each board meeting, or someone to give their story if they can't be there. It helps to remind us what we're there for.

Board members are always in attendance at big consultation events – e.g. the recent one about the eating disorders and the new CAMHS inpatient unit. With regard to anything about service development, the board papers would include details of how patient voices had been heard.

As well as these more structured ways, there are unstructured ways when board members are out and about visiting services, where they'll talk to patients. The majority of board members do this. It's hard to get the views of elderly people or others who find it difficult to get out of the house.

It's really hard to do anything at board level that looks like you're not just ticking a box. The board also has to cover its business within the meetings. The way we're doing it at the moment is only one person's story. We could show films – this could allow more patient voices to be heard. It feels that engagement is easier in hospital trusts, where staff/board can just go onto the ward and talk to patients. It's really difficult bringing people together within a community trust because of the nature and wide range of services. I would love to bring more patient voices into our work and to the board at a more meaningful level

What would your vision be of what engagement with people within LCH would look like in the future?

A clearer and systematic way of capturing the work and hearing about the good work that's going on. It would feel that it would be impossible for anyone to realise that the patient was not at the heart of everything we do. It's about really understanding what patients want, what's wrong with what we do and what's great about what we do, and this may mean that we have to break a rule and change things. We're in a good place to take things forward – our workforce really cares about patients.

Some people maybe a little bit defensive in exploring with the public about what they want but we're there to service the public, they're not there to fit into our patterns. I want staff to feel free enough to respond to ideas for change and know that the Trust will have their back. In some ways, the culture is currently quite conventional. If demand for change is there from the public, we want staff to know that our culture is to listen to that and respond, and that's there with backing from Board.

Any other comments about how LCH engages with people.

I want us to be in much more constant informal dialogue with the public and this is very difficult in a community trust with the geography we cover. Want to be more creative in listening and understanding and for people to know how important this is to us.

Recognition for good patient involvement is also important, to recognise those areas/services that are excelling. It's important to celebrate those achievements.

Name of person:	Ian Lewis
Job role:	Non-executive director
Contact details/ best way to contact you:	Email: Ian.lewis1@nhs.net Mobile: 07768646227

Role and background

Has been non-executive director for LCH for 18 months. He is a retired doctor, previously a Consultant Paediatrician in children's oncology at LTHT, and then Executive Medical Director at Alder Hey Hospital. He also co-chaired the Children and Young People's Health Outcomes Forum – an independent group of professionals, third sector leaders and public representatives, who advised the government.

As well as sitting on the main board, Ian chairs the Quality Committee which seeks assurance that there is quality, safety, and excellence in patient care. This includes patient experience and involvement. The Quality Committee comprises 3 non-executive directors (all independent), Director of Nursing, Medical Director, and CEO. Also in attendance are the Director of Operations, Clinical Director and Clinical Leads of the three Clinical Business Units.

Do you feel that engagement with people is currently embedded within LCH? If yes, how? If not, why not?

"The intention is there, yes, but we're not there yet." The engagement Ian has seen has been formal in the form of a presentation of patient stories at board meetings. It's not intrinsic within the organisation and doesn't feed through to board level. Feels that it needs to be more powerful as currently it is not clear that the strategic direction is driven by patient experience (not to say it doesn't influence it). Strongly believes that people's voices should not be tokenistic - feels that this is a shared feeling on the board so would not want to go down the route for example of having a token service user on the board. Of the three business units at LCH (children, adult and specialist), he has the impression that more good practice around patient experience is coming through from the children's unit.

Engagement does happen at LCH some of which is excellent in particular services but, it "is patchy rather than across the board." He felt there was, "no clear picture coming through." Would like to see LCH capturing information better, explicitly and implicitly in the best way possible and in a meaningful way.

Do you have any written plans/policies around engagement with people?

Ian provided us with a brief report on patient engagement from Quality Committee meeting dated 24th September 2018 which covered how LCH participates in and encourages patient engagement in services and fulfils regulatory requirements. Not sure whether there is an actual strategy around patient engagement.

What do you see as the existing challenges/barriers to good engagement with people?

Needs to be given the resource and time, recognises it's not easy and would require an element of training. Engagement is not necessarily an intuitive process – it needs thought and planning. When engagement has happened well, it's happened as a consequence of good leadership.

Engagement with adults seems to be a harder process than engaging with children. Saw good practice around engagement with children when working at LTHT and Alder Hey.

Feels that LCH could benefit from mentorship to improve how patient voices inform direction and co-production of services etc. The challenge is how to avoid tokenism and do engagement meaningfully.

Can you give any examples of how people's voices have been shared at board level?

The formal board meetings start with patient stories, but patients are not always there in person. When this happens, a clinician will tell their story, using their words, but it's more powerful coming from the patient themselves. There are 6 formal board meetings per year (and 4 workshops) with patients present at about half of these to tell their story in person. Members of the board can and do ask patients questions. But we need to make sure that it's not tokenistic and that patients get proper feedback about the issues raised.

Feels they are a strong board, being corporate and supportive. They are patient driven and want to bring people's views to the board and use the patient's perspective when asking questions. However, it's not intrinsic - the ethos is there but it's not written down – it's "ripe for improvement".

The board is open to the public but unsure how it is publicised (website?), and very rarely attended by members of the public. Not sure these meetings are the best or most useful place for a patient to attend because the board use a lot of jargon unfamiliar to the general public and items on the agenda tend to be lengthy. The AGM is better attended by members of the public, it's in a more accessible format and is advertised in the local press.

Perhaps there are better, more meaningful ways of engaging patients at board level for both patients and the Trust. E.g. 'meet the board' sessions, having patient forums and hearing from these at the board.

What is the best way of representing patients in the work of the Quality committee? Direct input? Healthwatch being part of it? We sometimes hear the same patient story at Quality Committee as we've already heard at the board – not sure if this is a good use of time. Would be better to have more variation.

Children's takeover of the Quality Committee is being planned for April.

What would your vision be of what engagement with people within LCH would look like in the future?

"Taking the views of the patients into account at all levels and building on existing services to meet their needs."

"I'm aware that LCH is only part of individuals pathways' which often include hospital services, primary care and social care, so it's important to influence both our own services but also use that information to share with partner organisations so that we're not working in silos."

Ian would like to see more patient and family involvement in the process when things go wrong (or right). Teams would be thinking about a patient's particular experiences and pathway through services and lessons learnt and using this to help design pathways and systems. It would also inform the strategic direction.

Any other comments about how LCH engages with people.

LCH is not a Foundation Trust and reports and is accountable to NHS Improvement/ NHS England who recruit the Chair. Executive Directors and Chief Executive are appointed internally by the LCH Board. Feels that a Foundation Trust structure makes an NHS Trust more accountable to local people, who can become members and governors.

Part of a non-executive director's role is to try and talk to patients when they are out and about to discuss their experiences. Some do it more than others, some don't feel as confident. Perhaps something is needed to reduce this barrier.

Name of person:	Stephanie Lawrence
Job role:	Acting Executive Director of Nursing
Contact details/ best way to contact you:	Slawrence6@nhs.net

Do you feel that engagement with people is currently embedded within LCH? If yes, how? If not, why not?

No, not overall. Engagement is embedded in pockets, but I couldn't tell you what engagement is going on or where's its happening. There's no central oversight or any formal mechanisms. Support is required to develop this. Feels that LCH are not using patients to their full potential. "information from patients could be utilised better."

Do you have any written plans/policies around engagement with people?

Nothing at the moment, but a new Patient Engagement Lead has been appointed. They will be writing a strategy for the direction of travel and the operational roll out.

What do you see as the existing challenges/barriers to good engagement with people?

I think staff find it a bit scary and feel intimidated by the perception that patient's expectations might not be realistic (particularly around the planning of new pathways and services). There's still bits of the culture of 'clinicians know best' and also the fear that what patients want may not be deliverable within a service and that it raises patients' expectations. Also, possibly the fear around, "What if patients ask me something that I can't answer?"

Time to properly engage and to explain to staff and patients what it means for them can be a barrier.

Steph receives complaints and investigates serious incidents but feels that LCH doesn't involve patients and families enough in this. Feels that they should be part of the process if they want to be. Although LCH enacts it's 'duty of candour', and apologises where something has gone wrong, it feels as though this is sometimes just paying lip service. She wants to know more about what patients want to see happen as a result of an incident, but believes staff are frightened of this (in case something they say may result in action or a claim, or because of feeling guilty).

Main challenges - staff time and fear.

We need to address fears by education, training and leading by example, show people it's okay to be open and honest, and share how things happened in practice.

Can you give any examples of how people's voices have been shared at board level?

At the board meetings we always start with a patient story. If a patient is unable to attend, a member of staff will have liaised with them and they will present to the board. Although it feels a bit tick box, it helps to make sure the board understand LCH services better and how it feels to receive care under LCH. For example, a young CAMHS patient shared their experience at one board meeting and this was really powerful. The quality varies, and it can be very last minute. Sometimes patients can't attend due to other circumstances and it has always been very rigid about when patient can share their story (9am is no good for parents who have to do school run!). Need to be more flexible. Steph would like to see a bank of patient stories which could be presented in the event of circumstances changing, and patients not being able to attend. Currently no guidelines or information for patients about what to expect when sharing their story at the board meeting.

