



The National Centre
for Involvement

Turning Involvement into Everyday Practice

**South Staffordshire and Shropshire Healthcare NHS
Foundation Trust**

Final report from the NHS Centre for Involvement

July 2007

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1. Organisational development at the NHS Centre for Involvement

1.1 What is the NHS Centre for Involvement?

The NHS Centre for Involvement (NCI) aims to support NHS staff and organisations do successful and sustainable Patient and Public Involvement (PPI) that improves the quality of services.¹ The Centre was officially launched in November 2006, and is led by a consortium of three partners: The University of Warwick, Long Term Conditions Alliance and The Centre for Public Scrutiny.

Working closely with the NHS in England, the NCI seeks to embed involvement into mainstream health service culture and practice. This includes equipping staff to do high quality involvement on the ground, as well as building the capacity of NHS Trusts to support and sustain involvement over time and across all parts of an organisation. The NCI also works closely with key national organisations to develop a national infrastructure which can facilitate good involvement practice.

The NCI believes that involvement drives a patient-led NHS by:

- improving the patient experience;
- generating mutually supportive relationships between patients and professionals;
- engaging with local communities; and
- developing responsive and publicly accountable services.

1.2 Key principles of effective involvement

The NCI has developed five key principles of effective PPI. These are intended to help NHS organisations engage more successfully with patients and the public. They also provide the foundation for the NCI's future work in organisational development, research and learning. The principles are outlined in the box below.

¹ This report regularly uses the term 'Patient and Public Involvement' or its acronym PPI. However, this general term encompasses a range of groups that may define themselves in different ways. As well as patients and the public, this includes service users, clients and carers.

Key Principles of Effective Patient and Public Involvement

Be clear about what involvement means

- People in all parts of the organisation need to have a shared understanding of what is meant by involvement and its purpose.
- Be clear about the difference between working *for* and working *with* patients and the public.
- Be clear about the different possible purposes of *collective* involvement.
- Make sure there are adequate resources including money, time and people – skilled staff, engaged and informed patients and the public.

Focus on improvement

- Involvement is a means of improving services, not a problem to be solved.
- Organisations must not only engage with patients and the public but also demonstrate change as a result of that engagement.
- Embed a systematic approach to involvement that links corporate decision-making to the community.
- Ensure commitment and leadership from the Board, the Chair, the Chief Executive, directors and clinical leaders.
- Support staff and equip them with the necessary skills.

Be clear about why you are involving patients and the public

- Be clear about the objectives of the work, its rationale, relevance and connection to organisational priorities.
- Be honest about what can change, what is not negotiable, and the reasons why.
- Find out and use what is already known about people's views and experiences.

Identify and understand your stakeholders

- Define who needs to be involved, who needs to be informed and who is likely to be affected by the issue under consideration.
- Make sure all stakeholders are appropriately involved and ensure that your involvement activity is relevant to your stakeholders' interests.
- Consider who is likely to be affected by the implications of the matter in hand.

Involving people

- Promote opportunities for people to be involved. Find out how people prefer to be involved.
- Make sure your methods suit the purpose of the involvement exercise.
- Make special efforts to reach out to people whose voices are seldom heard.
- Share the information and knowledge you have so people can understand the issues.
- Make it clear to people what you are doing and why, including what you can and cannot change.
- Be clear to people that their views will feed into decision making processes;
- Provide feedback to people about what you have learned from them and what action you intend to take in response.
- Ensure patients and the public have the support they need to get involved.

1.3 How are we working to support local NHS organisations?

The NHS gets feedback from patients, but survey and focus group reports often sit on the shelf. One off involvement initiatives may not lead to ongoing engagement around how services are designed and delivered. There are oases of good practice amid deserts of non-engagement. All too often inspirational champions of involvement are isolated and staff who want to engage with patients and carers don't know how to do so. NHS organisations may feel that they are involving patients and the public, but how often can they say that this involvement leads to demonstrable improvement in the quality and experience of services?

The work of the NHS Centre for Involvement is organised across several distinct but interlinked domains. The Organisational Development (OD) domain works directly with NHS organisations to develop involvement at a local level. The OD team works with one NHS organisation in each Strategic Health Authority each year across the primary, secondary and specialist care sectors.

Each OD project looks at involvement at both a strategic and service improvement level. At the strategic level, an organisational diagnostic is conducted to find examples of good practice in involvement within a Trust, and also identify priority areas for improvement. Focusing on organisational systems, processes and resources, the diagnostic looks at how involvement can be mainstreamed across an organisation to become part of everyday practice. At a service improvement level, a specific piece of work is designed to model best practice in involvement around a priority issue or with a specific patient/user group. The approach taken is outlined in detail in the following section.