What would your vision be of what engagement with people within LCH would look like in the future?

I want to see engagement at every opportunity – whenever there is a change, review or new pathway; when there is a serious incident or complaint as well as in general routine delivery of care. Friends and family test (FFT), which we have to do, could be expanded on and made more meaningful as they don't currently do much with the collated information to provide feedback to patients. They have just started to go back to individual services with information from the comments box on FFT, and are thinking about a 'you said, we did' section on website.

There needs to be a real focus on patient experience from board level to frontline and vice versa, and more patient voice is needed at the Quality Committee (this could be a patient or someone like Healthwatch to give additional challenge).

It would be good to have more patient presence on the recruitment panels for frontline staff e.g. CAMHS currently has young people on their panels.

Wants a more joined-up process. There are pockets of good work but it's not consistent.

Any other comments about how LCH engages with people.

In Dec 2018, we had a workshop for staff interested in patient engagement (Involvement Champions and others). The focus was on what people wanted to see in the future. This will now be a quarterly forum for staff to understand what's going on, the support and the services involved.

There was previously an awards system (Involvement Standards) for engagement implemented when Engagement Manager Em Brown was in post.

Name of person:	Sam George
Job role:	Communications and Engagement Manager
Contact details/best way to contact you:	samantha.george6@nhs.net Mob : 07949102413
Role and background	

Focus on service changes that are happening in the trust. Role came into post 18 months ago. Before I was in post, Em Campbell did a wider engagement role including Involvement Champions, all service change engagement work, engagement with members (now friends of LCH), links with volunteers, the Trust charity etc. When Em's post was de-established and I got service changes element, some elements haven't fitted under the remit of a specific person/role. Although we have all still tried to keep moving things forward, it's not necessarily been someone's dedicated role and I feel some of the elements haven't been a priority. My role was originally two days a week and as of September last year, three days a week and a much more specific role.

I sit in Communications Team. If a proposal comes in and team wants to make a change, e.g. change of opening times of clinic, location, pathway etc. We look at the proposed change and what engagement/consultation would need to take place. We put ideas down in brief, put it forward to senior management for approval and the service does an equality impact assessment. If approved, we go forward working closely with the service and undertake the work.

There haven't been any formal consultations since I've been in trust, just engagement and involvement projects where I give advice to teams and support with any of the stakeholder engagement which falls out of this. If it is what is classed as significant change which will have a big impact, we would do a formal consultation (12 weeks, and also consult with Overview and Scrutiny Board involved and strict regulations to follow in terms of consultation).

If there's big changes to the service, if LCC or CCG commission service – they usually do consultation work initially – then change the contract in light of the consultation. As a provider it's more localised changes we're involved in, this has been my experience at the trust in the last 18 months anyway. Bigger changes currently seem to happen at a commissioner level.

If we are going to go out to engagement, Sam's job is to support the stakeholder engagement, produce reports and briefings to the overview and scrutiny committee, support and advise the service, produce the communications materials which are required for the engagement.

Head of Comms Jane Murphy (sits under Thea, CEO), works alongside Sam Prince (director of ops) so things are fed up to Board level that way.

More recently Tracey has joined Sam as a job share working 3 days a week to support the communications team.

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

Child development centre – wanted to move from St James Hospital (SJUH) to Reginald Centre. Reason for move was that building at SJUH wasn't fit for purpose. Put forward proposals to the public for feedback, held meetings. At clinics, people were encouraged to fill in surveys. We received comments from 78 people including patients, carers, referrers (such as a GP) and members of the public.

Engagement is always led by the service. Sam's role – more an advisory role, e.g. how to run the meetings, focus groups, online survey etc. Service carries out the consultation itself and gather the results – look to see what people said and what we need to change or what we can provide as a result. We help by providing literature, supporting teams to develop a communications plan, key messages, making information understanding and accessible, supporting team to create stakeholder maps, access to our social media channels , working with the media - putting info in newspaper/ or responding to media enquiries, stakeholder engagement with partners and overview and scrutiny committee, advertising the opportunity to have your say across our corporate channels and partner communication channels etc. We would also respond to any councillor enquires about the service change. Can guide them a little bit around questions, all responses go directly to the service.

Building new CAMHS inpatient unit at St Mary's Hospital site - worked closely with Chris Lake to get feedback from young people on plans, interiors etc. this was following a public engagement event where we showed people plans for the build and asked things like 'what do you like/don't like?'.

Sam attends these engagement events. About 60 people attending CAMHS event. Lots of people who attended wanted to know wider implications of the build on St Mary's site.

Health visiting and school nursing merging. New service where 'ChatHealth' where YP can text in. Sam has asked Chris to run new literature past young people and families to ensure its accessible and understandable. There's a lot of engagement work required with key stakeholders for the new 0-19 service, explaining to key referrers about the service, changes, support available. Gaining insight about current perceptions of the service. Explaining to the public about the new service. Working with commissioners, working with the Third and voluntary sector. We are working with the service to develop the communications plans, create the communications materials to support the role out of the new service. Building positive reputation of the new service, increasing understanding, promoting the new service.

We've also supported the Community Dental Service in Leeds to gain feedback on the service they currently receive, explaining how the service want the service to be in the future and explaining the results of this in running a pilot service.

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?

With the Child Development Centre, we held two events once we had received all the feedback and invited everyone on the caseload so that we could share what was happening as a result with them. The invitation letter to this event included a link that had information about 'you said, we did' relating to the move, and what the next steps were. We held one event at SJUH and one at Reginald Centre, and also took them on a bit of a tour around the Reginald Centre. We had interpreters there on the day. We always ask if people require an interpreter and support this request where possible. At SJUH around 60 people attended, and 35 at Reginald centre. We also supported the team around communicating the move itself to all referrers, partners, and the public. We put together posters to be displayed on the old site etc.

We can advise individual services how to feedback to people involved in sharing their views and help to facilitate that. We can help with 'You said, we did' posters and share on website etc (especially with bigger consultations). We can suggest what should be done, but individual services are not monitored centrally on how they follow up feedback. We do have templates on Elsie that teams can use to produce posters, leaflets etc to communicate their 'you said we did' information.

Some of the engagement that comes to us (e.g. clinics that want to move) hasn't resulted in engagement work because Senior Management Team discussions and impact equality assessments have meant there's been a switch around, and the change hasn't resulted.

For the CAMHS new unit engagement/information event we took people's email/postal addresses who wanted to be kept informed/updated and involved and we will communicate feedback to them directly via this route once we know what has happened as a result of their feedback.

For Community Dental Services they produced localised communications to communicate their 'you said, we did' posters.

Last year we also involved our members 'Friends of LCH' in changing the term 'members' to 'friends' of LCH, to describe people's relationship with us and how people can continue to be involved in the work of LCH. We fed back to people via the database and email so people could understand the change of name.

Discussions in Quality Challenge about involvement plans, not sure how well this is received, or how many people signed up. Teams are asked to complete a set of self-assessment standards where they have to look at and evidence what they are doing in terms of quality. For corporate team it isn't compulsory, but not sure about service teams.

Do you do anything to make opportunities to get involved attractive for people?

We help with the Communications side of work. When we were looking to become a Foundation Trust, we had 6000-7000 members. We wrote to all of these when GDPR came into force and asked them to tell us if they wanted to stay on our database. We now have 600 Friends of LCH – they are more active and want to be involved in what we do. We use the database to send out opportunities for involvement (e.g. recruiting volunteers for PLACE inspections, judging for staff awards). We also work closely with partner trusts, the CCG and Healthwatch. We ask the CCG reading group to look at our literature and give feedback, and Healthwatch help us to advertise engagement opportunities. We can provide support for services to produce literature for engagement for service change, and help by sharing across our communication channels etc.

Services can come to Comms Team for help with regular engagement e.g. if they wanted a poster creating about a group or forum etc. Elsie intranet page also has templates for newsletters, posters etc that services can access. If they're wanting something a bit more bespoke or advice about what language to use etc, they can talk to us. We also have a graphic designer who sits within Comms Team.

For our recent insight work for the 0-19 service. We offered an incentive for people who took part in the online feedback to win ASOS vouchers.

We can reimburse travel expenses for attendance at events - an example of this was the CAMHS engagement events for the young people.

Do you have anything in place to ensure a diverse range of people are reached in your engagement work?

We offer interpreters as standard at events and focus groups. We put on all our documents that if people need help to understand a document, they should get in touch. If there are language barriers or difficulties in communicating, the service would talk through changes face to face when patients are attending appointments.

We make sure we communicate what changes are, how it affects people and which areas of the city are most affected. We link in with local people e.g. third sector providers. For example, when 0-19 services were changing. we recruited company 'Magpie' to do insight sessions, to gage things like the current understanding of health visiting and school nursing, information people felt important to receive, and how they would you like to receive this. Some of these sessions were hosted with asylum seekers, gypsy and traveller communities (came back that they get a lot of their information from social media) and others. These sessions were also undertaken across different areas of Leeds to gain more representative feedback, including:

• Deprived area
• Affluent area
• Neutral/average area
• Culturally diverse area - multilingual and multiple faiths and possibility of language barriers
• Urban
• Semi-rural

• Rural (if relevant)

Making sure information is accessible where people want to access it. We do rely on working closely with our outreach workers and 3rd sector/voluntary organisations to help us target a diverse range of people.

Do you feel that engagement is something that LCH should prioritise? If so, why?

Totally. We're ultimately here to serve the people of Leeds. Without getting their feedback and views and involve them in what we do, how can we provide them a good service? Engagement shouldn't be one off, it should be ongoing, not just engaging in changes that we're planning, it should be at a local level too, and acting on things like Friends and Family feedback.

What do you see as the existing challenges/barriers, expand on survey answers?

- Not knowing what services are already doing in terms of engagement and what we can tap into. There was a scoping exercise done by Amy over a year ago about what was going on in terms of involvement. This has been shared with Joanne Twigger (Engagement Officer)
- Doesn't seem to be any central co-ordination of knowing what involvement is going on across the organisation. This makes it hard to know what's going on, to link up involvement across existing groups. e.g. what groups do we have already in existence across trust that we can test an idea with. At previous organisations where I worked, the Patient Experience team held a database of groups that we could approach. We used to be able call them to ask who we could link up with.
- Barrier for service change - knowing which groups to talk to. Children works really well because Chris has links in, but we don't have the same links in Adults and Specialist Business Units.
- Understanding what the vision of the organisation is in terms of engagement. What are the expectations in terms of engagement? Doesn't feel this is in place at the moment. Previously there were nuggets of this with the Involvement Standards and Champions work and the quality challenge. But not now, since the Engagement Manager post has been vacant.

Do you feel that there is enough resources available for engagement within LCH? If not, what kind of resource/support do you think is needed? E.g. staff, budgets, incentives etc

When Em Campbell (Engagement Manager) left, we did a gap analysis around what could be absorbed and what was left. This was based on current work flow and what each team member could support, some gaps were identified.

Before recruitment of Engagement Manager and Officer posts, there definitely wasn't enough resource. Good that new posts are now in place, but aware that there is a lot of work to do, and not sure whether it will still be enough resource for the size of the Trust.

With service change, engagement can take quite a long time to come to fruition with lots of starting and stopping. This can impact significantly on the resource of the service when given the green light e.g. advertising, letters, admin, cost, analysing results, setting up focus group, events. I think services don't always fully understand the resource implication.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?

Currently, people can share examples of good practice by linking in with Comms Team. We currently have Community Talk (weekly staff email) - any examples of good practice can be shared in there.

There's been a review of the criteria of staff awards to put emphasis on involvement, with people at the heart of them. Staff awards happen annually across the Trust and staff can nominate other staff, we had 89 nominations this year. Over the course of a week, we go out to places of work and surprise award winners. All business units have celebration events and there's another staff recognition scheme, 'Thanks a bunch' where staff can nominate colleagues for living the trust's values (these have a lot about engagement in them i.e. 'treating people as individuals', 'listening, learning and improving').

There could be a more consistent approach for sharing learning as it's a bit ad hoc at the moment. You can find examples of engagement in the Quality Account and Annual Report, but this is yearly and targeted at a particular audience. There are examples of service changes on the LCH website and also previous engagement work. There's no consistent reporting that I am aware of from a service perspective, other than what might come out of the Quality Challenge. I would only ever access this information when needed for a particular service change proposal though.

Involvement Standards – people were asked to produce involvement plans about how they were going to encourage involvement throughout year, what their priorities for engagement were. The scheme has lost momentum. We did a bit of a review of the standards and offered thoughts and advice to Marcia Perry about them. They were self-assessed and certified, so the service themselves would decide whether they got bronze silver or gold. I feel that Bronze should be what we were all should be doing as a minimum anyway, what it asked for wasn't anything extra. There's definitely the potential to do something like this that encourages involvement in the organisation, maybe relaunch it and do something a bit different with it.

What are your aspirations for the future for patient, public and carer engagement within LCH?

A more standardised approach and more structure. How we engage for service change hasn't been reviewed for over 6 years, but it could be updated to fit together with the wider picture.

How can we can work together better so we're not all doing bits in little silos? I think that's achievable. Involvement can't be standard for every service, but at least there could be a framework for people to work within with a bit of flexibility. Services should know what support is on offer. In the middle of it all, should be the vision, what we're aiming for in terms of involvement.

Not everyone understands the importance of engagement, why do it? why do it well? We need to raise awareness of this. E.g. pull out case studies of where it's gone well and where feedback has made a real difference. We need to keep momentum going with the public.

Work more closely with our partners so we aren't duplicating work and link in with existing groups to see how we can all work together better.

Any other comments about how LCH engages with people.

Really excited that Heather and Jo in post to bridge the gap with what we're already doing.

Name of person:	Chris Lake
Job role:	Involvement Lead for Children's Business Unit (CBU)
Contact details/ best way to contact you:	chrislake@nhs.net 07985 267740

Role and background

To lead on involvement within the Children's Business Unit (CBU). Also links with the children's services from Specialist Business Unit (e.g. Wetherby YOI and Adel Beck Secure Children's Home). New role, been in post for 7 months but was absent for a number of weeks last year.

Co-ordination role -to get momentum going, ensure it keeps going and share experience and good practice across CBU.

Supports individual services wanting to develop their involvement.

E.g. if services get feedback and feel "I've got an idea but I don't know how to take it forward." – the idea is that Chris can help facilitate this.

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

At the moment, engagement and involvement is happening in all services within CBU.

CAMHS is quite well established in terms of engagement because of Chris's previous work as Participation Worker – this role hasn't been replaced.

Nicola Walker (Healthcare Worker) has been allocated some hours a week away from frontline duties to concentrate on involvement work – she is the Involvement Champion at little woodhouse hall (LWH) and runs their participation group.

Chris had a gradual transition to oversee children's services, so he feels that things are in place so that good involvement will continue within CAMHS.

Chris will be supporting Nicola at LWH. CAMHS have also just recruited CAMHS assistants and part of their role is to do involvement with the CAMHS bases (East, South and West Leeds, and the Eating Disorder service) – this is written in as part of their job description. Part of these new roles will be to re-establish the participation group (community services) and look after recruitment panels. Chris will train new staff to do recruitment and help with first lot recruitment.

Chris will meet with CAMHS assistants and Nicola Wood monthly and help put together an action plan to take their ideas forward. He is hoping to roll out this CAMHS model with other services in the CBU.

In CAMHS, they have patient experience meeting bi-monthly. (attended by CAMHS clinical lead, Consultant Psychologist who reviews feedback, and Involvement

Champions). They look at all forms of feedback and any issues/suggestions from FFT. They also ran a couple of workshops (one for parents and one for young people one to look at feedback that had come in). Thinks this is quite unique to CAMHS.

CAMHS - Outcome measures form completed after each appointment. E.g. has appt been useful (sliding scale)? How people are progressing? As well as free text boxes.

Chris is trying to work with other services within CBU more and promote involvement with their teams. For example, he has been working with Hannah House (respite for children with life limiting illnesses). They are starting a parents' coffee hour - this helps to breaks down barriers and is a way for parents to meet informally with staff and other parents.

It can be a bit isolating for Involvement Champions and is important that they've got support or someone to go to. Sometimes the role is just about giving people the confidence to take things forward.

FFT –The feedback that can be added is a bit restricted and limited. In CAMHS, they changed the design of cards after feedback from young people around how they could be more suitable for older young people who felt that the monkey design was aimed at smaller children.

There are Involvement Champions across LCH. The Engagement Manager post was vacant for a while, so Involvement Champion meetings didn't happen within Trust. – Chris is working to try to re-establish these meetings within CBU. There were 10-15 Involvement Champions from within CBU who attended the last meeting.

Chris has just produced first Involvement newsletter for CBU (see separate doc). The purpose is to act as a reminder to staff, that Chris is there and accessible, promote what we're doing, and for services to showcase and be proud about any involvement work they're doing. It's also a way of capturing evidence. It's short (one side A4) and forwarded to all team managers with the idea that they share with all staff. This is replicating what we did in CAMHS, where a similar newsletter went down really well. Have also put together a poster offering support to set up parents/young people's fora etc and is using a consistent image in newsletters/posters that's recognisable as CBU Involvement. We can't have branding within the NHS, but it's so people hopefully become familiar with who we are.

Option to invite children, young people and families to LCH board meetings to tell patient stories.

Chris is looking at doing a self-assessment within CBU (see separate doc) to find out where services are at in terms of involvement within the teams – this will go to all Involvement Champions within CBU to complete. Results will be shared with management team.

Starting to look at Your Welcome standards. Thinking about starting to introduce the 15 steps (NHS tool/template for young people and families to visit health centres and places they have an appointment. It was written by a parent: 'within 15 steps she can say whether service it will be helpful')

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?

Any feedback or suggestions we got from young people at CAMHS participation group in Little Woodhouse Hall was forwarded to the management team in CAMHS. This was looked at with management and then anything that happened as a result was fed back directly to young people in the participation group. 'You said, we did' posters produced that could be shared on Facebook page for parents.

Do you do anything to make opportunities to get involved attractive for people?

Just starting Children's Business Unit youth board. It's at early stages, we've got a steering group set up with 7 young people from three different services (CAMHS and two others). We advertised through the Comms team, and workers from different services helped get young people on board. The youth board will be a monthly meeting for young people aged 14-18 where they will have the opportunity to give feedback, raise suggestions, respond to consultations and we will try to build a workshop into every meeting. It will be held centrally at The Carriageworks after school.

As a non-clinician, I can have my number and email publicised so I'm accessible and easily contactable by the public and people who use services.

Do you have anything in place to ensure a diverse range of people are reached in your engagement work?

Main audience is currently people who are using services. In the future would like to reach out to other communities.

Do you feel that engagement is something that LCH should prioritise? If so, why?

100%. It's proven and it works. I've seen the benefits it brings to the Trust, the young people involved, and parents.

It's important for developing people and giving people skills. For people who have been disadvantaged because of their health e.g. not attending school etc. these opportunities to get involved are really important.

What do you see as the existing challenges/barriers, expand on survey answers?

Time can be a barrier for clinicians if they've got back to back appointments.

How people make time is down to each service. Sometimes smaller teams find it easier, as they have more control. Things are done on a smaller scale, and it's easier to manage.

People are definitely keen to be involved.

"Would love to do more of this, but don't have the time" is something that Chris hears a lot.

Would love to involve more people in all our recruitment, but time required to prepare young people is a big resource and this can be a barrier.

At the moment, if someone has an idea, in some services, staff may not know how they can act on feedback. Part of my role is trying to become more visible so people know how to contact me and can help them with this.

Do you feel that there is enough resources available for engagement within LCH? If not, what kind of resource/support do you think is needed? E.g. staff, budgets, incentives etc

There should be more resources.

There should be a budget for involvement, easily accessible to those working within involvement. It could be held centrally that services could tap into to cover things like expenses, room hire, refreshments.

Would be good to have toolkits for services, e.g. if they want to claim expenses for a group they're running, they should be able to click on ELSIE (intranet) and be able to find instructions for how they can claim these, instead of having to phone up and try and speak to someone from finance. Easily accessible resources, e.g. training packages for how to recruit staff, how to interview people etc. It should be made easy for people.

Blank posters, templates for meetings. Bank of resources for use within the trust.

Might be good to look at where new roles across the Trust are being advertised where involvement could be included as part of role if appropriate. It's important though that involvement opportunities should still be open to everyone who is interested in getting involved in engagement work e.g. by becoming an Involvement Champion. It shouldn't just fall to those who have it as part of their official job role.

Possible additional resources in each unit for those services where it is hard to free up time to 'do the doing' required for involvement.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?

At the moment within CBU we have a newsletter, Involvement Champion meetings. There is also a celebration event for CBU in December each year to showcase good pieces of work through the year – not just involvement but a lot of it does showcase involvement and is really well received by staff.

What are your aspirations for the future for patient, public and carer engagement within LCH?

Involvement should be happening and showcased in all services. Important that people should be proud of involvement, see the benefits of involvement and there should be enough time and resources for that to happen.

Any other comments about how LCH engages with people.

Feel the trust are really supportive and are heading in the right direction.

Thea's 50 voices – group of 50 staff who apply to do it each year. Take part in workshops led by Thea and make decisions on things that are happening in the Trust. At the last one, we discussed staff surveys, to give staff point of view of why we might be stuck on a certain issue. Also 'Ask Thea' on website where any staff can ask question. Staff appreciate this.

Name of person:	Em Campbell
Job role:	Neighbourhood Teams Service Manager (West 2 - Woodsley, Holt Park, Yeadon) Adult Business Unit
Contact details/ best way to contact you:	07507 781320 em.campbell@nhs.net
Role and background	

Neighbourhood teams are the old district nursing, community matrons, adult domiciliary physios (they do home visits) and intermediate care team. All these services were brought together about five years ago to form integrated neighbourhood teams. They include community nurses, district nurses, community matrons, Occupational Therapists physiotherapists, pharmacy technicians and end of life care. All these people work together to provide patient centred care and are also integrated with Adult Social Care (ASC) – in most teams they are collocated with ASC but not this one. They are moving to work more closely with GPs and practice nurses through Local Care Partnerships. Em manages West 2 which covers 3 teams/areas Yeadon, Holt Park and Woodsley. Teams are named after health centres they are based in but actually cover vast areas. There are 13 teams across city. Each portfolio has a Clinical Pathway Lead as well as a Service Manager and there is also a Neighbourhood Clinical Quality Lead and Operations Lead in each base.

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

Neighbourhood patient satisfaction survey – Patients are asked to complete form at discharge. The response rate isn't good – is this always best time to collect this information? Also because of the nature of the client group, some patients die. The form is a combination of FFT and LTC6 form (Long Term Conditions 6 - covers nationally agreed outcomes when we integrated. Patient recorded outcomes including patient satisfaction). Recognises that the form could be a lot better as lots of small text and no pictures. Forms get posted with a freepost envelope because staff weren't taking them out.

We also respond to feedback, informal concerns as well as formal complaints – this could involve a visit or a phone call. If someone phones up and speaks to someone about the service, we follow that up at a local level before it becomes a formal complaint. E.g. we went and talked to patient and relatives about a concern they'd raised - it didn't resolve what they wanted but helped explain and clarify what we could and couldn't do. We're good at reactive feedback but not so good at proactive feedback.

In Yeadon we have a good relationship with Otley leg club which is run with our staff in conjunction with Otley Action for Older People (OAOP) and Otley GP practice. There's a social and health promotion aspect to the club which takes place at OAOP.

Patients can come back as member even after their leg healed, and it also has the benefit of transport provided by the Neighbourhood Network. We get some good feedback coming through there – if staff are hearing things about how things are working, they will feed it back to us. No formal mechanism as such but the informal conversations are useful. Helps that patients don't have to feedback directly to our staff which I think would be a barrier for some.

Informal conversations asking 'what's good about it? What could be improved?'

Would like to broaden this kind of work to seek more feedback through Neighbourhood Networks. Wants to have more focus on meaningful conversations and cut out what's not being used. E.g. not sure where or if data from LTC6 is actually shared or looked at, wants to find this out. Em gets a report from FFT but not LTC6 so the potentially interesting information is lost as not fed back to the teams.

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?

FFT questionnaire results are put on the system and results come back to each team. Comments are shared with the team at team meetings. In Yeadon there is a board in the office with speech bubbles to share comments with staff.

Not currently a mechanism to track what happens as a result of comments. Could something be added onto end of existing survey like a 'we said, you did' section? Needs to be streamlined, don't want staff to have to take out loads of forms.

Do you do anything to make opportunities to get involved attractive for people?

There's a lot more that could be done in this respect. Could make the form better - small writing, difficult for someone with multiple long-term conditions, too long. Could we have less reliance on surveys and forms, use the opportunity to talk to people when they are talking to us already.

E.g. admin worker asking one or two questions when they've already rung up about something else. E.g. What's going well and what could be better? Could use smart phone links for carers who have the technology. Could we have the conversation rather than a form e.g. teams could go to Neighbourhood networks to have a cuppa and a chat and ask how service going.

Do you have anything in place to ensure a diverse range of people are reached in your engagement work?

No. The questionnaire is sent out across the board. Nothing on form offering it in different languages. Staff would know if it needed to go in a different language. Thinks more could be done to find out more about those who aren't accessing services and what the barriers/difficulties (real and perceived) are. We need broader engagement with the wider community, not just those accessing services.

Do you feel that engagement is something that LCH should prioritise? If so, why?

Yes. Because we won't improve services unless we do, or we'll change them in ways that actually make them worse for people. We need to prioritise it as part of the movement towards self-management and more equal partnership between patient and clinician.

What do you see as the existing challenges/barriers, expand on survey answers?

FFT is very prescriptive – e.g. has to be completed by the person receiving care, can't be done over the phone with them, needs to be anonymous etc.

I'm really on board with all this stuff but haven't been able to make it a priority, as the priority will always be things that I have to report on. If it's not being discussed at a very senior level, it won't be a priority, even with the best will in the world. There needs to be an organisational lead on engagement/involvement. Also have to get buy-in from team, it needs to be everywhere in the organisation, not just coming from me.

Are we reporting on the right things? In each business unit, there is a performance meeting that feeds up to board. There's only one question about people's views asking for FFT numbers and recommendations. There aren't any questions like "what was the last thing that changed as a result of feedback?" – Something like this would be a prompt for people to prioritise it and could be used as an opportunity to share good practice within the business unit.

Culture not there, staff don't hear about it. No-on is saying it's really important how we improve services based on feedback. Sometimes because operational and clinical management are separate in this unit, involvement and feedback falls between the two, because the responsibilities lies with both sides of management.

Do you feel that there is enough resources available for engagement within LCH? If not, what kind of resource/support do you think is needed? E.g. staff, budgets, incentives etc

There needs to be a central resource whose sole focus makes it everybody's business. Need to be able to advise on how to do engagement practically and simply, and answer teams' questions on what they can and can't do. Central team could come up with a menu of different ways teams can ask for feedback, how they can do things differently and help promote them, and help teams think about and remove barriers. How to use technology better, e.g. can we text them survey link? They could proactively encourage people, but encouragement needs to come from both central team and management performance – they need to dovetail. Helpful to have people in central team who know the difference between business units – e.g. adults business unit majority of service users out in the community, don't have a 'captive audience' like children's services e.g. CAMHS inpatients, clinics etc. They need to be understanding of different teams.

There used to be both an Involvement Team and Patient Experience team (who did FFT and complaints). This meant that we often had different priorities and things weren't joined up. Thinks involvement now comes under Patient Experience which is better. But consultation about big service change happens through the comms team. When a service change happens, it's important that public consultation (through comms) ties up with individual service user engagement.

As well as a central resource, it could be useful to have some resource within each business unit to help with proactive engagement and some of the 'doing' and practical stuff. Someone to help each team and keep engagement on the agenda, as well as help with engagement. The danger of this would be that then it's seen as their job, and service staff take a step back. Important that such a role would support people do practical stuff but always bring it back to the team, so it's owned by them.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?

Involvement Champions was an initiative run in the past where people from each service with an interest in involvement could champion involvement, it wasn't a specified role to do all the work, just to champion it and ask questions. They would meet to share good practice. It needed more buy in from management – sometimes Champions said they felt powerless if managers didn't buy into it.

The focus of the Involvement Plans had previously been about gathering views. When Em was in the role, she simplified the programme and shifted the emphasis to 'What difference has been made as result of feedback?' It was a move from submitting reams of evidence and focusing on the number of responses. It was a real culture change. Annual plan had to be submitted to the Involvement Manager every 12 months. It asked, how are you gathering views, what are doing with it and how are you feeding back to patients. It used to be reported centrally to the Board (in Director of Nursing report) and on the LCH website. None of that is happening now. When there was a full Involvement team, we were able to chase up with managers if we hadn't heard from them. The focus should be on celebrating what's changed as a result of engagement – sharing the difference it makes to staff as well as patients is important.

What are your aspirations for the future for patient, public and carer engagement within LCH?

Every member of staff, if they were asked what changes have we made as a result of feedback, would be able to give an example. That it is part and parcel of what everyone's doing. That we are better at gathering and collating views in a co-ordinated way.

Any other comments about how LCH engages with people.

Really pleased that it's on the agenda and that Healthwatch have been commissioned to do this piece of work.

Name of person:	Amanda Jackson
Job role:	0 – 19 PHINS Public Health Integrated Nursing Service (health visiting and school nursing) Clinical Team Manager
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Role and background

One of 10 clinical team managers. Health visiting and school nursing has been re-contracted to become one 0-19 service from 1st April 2019. Within the new contract, Amanda's workstream is comms and stakeholder engagement. New to management from October 2018, was previously a health visitor.

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

- Face to face anonymous FFT questionnaires about health visiting service, also parents and carers cards (asks 3 questions – smiley faces, what do you think we do well, what could be improved?) – done in public places (e.g. shopping centres as part of service review).
- Baby clinics - have previously done counters in boxes asking a simple question.
- 0-19 service currently working with marketing company 'we are magpie' who have done insight focus groups with children and young people and parents and carers, in 6 areas with lots of groups (182 responses). They have been going into breastfeeding groups, baby clinics and community groups. They've been asking questions like, what do they know about service, health visitors, school nurses, what they would want from service? Barriers to access, how to improve, mood boards on leaflets etc. Part of new contract that we had to do engagement and had to be someone external.
- Leeds City Council did big consultation when 0-19 service went out to tender so this will have fed into service specification and design of service.
- Focus groups with young fathers (young parents and young fathers part of new pathway) – consulting about new pathway.
- FFT used to be given out by Health Visitor at 6-8 week contact and by nursery nurses at development review at 8-12 months, plus given out during any targeted work. Stalls as part of NHS 70 in a couple of shopping centres where we used FFT and added in a couple of extra questions about the new proposed 0-19 service.
- Facebook page – link to FFT pinned on there. Was involved in Facebook page as a Health Visitor but was more a page to give information and updates, not do engagement and ask questions. I think this is a missed opportunity.
- Think FFT could be more service specific – also, what does it actually mean to the service user?

All 12 health visitor teams have an involvement champion and deputy (24 in total). Under new service there will be 6 teams so 6 champions and 6 deputies (12 in total). Involvement champions from the service meet quarterly.

Plans to carry on with parents and carers cards and FFT, link in with Chris Lake a bit more, also plans to go to YouthWatch meeting to get feedback about ChatHealth posters.

Service users will be involved in photo shoot next week for literature for the new service. Staff and young people will feed back on drafts of the new literature.

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?

We share good and negative feedback with staff at forum every month attended by school nurses and health visitors, and anything that has changed as consequence of feedback. This is also shared within individual teams at team meetings or fed back individually if appropriate.

We have sometimes put up 'You said, we did' posters at clinics, e.g. when there was an issue with a drop-in venue.

FFT data – goes through to Quality (Helen Rowland), numbers come back to me and I can log on and look at data. Data is also fed back into senior leadership team 0-19 which meets weekly. At the moment, not much happens with comments left on FFT, it just sits there on the system.

Do you do anything to make opportunities to get involved attractive for people?

Posters put up about Chris lake being involved, and opportunity for young people to join youth board. Told staff they can put young people forward.

We have involved volunteers in baby clinics because they said they were interested.

Do you have anything in place to ensure a diverse range of people are reached in your engagement work?

- 'We are Magpie' – specialists at engaging CYP and in health. Outreach to 6 areas in Leeds to represent diverse area in Leeds. Insight groups run with Gypsy and travellers' community.
- FFT goes out to every visit – universal service so everyone gets chance to have their say via FFT.

Do you feel that engagement is something that LCH should prioritise? If so, why?

Yes, because we need feedback to shape what we're doing. How do we know if we've targeted the service correctly? How do we know it works for people? It might work for us, but not for them.

What do you see as the existing challenges/barriers, expand on survey answers?

- Language is a massive issue. For example, with the FFT - when interpreters are in attendance at appointments, we sometimes leave and ask them to talk through FFT with patient when clinician isn't present so that it's more impartial.
- Time is a barrier from both our point of view and service users' point of view. 'We are Magpie work' is really good – it's everything we would love to do but don't have time.
- Service users don't often see what the outcome of feedback is. They often don't see what the point is and where there's any benefit to them.
- Expectations – what service users want sometimes isn't realistic.
- Important that engagement is consistent across the trust/NHS because public will see all services as one. If experience not good with one service affects whether person gives feedback again to different service.
- Sometimes it's hard for individual services to know where to start with engagement or how to implement their ideas.

Do you feel that there is enough resources available for engagement within LCH? If not, what kind of resource/support do you think is needed? E.g. staff, budgets, incentives etc.

Someone who is dedicated to just spending time doing engagement. In an ideal world this would be a role within the service to have a co-ordination role, chasing up staff and encouraging engagement. Could also spend time doing things like putting together presentations to collate feedback of what people's views are.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?

I think it currently does this – I've seen a few things on Elsie (intranet), posters on walls at Stockdale relating to good service feedback. Within the Children's Business Unit (CBU), I attend the CBU Involvement Champion meetings, so I know what's going on in other services. I don't know so much about what's going on wider in the Trust. I'm new to role so it's difficult to say.

What are your aspirations for the future for patient, public and carer engagement within LCH?

- More of what Magpie are doing, focus groups, insight groups, service specific drop ins facilitated by someone from a service with a theme of what they're seeking feedback about.
- Opportunity for young people to come and see what a service does and get a better understanding of what we do, and how the service works. We get better feedback if people have a good understanding of service. Would be good if something like this was co-ordinated Trust-wide and not just for 0-19 services. It would be easier for

services to try these things if systems and guidelines were in place, and people could access support/vetting centrally.

- Service users could shadow staff for a day, not necessarily just young people but in different services across the Trust.
- Service user boards or fora
- Children's centres have a massive footfall – we could harness this in terms of seeking people's feedback
- More ways to engage online – we could use technology more.

Any other comments about how LCH engages with people.

Name of person:	Hanna Haziem
Job role:	Service Manager, Children's Speech and language therapy service
Contact details/ best way to contact you:	Hana.haziem@nhs.net 07903 879477

Role and background

Hana as service manager along with PPI team within service (Involvement champions) have responsibility to lead on engagement activities. Involvement Champions are all clinicians (main one Sally Hansell) who were given a small amount of time to do Involvement Champion role (maybe an hour a week).

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

FFT posters displayed.

FFT postcards sent out to children and parents following clinical appointment either in school or the community. Response rates not great, we send them out and don't get them back. We ask them to return by post. At school, we send the FFT postcard home with children but think that they often just end up in book bag. We use the standard FFT child friendly postcards (with monkey on).

If parent can't fill it in as not present at school appointment, we wondered whether school staff could do it on their behalf as teaching assistants work very closely with children. They attend therapy sessions with children and carry on working with them through the 12 week programme.

Parents and young people on interview panels for clinical staff. E.g. Deaf and hearing impairment team – parent and ex-service user (young person) sat on the panel. They had a separate panel and came up with the questions e.g. "How would you better engage with us as parents of service user/young person?", "How are you going to make me interested in activity I need to do, if I don't want to do it? (Young person)". We have involved parents on interview panels for a while, but this was the first time to have young person (August 2018).

Good to involve young people and parents in interview panels because it gives their point of view which is more about personality and gut instinct. Although this adds a different dimension, if they are on the main panel, they also need to be able to score each question impartially, so there needs to be a balance.

We can all lose sight that the family is the most important thing in our service. Having service users involved gives out the message internally and externally that families are central to what we do. It's the ethos of the majority of our staff but people can lose sight of that.

Parents have always been involved. We have a list of interested parents and always ask those who attend parent training courses (e.g. Makaton) if they are interested in being on an interview panel or helping us feedback about leaflets.

Recently we have had help from Chris Lake around involving people in interviews and are keen to carry on working with him. He has a lot of good practice form work in CAMHS around training young people, scoring interviews, confidentiality, legalities etc.

All our Speech and Language Therapists (SLTs) been on health coaching training (mandatory) with the view that when writing support plan targets, the parents will always be asked what they want out of the therapy session. This is then taken into consideration and balanced with clinical relevance when planning therapy.

Some SLTs still very stuck in the consultative model (where clinician is the one to give and suggest advice).

Trialled sticker chart re service user satisfaction once block (up to 4 sessions) finished. A bit like a sticker chart linked in with targets to say how parents felt the work went. Not consistently done - don't think it's been pushed as much as we could have done. Idea was that they would bring it back to their final session or posted back. Might be better to have something online or texts, other ways for parents and children to be involved.

Would like to think about having parent and youth forum in the future.

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?

FFT information comes back via general manager then through to Hana. Her and Clinical Lead look at feedback. FFT doesn't give us much feedback that is tangible or can be acted on.

We share compliments on DATIX system and share with relevant staff members.

We ask staff to let us know if we've had any compliments.

We deal with any issues that arise locally as and when they come up. Sometimes we have to balance concerns and requests from families (E.g. parents want more therapy for their child), with what we believe is clinically relevant for child. We have to balance ensuring our service meets needs of children but still fits with what we're commissioned to do.

Feedback to parents given about who is recruited after they have been involved in interview panels.

Do you do anything to make opportunities to get involved attractive for people?

We offer to reimburse travel expenses, by sending parents a form to complete. We say thank you and give them a bunch of flowers at the end of the interview process. We

don't currently offer any training prior to involvement in interview panels but would like to do more of this, especially if going to do this more with young people.

I think we could do more to ensure we hear a diverse range of voices. The majority of our service users will have communication needs. How can we make sure they have a voice? I think it's doable, but we need to find ways to do it.

Challenge – e.g. we use a smiley face about how they felt about person – really want it to be meaningful not tokenistic.

Need to get better how we ask parents to be involved. Parent training team will always ask but not sure how robust the system is (are people who say they are interested always logged on the list?). There is no system in place, more ad hoc. Have a large pool parents would mean we have a wider range of voices from different backgrounds.

How accessible is FFT? Interestingly we have high response rate from our stammering team who are generally not cognitively impaired.

We have issues with targeting parents who English is not their first language. Even getting them to appointments is difficult. We had the idea of developing an online form which would be sent before an appointment to ask, "How do you feel about your symptoms?" in different languages (an IBS service did this with some success at engaging people with English as an additional language). We were told that service would have to pay for translation costs.

Absolutely. That's the reason we all come to work. We supply a service for families and children to improve their lives but without the ideas of what they want, how are we going to do that effectively? We want people to feel supported, taken on a journey with us, rather than 'this is what will happen to you'. Accessing a service can be frightening. Our job is to put people at ease. E.g. at Wetherby YOI there was a low take up rate of our service despite their being a high rate of communication impairments among offenders. After speaking to service manager at the YOI it turned out that service users didn't know what a speech therapist was and that's why they didn't attend appointments. They have now devised a leaflet explaining what SLTs do, what kind of thing they can expect to do at appointments etc.

- Time
- Information governance (around sending texts etc.). For example, how do we involve parents more in appointments? Information governance says we can't put

anything about the nature of the appointment, only the date and time of appointments. Would be interesting to know how other's services do this e.g. 0-19 service, CAMHS? Are there discrepancies? What can be done to make it easier for us to communicate with parents by text?

- Clarity around what other services are doing (we lack that clarity as a service, temptation to hold fire until we're clear what other services are doing).
- Ensuring consistency – e.g. if one SLT is asking parents to be involved in a parent forum in one patch, it should be happening across the board.
- Making involvement accessible – targeting all families irrelevant of language spoken and/or communication needs
- Ensuring full engagement from families when we do visits in school settings. Parent gives consent at referral stage, then there is a waiting list before child will be seen in school. Because parents don't attend visits, there are sometimes issues where they don't feel as engaged as they'd like to be. This is partly to do with the way the appointments are booked. Either service books direct with school or centralised booking system (two out of five patches book appointments this way) where service emails school and they book in individual appointments for children online. SLTs tell schools to let parents know that we will be seeing their child in school, but this doesn't always happen. Have had phone calls before with parents upset because they haven't realised child was being seen at school. Needs to be more of a direct link with parents to tell them that we're making the appointment. With preschool parents, it's not a problem as they get a text asking them to book the appointment because they have to bring children to clinic. With school age children parents, there is no engagement, although parents can liaise over the phone or at Education and Health Care Plan meetings.

Do you feel that there is enough resources available for engagement within LCH? If not, what kind of resource/support do you think is needed? E.g. staff, budgets, incentives etc

- Having Chris as a resource within CBU is working well - he's available for support.
- Enough resources in team to manage and schedule interviews where parents/young people are involved but not enough to collate a list/database of parents/young people interested in being involved and communicate opportunities to them– could do with more admin support to manage this.
- Resource to translate key letters to get people involved where English is not first language.
- Resource and expertise to get more concrete and qualitative feedback about how service users feel – from schools, parents, young people. Would need more resource and/or guidance around this, and about what other teams do.
- We used to have a membership team where services could access LCH members to be involved in different activities. We did use members in an interview process several years ago but the demographic wasn't really appropriate for our service (elderly men) so we made the move to involving parents which was more appropriate

- As well as thinking about what's out there, we also need to think about what resources we already have. E.g. are there any SLTs interested in supporting the PPI team within speech and language therapy service. We have Involvement Champions but don't get a lot of feedback from them. We used to have a slot at staff meeting but this has dwindled. Because they are all clinicians, PPI would drop off if pressures of clinical work increase. At the moment only a very minimal amount of their time is allocated to PPI (maybe an hour a week).
- Parents of children with complex needs may have useful insights in terms of different services within LCH that their children use (e.g. school nurse, CAMHS, physiotherapy etc.). E.g. A parents' forum within CBU could be a useful resource to capture those insights from those parents who have lots of different professionals for same or different children.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?

Currently we have a weekly newsletter within our team which shares information about courses, dates, but also positive news e.g. one of our SLTs mentioned on radio 2 Sara Cox show.

When I was looking for ways to involve service users, the information wasn't readily available to me – it just happened to be that someone mentioned CAMHS, and I got in touch with Chris Lake. There should be better ways of celebrating and sharing good practice to make it easy for staff to learn from it.

Lessons learnt seem to be more widely broadcast when errors have been made. E.g. complaints, rather than when people do things well.

Children's Business Unit annual celebration event - difficult to get our staff to go to it. We do have our own staff meetings where we can celebrate achievements. At each team meeting we get people to talk about their work in different settings.

What are your aspirations for the future for patient, public and carer engagement within LCH?

I'd like every parent to feel that they know when their child's appointments are and that they can be engaged along that journey.

I want us to be accessible. Recently I had to remind SLTs that they can give out their email addresses to parents. Some staff don't' give out emails as they feel they might be bombarded by unrealistic requests for more therapy. Some worry about the pressure of parents asking questions that they can't answer (we do tell them that we are always available to help as managers). If SLTs seem to be inaccessible, it raises frustration amongst parents.

Any other comments about how LCH engages with people.

Name of person:	Jo Di Capua Kayleigh Abbott
Job role:	Jo - Service Manager Police Custody Kayleigh - Quality Lead Police Custody
Contact details/ best way to contact you:	j.dicapua@nhs.net 07949 102443 k.abbott1@nhs.net
Role and background	

Police custody service covers whole of Yorkshire and Humberside. Since the end of March last year there has been one regional contract with LCH who previously held 4 individual contracts (West Yorkshire, South Yorkshire, North Yorkshire and Humberside.

Healthcare professionals are based in 14 custody suites in police stations that are in use all the time, plus a couple of others that are used occasionally. They provide health care within the suite and are made up of a nurse, (learning disability, mental health or general nurse) or paramedic. They also have an on call forensic medical examiner (doctor).

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

Don't currently do any formal patient engagement. Have tried different things in the past but have been lots of barriers and difficulties due to the nature of the work and setting in a police station (see below).

Used to do a patient survey. The healthcare professional would have to do it with them as they aren't allowed to give people a pen (in case they harm themselves) so it wasn't impartial.

FFT really not appropriate – who would recommend police custody to family and friends?? Prison health care settings are exempt from FFT but nothing is said about custody settings in NHS England guidance. We have always tweaked the question a bit to make it more relevant.

We also tried to have laminated sheets with smiley faces asking people to pick how they felt their experience was as they went out of the door. It said, "How was your experience of healthcare today?" and had five different smiley/sad/neutral faces to choose from. This wasn't done consistently as staff didn't want to ask people to participate in it depending on how the consultation went, and the mood of the prisoner. The health professional wouldn't want to ask them to do it if they felt it would antagonise person and therefore becomes a safety issue. If they only ask people for whom the consultation has gone well – then it's slanted. Then it becomes pointless. Also, the face they picked would very much depend on whether they got what they wanted during the consultation (e.g. if they got their medication they

would give good feedback, if it wasn't medically appropriate to give them medication which they wanted the feedback would be bad etc)

They are looking at different formats and options they could use with FFT lead (Amanda Hayes) but it has been very stop and start due to Amanda being off sick and there being only one person in that team who can advise on this work. Ideas were things like perforated 'pop out cards' so that people could pop out the option they felt summarised their experience and wouldn't require pens and could then be collected. Another option is FFT work with MES – the possibility of using iPads to get patient feedback as there has been some service improvement budget offered to help with this. Again, this has taken months to explore this as Amanda is the one with links to MES.

Could it be part feedback from us and/or stakeholder feedback? We could explore trying to get feedback as part of booking out process or tag on question to any feedback form that police do. Or would people give honest feedback at that point where they might just write or do anything to get out?

Would want to capture the anecdotal stuff – this is the useful bit, but we found that the comments cards were hardly ever filled in. How you get meaningful and worthwhile feedback when patients aren't allowed to use a pencil as the could use it as a weapon?

Complaints process. We do get feedback from people that way, and when we get a complaint, we capture that information and act on it. But this kind of feedback is limiting and means we only hear about the negative things and don't get any of the positive stuff. How can we capture the good work of health care professionals in our service?

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?
n/a

Do you do anything to make opportunities to get involved attractive for people?
n/a

Do you feel that engagement is something that LCH should prioritise? If so, why?
Yes. It's important to improve things. It's alright thinking we're doing the right things, but how do we know if it's what patients want if we don't get their views. Often feedback can result in very small changes that we wouldn't have thought of. Being inside the service it's difficult sometimes to see it from the point of view of the patient. It would give us information to influence how things could be changed which are beyond our control due to the restrictions of the service and the nature of the work

with the police, and their systems. But it's also about patients having realistic expectations. We work in a restrictive and controlled environment which is police controlled and is also bound by legal things, not just NHS guidelines.

Absolutely can be done, but we need specialist support which we would feed into, to help us with it as a service.

Within our service it's important as we're geographically huge. It would help us to understand whether what we see as a leadership team should be happening is really happening on the ground in all the different areas. Although Jo and Kayleigh have overall responsibility for patient engagement in the service, it is the clinical team managers in each area for ensuring that it happens in each area.

- Language barriers
- Literacy issues
- Different levels of capacity due to intoxication, withdrawing, or mental health.
- Time – we are often very rushed by police staff. The police clock dictates us moving along quickly as there is a 60 minute response time per person. If we spend more time with one patient, then there's a backlog of other patients to process. Also, other time pressures due to there being a limited time window to get forensic samples etc. People spend an average time of 6 hours in custody and can only be held for a maximum of 24 hours.
- State of mind of prisoner – often they are agitated, and we are not telling them what they want e.g. they may want to be sent to hospital to prolong the clock, but our healthcare staff are assessing them and saying that they don't require hospitalisation. How do you unpick what's constructive feedback and what's not? What's about the service and what's about people feeling disgruntled because they haven't got what they want. Th feedback needs to be meaningful.
- All detainees have a risk assessment, and the risk is very real when you are on your own in a room with a person – there is a lot of aggression and volatility which needs to be managed very safely. Sometimes it just isn't an appropriate time to be asking them questions about how they found the service – it's a very acute situation.
- Discussed briefly of whether or not it would be more appropriate to get feedback about the service from people who have been through the process but aren't currently in the acute situation. E.g. talking to prisoners, or groups of ex-offenders etc

No. We are a really specialist service and need some specialist support on how to come up with meaningful ways to engage with people. We need a different approach. It currently falls back on us because the central team doesn't have specialist resources to dedicate to helping us, or don't know how to do it.

We need someone that can sit and help us work out options of how we can do it and put together action plan. And then there's the resource needed to collate any results which time can be consuming.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?

Because we had a restructure, engagement now gets talked about in the Specialist Clinical Forum which is attended by Clinical Leads within the Specialist Business Unit, but it's all about the FFT. Often engagement gets lost in the middle – as it's not clinical or operational, but both. I heard at this forum that some services send out FFT by text message.

Don't have Involvement Champions and never took part in the Involvement Standards.

What are your aspirations for the future for patient, public and carer engagement within LCH?

A consistent way for patients to be able to give their feedback of the service and that it's a part of everyday business. It needs to be simple and they need to feel that their views are valued at that point. They are a patient not our detained person, but they don't always realise that we work for the NHS and not the police.

Any other comments about how LCH engages with people.

Name of person:	Lynda Dexter
Job role:	Advanced Podiatrist in Mental Health and Learning Disabilities
Contact details/ best way to contact you:	lynda.dexter@nhs.net

Role and background

Patient involvement lead for podiatry service. Involvement champion. There are approx. 50 members of staff across the Community Podiatry service. As well as being the Involvement lead, Lynda has small team of 4 other workers to help do engagement work. At her grade, she has flexibility within role to do it. Works citywide, based in Becklin Centre. Engagement role is citywide.

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

We have podiatry assistants carrying out two sessions a month (full day) floor walking in clinic (they are out of uniform, at different clinics to where they work to try and make it more impartial). We rotate the clinics. They ask FFT question and a couple of other questions, e.g. what we do well, what we could do better, anything they'd like to see different in podiatry.

Started 'Podia-tree' to allow patients to feedback comments directly to podiatry. We have 4 trees in clinics at a time and rotate them each month so we cover all the clinics. Rotating it keeps it fresh, and stops patients being bored of seeing it and means staff get a break from inputting comments.

We have patient newsletter twice a year asking for views, tell people what's happening, give feedback, diary dates. These are supplied to all health centre podiatry waiting rooms.

Have recently held a focus group in Morley. Theme of the focus group was just general e.g. 'How do you think we're doing?'. Also asked some questions about new website around self-management that we're developing. People generally said a lot of positive things but not many ideas on how we could improve. The feedback about the website was really helpful.

Another focus group planned for June time to be held in Chapel Allerton (to try and reach different demographic). We will be getting patients to think about recommissioning the service from their point of view – what would they do with limited pot of money, what should be priorities?

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?

- Newsletter – has a 'you said, we did' section, and we also feedback directly to patients if they want us to.
- Views from patients at focus group will feed into development of website.
- We fed back from focus group directly to participants.
- Put feedback on podiatry noticeboards in waiting rooms in clinics in health centres.
- Feedback from podia-tree goes onto Elsie, there's also a section for compliments. Member of staff at clinic puts it on it on. But because of difficulty accessing the system (due to being band 7 clinical I am unable to access Datix system) a lot of the feedback isn't seen or analysed – it just sits there.
- Staff bulletin goes out on a weekly basis to everyone in the service – has a 'shout out' section – compliments can be fed back to staff that way.

Do you do anything to make opportunities to get involved attractive for people?

- For June focus group, we wanted to hold it over lunchtime to attract people, so asked for budget from service for lunch. This wasn't possible from the podiatry budget.
- Clinicians are asked to ask patients if they're interested in involvement opportunities. We're currently collating a list of patients interested in being involved.
- 'Podiatree' – different and creative way of seeking feedback

Do you have anything in place to ensure a diverse range of people are reached in your engagement work?

We get a lot of BAME people whose first language isn't English using the clinics so the clinic floor walk works really well to get views of these patients, as staff can fill in forms with them. We've been targeting inner city clinics for this activity. It also enables white British people with poor literacy and those with learning disabilities to share their views.

Learning Disability Network (LYPFT) - I go to that meeting to promote podiatry and find out any issues they've got. Easy read FFT has a smiley face and people can tick a number but won't be able to write down any comments.

Do you feel that engagement is something that LCH should prioritise? If so, why?

Yes, definitely. How can we make things better if we don't hear the views of those accessing the service?

What do you see as the existing challenges/barriers, expand on survey answers?

- TIME - takes time to organise things. Staff telling me they've too much to do to be involved. We were thinking about going to existing groups (e.g. black elders, older

- people's groups) where we could talk to people about community services but it's having the time to organise it and get staff that are motivated to do it. The answer from staff is always "I don't have time".
- No budget, within service - would be better to have a central involvement budget.
- Trying to get people to an area when we can't offer them travel expenses – it's difficult to get people there. Only 4 out of 15 who said they would come came to last focus group in Morley (they were all from Morley). All clinics are in different areas of city not central, so we have to just rotate areas where we run the focus group.
- FFT – we've got a cohort of patients that are static and don't want to fill it in every time. Older age group don't like being asked about their sexuality. Not clear whether we can adapt FFT and add our own questions to get better feedback. FFT is the one we're measured on, so we have to do it.
- Front of house admin hand out the form for us but this isn't consistent across the city.
- We are unable to send SMS messages for FFT due to information governance issues, but it would help us to reach young people, and people who attend for Bio appointments. GPs and LTHT use this method so should be possible within an NHS services.
- Barrier that Band 7 clinical can't access Datix system (complaints and compliments). My boss (clinical lead) tries but doesn't always have time to look through and feedback. Would be better if information was collated in a better way, and system could feedback to us e.g. they send us reports.
- If we could get access to the system we could do this more. At the moment we get feedback from patients, but a lot of it just sits there on the system and we don't do anything with it. We deal with it if we have an issue, but don't have the time it takes to analyses data/collate info, themes and trends and feedback.
- Used to have readers group in LCH but no longer exists. If we're making new leaflets, used to be able to send them there for them to look over and give advice. Comms team very busy so we often just end up doing our own, as it's quicker.

Do you feel that there is enough resources available for engagement within LCH? If not, what kind of resource/support do you think is needed? E.g. staff, budgets, incentives etc

- No, definitely not.
- Need an involvement team in the Trust who we can report back to and they can support us in an advisory role. They can figure out all the themes and help to collate and analyse the data e.g. by demographic etc.
- Someone to really look at the feedback we're getting which is just sitting there on the system. I don't have time to do this – could be a lower band to do this and send a report on the themes.
- Info that we're missing could be beneficial. The way systems are set up, only some people have access to MES and Datix system.
- Advisory role, to help set up engagement activities, even to help facilitate it and organise it.

- If the Trust is serious about engagement, it should provide a central budget just for involvement so that it doesn't have to come out of service budget. Something that could just cover travel expenses, refreshments etc.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?

- Currently we have Thank you events for staff to nominate others.
- Don't see much around what's happening in the Trust, I see the odd story in Community Talk, AGM, but it's ad hoc.
- Involvement standards – it was self-assessment, and we provided evidence. Felt like it was a tick box exercise, just services assessing themselves, where's patients' views in that?
- Would be good to share ideas with others doing engagement role in other services. Helpful when you get stuck. E.g. we struggle with static patients with survey fatigue, what do other services do about that?
- Quality challenge (Once a year) - has FFT and patient involvement information in it. Goes to commissioners, performance panel and board. Focus in performance panel on FFT.

What are your aspirations for the future for patient, public and carer engagement within LCH?

A much more uniformed Trust wide response to engagement. With a dedicated team that filters and helps people to engage with patients, the public and carers. At the moment we're doing it but not that effectively to make real change. It needs some momentum, we need to change things up and get out there. Actual time given to patient involvement, roadshows etc Loads of things we could do if we had time and resource.

Any other comments about how LCH engages with people.

Name of person:	Rebecca Kelly
Job role:	Specialist Neurological Physiotherapist, Community Neurological Rehabilitation Centre (CNRC)
Contact details/ best way to contact you:	rebeccakelly3@nhs.net

Role and background

Heather Archbold and Rebecca Kelly now engagement leads in Community Neurological Rehabilitation Centre (CNRC). Suzanne (OT) no longer doing champion role as on secondment so three people who used to help her are now doing the champion role.

Rebecca, Heather and Rachel (all have clinical roles - OT, physiotherapist, speech and language therapist etc.). Leone (co-ordinator for stroke team) also helps with role

Can you give more details about engagement work you have done in the last 12 months (go through examples given in survey response). When, where, how, outcome, any reports/publicity materials? Any good practice?

Neurology user carer forum - meets every 3 months. Well established, it used to be every month but there was a lot of repetition and people were using it more as a place to get together to air their personal concerns, when it's supposed to be about the service not individuals. Now it's really structured with an agenda, much more focused and works better. It has a set format. We arrange chair for next meeting at the end of the last meeting, staff go through agenda with chair and explain what's happening. We always ask what issues they want to address in the future. Forum meetings always attended by one manager so that feedback is heard. We encourage people who want feedback about a service or change to come at first thoughts level rather than come when something has been nearly decided, to get people's views.

People who come to the forum are service users/carers – around 10-15 people attend each time. Virtual members can engage by email but we don't hear a lot from them, but we always offer it. We're trying to get a more diverse group with different demographics. At the moment, it's very white middle class and a lot of people with MS. We offer patient transport to get to the forum which is held at St Mary's Hospital.

Some work the forum has been involved in:

- Designing leaflet about wound care, our forum users fed back about it
- Leaflet for community CNRC, fed into it early.
- Users fed back that all hand gels in the Community Neurological Rehab centre were too high up for wheelchair users, wo we got lower hand gels put up. Service users went around with a member of staff to advise on the appropriate height for hand gels.

- Currently trying to link in with commissioner who is working across neurology services across the city. Forum working with project manager (employed by LCH but working across the LCH and LTHT) who works with the commissioner to streamline neurology services as there is a lot of duplication in community and hospitals.

Satisfaction questionnaires (see example) given out at discharge. We can leave with patients to post back or help them to fill it in. Also, if a person makes a comment midway through treatment, we use this form to capture feedback. All three parts of service (inpatient, stroke service and us) are all using different feedback forms, we're trying to streamline forms. We also all do FFT.

What happens, if anything with feedback people give you? How do you monitor and share what happens as a result?

We input compliments onto System 1 (patient computer system) and ESR e.g. if a patient gives us a thankyou card/box of chocolates. Complaints and compliments fed back to staff at bimonthly team meeting.

On the minutes of the user forum, we always follow up any actions. Manager from this unit and at least one member of staff team always comes. Good that manager there as this increases chance of actions being taken. We always feedback via the meeting any changes that have happened as a result of feedback.

We collect satisfaction questionnaire and FFT forms and send to the Complaints Claims and Patience Experience Manager (Amanda Hayes), she collates the data. At the moment I'm photocopying all the forms before I send to Amanda, as once they're gone, we don't have access to the comments section (the useful bit), only the FFT statistics. Manager goes through them and gives feedback at our team meetings. Not good use of time or resource to spend all this time photocopying.

Do you do anything to make opportunities to get involved attractive for people?

We're having a drive on this at moment as we haven't had any new members for a long time we tend to get same people - 'Professional service users'. As part of initial assessment, we always give out leaflets about the forum. All team aware of it, but as Involvement Champions we have to push it. I feel that there's buy-in from staff about promoting it but there's always high staff turnover in such a large service. People recognise that we are as good as we are because we get service users' opinions. We ask new starters (staff) to attend the user forum (they can share what their role is as well as learn about the forum). We also promote the forum via the noticeboard in the waiting area of the centre.

We provide transport. Most people have had treatment at the service so they're familiar with where the meetings are held.

Sometimes we get new people come along but they don't stay. I think it sometimes seems to people who attend as though things aren't happening, and that maybe they

would like to see things happening more quickly. We're going to try and focus on making this better. There are also issues around people's work commitments (meeting is during the day) and deterioration in their neurological condition which may affect whether or not they continue to attend.

Do you have anything in place to ensure a diverse range of people are reached in your engagement work?

Aware of need to be more diverse and trying to get more people. The forum is during the day so it limits who can attend. Thinking about how we can use social media more to reach a wider audience.

Do you feel that engagement is something that LCH should prioritise? If so, why?

Yes, because we're providing a service for people and if we don't know what they want how are we going to provide a service for them? In terms of involving people in their care, it's integral to our work, a mind-set, when a person comes in here, the first thing we ask them what their goals are (not ours) and work on achieving them.

What do you see as the existing challenges/barriers, expand on survey answers?

- We want to try to get more feedback from a more diverse range of people
- Getting staff involved to promote it better
- Feedback cards, we're not getting many back. Could we ring or text people to get their feedback? Some people can't hold a pen or have cognitive impairment which makes it difficult for them to understand the questions. We would need to have a conversation with these people to get their feedback. Good for someone impartial (i.e. non-clinical) to ask them.
- Time – For example, I want to get a 'you said, we did' board up in the centre, once we can get access to comments – but it's difficult finding time to do this, when I work part time
- We had a counter system but didn't really have enough patients to make it work.
- Some of the feedback isn't always constructive enough to allow change (e.g. soggy chips, shower temperature, 'too much or too little physio', or time of session.) we do feedback when change isn't possible. It's important to set out stall and create realistic expectations of the service.

Do you feel that there is enough resources available for engagement within LCH? If not, what kind of resource/support do you think is needed? E.g. staff, budgets, incentives etc

Haven't got enough staff time to run the forum properly (I work 3 days a week) – I used to be just a helper in this role to help Suzanne who had more flexibility in her role. We're all clinicians so treating patients has to be our number one priority, anything else has to take second priority. It's an add on to my clinical role because I'm

interested in it, whereas for Suzanne it was more part of her expected role (she's a band higher).

To put up 'you said, we did' board is maybe half a day's work. I can't take a third of my week to do this. Some help to do the practicalities. Quite worried about impact on workload. Would prefer additional help to do these boards across the city. My preference would be to focus on clinical work.

Not sure if someone I can contact to help with involvement. Would be useful to have help and support in terms of how to implement ideas.

How do you think LCH could recognise and share examples of good practice of engagement within the trust?
Involvement Champions, someone came out to introduce this but didn't give any hands-on support. Suzanne liked the gold, silver and bronze Involvement Standards – it put a pressure on the staff by saying 'we want to get from silver to gold'. Interested in finding out from meetings/newsletters what other teams/services within the trust are doing, but it all boils down to time.

What are your aspirations for the future for patient, public and carer engagement within LCH?
Users and carers to be more involved in the staff recruitment including frontline staff. At the moment this only happens at consultant level (organised by the trust). Would be difficult to co-ordinate by service. Are we getting the best people for the job when everything is done on scores? A patient interview panel would give a viewpoint form a different angle. Forum is working well as it is, we just need a broader service group.

Any other comments about how LCH engages with people.