In addition to our work with the LAS, the other OD projects are:

- **Barnsley NHS Foundation Trust** – focusing on engaging children and young people in emergency care (completed March 07);
- **The London Ambulance Service** – focusing on building relationships with the Bangladeshi community in Tower Hamlets (completed June 07);
- **The Walton Centre for Neurology and Neurosurgery** – focusing on continuity of care for people with neurological conditions (completed June 07);
- **Suffolk Mental Health Partnership Trust** – focusing on engaging clients in improving substance misuse services (ongoing);
- **United Bristol Healthcare Trust** – focusing on older people and transitions in care (ward moves) (ongoing); and
- **Heatherwood and Wexham Park Hospitals NHS Trust**: focusing on BME groups and communication in cardiac care (started July 07).

1.4 What does an organisational development project involve?

Each OD project takes place over a fixed period – from the Trust agreement to proceed to the delivery of a final report with recommendations. It is overseen by a steering group, which should include Trust staff (management and frontline), members of the NCI team and key external stakeholders. The steering group is expected to provide linkage between the project and the Trust Board, to whom the NCI team present their findings and recommendations. The NCI works with the Trust to share the learning from the project locally and nationally, and returns one year later to assess progress.

The strategic level work centres on an organisational diagnostic that brings together a range of information and perspectives to:

- explore the nature of involvement at the Trust;
- identify existing practice and progress in involvement;
- explore strengths, weaknesses and growth opportunities;
- highlight priority areas for improvement; and
- develop the foundations for a model of good practice.

What is an organisational diagnostic?

An organisational diagnostic consists of four stages and is like an involvement MOT:

1. **Documentary analysis:** we ask for copies of key PPI documentation for detailed review – such as the PPI Strategy, Core Standard 17 submission to the Healthcare Commission, minutes of relevant committee meetings, Board reports and policy documents.
2. **Mapping exercise:** Trusts are asked to construct a record of involvement activities that have taken place over the past six months using a template.
3. **Baseline assessment questionnaire:** the NCI has developed a detailed questionnaire, which assesses the extent to which Trusts have a strategic and high quality approach to involvement. Approximately 30-50 people are approached to complete the questionnaire online, including both Trust staff and external stakeholders. As well as exploring the general Trust approach to involvement, the questionnaire focuses on six key issues:
 - a. strategy and action plans;
 - b. senior commitment and leadership;
 - c. resourcing and support;
 - d. roles and responsibilities;
 - e. partnership working, equalities and diversity; and
 - f. mechanisms for evaluation and sharing the learning.
4. **Telephone follow up:** from the responses to the questionnaire, issues of concern and/or areas for improvement can be identified. A small number of people are then approached to explore these in more detail during short telephone interviews.

The culmination of the diagnostic is an organisational learning event, which brings together Trust staff and key external stakeholders. The findings of the diagnostic (and progress on the service improvement work) are presented at the event, with scheduled workshops providing opportunities for wider comment and to plan improvement work.

Alongside the organisational diagnostic, the Trust is also working on a service improvement project that focuses on a particular issue or user group. This is an opportunity to model good practice in involvement that can be shared across the organisation. While the strategic work offers a top down view on embedding PPI in the Trust, this is a bottom up approach to developing effective and sustainable ways of working by learning from experience.

Trusts are encouraged to take a productive approach to involvement, where patients and public are involved in providing solutions to perceived problems. The focus of the project should be an issue which is a shared agenda for action between the organisation, staff and patients and the public. The role of the NCI team is as strategic advisor to the design and delivery of the project. The team also carries out a national trawl of involvement practice to:

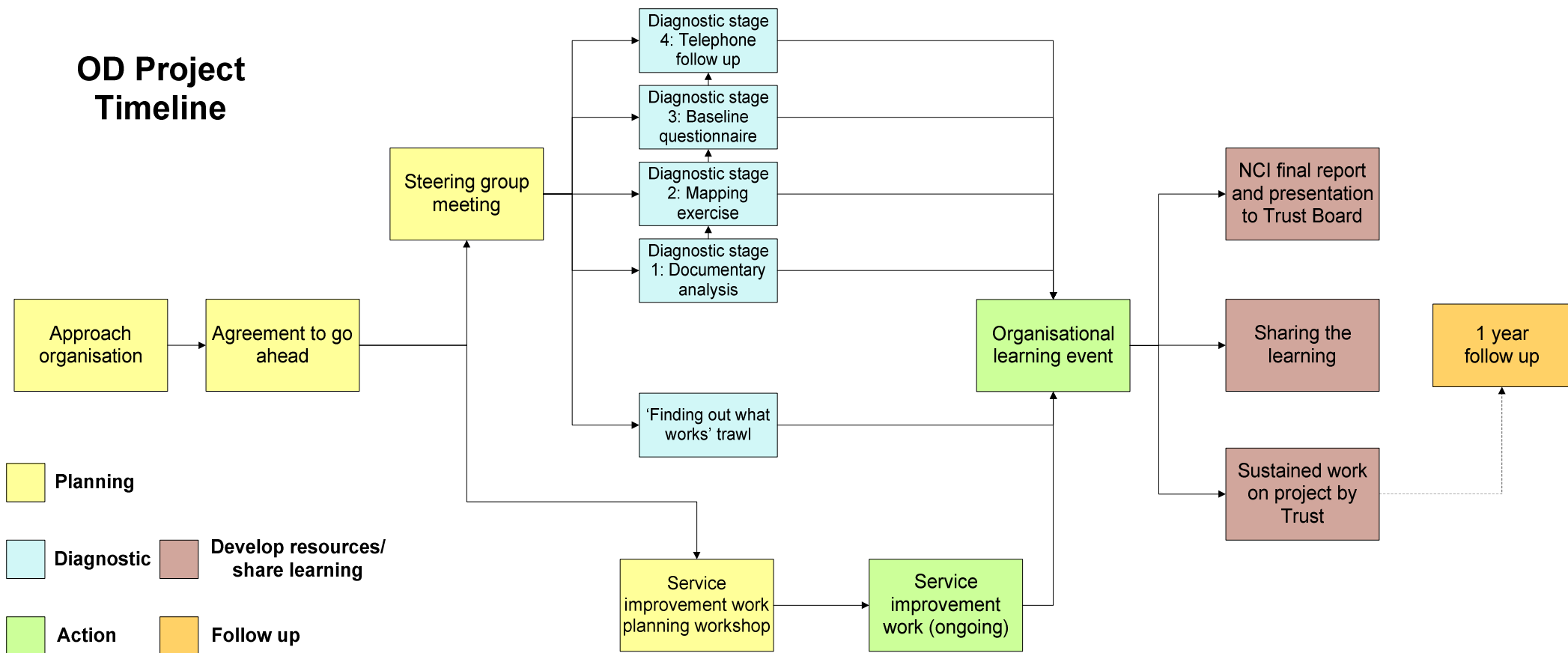
- identify and share the learning from relevant case study examples;
- highlight the main barriers and facilitators to successful involvement in the area concerned; and
- provide contact details of case study organisations and references for further information.

In summary, the aims of an OD project are to:

- develop a more strategic approach to involvement across an organisation;
- model best practice in involvement within a particular service area or with a particular user group; and
- share the learning locally and nationally.

The full project process is outlined in the diagram below.

OD Project Timeline



1.5 Who is on the team?

The project team for the work at South Staffordshire and Shropshire was led by David Gilbert (Director of Organisational Development) and Jo Ellins (Organisational Development Project Manager). Each team for the OD work also includes members of the People Bank – a community of people recruited to shape and deliver the work of the NHS Centre for Involvement. The NCI's People Bank includes patients and carers with direct experience of health services, members of the public with an interest in healthcare issues and NHS professionals. More information about The People Bank can be found at www.nhscentreforinvolvement.nhs.uk

From the People Bank, the South Staffordshire and Shropshire team also included:

- **Mary O'Reilly:** Mary is a mental health service user and member of the User/Carer Forum at Mersey Care Trust (www.merseycare.nhs.uk). Mary has contributed widely to activities at the Trust, including staff recruitment and induction, staff career development, service governance and the investigation of serious incidents.
- **Mark Leveson:** Mark is Head of User Participation and Development (Mental Health) at the London Development Centre, which is part of the Care Services Improvement Partnership (www.londondevelopmentcentre.org). Mark previously co-founded a local mental health user organisation in North London, and in 2004 received an NHS Champions Award.

2. South Staffordshire and Shropshire Healthcare NHS Foundation Trust

2.1 Background

South Staffordshire Healthcare NHS Foundation Trust is a Foundation Trust with its headquarters based in Stafford. It provides inpatient, community and prison in-reach services across a wide geographical area in South Staffordshire. The Trust has five clinical directorates:

- Mental health services;
- Developmental neurosciences and learning disability services;
- Forensic mental health services;
- Children's services; and
- Specialist services (including substance misuse, mother and baby, and eating disorders).

The Trust was formed on 1 April 2001. It became one of the first three mental health style Trusts to become a Foundation Trust (FT), on 1 May 2006. The Membership Council includes 21 public, service user or carer governors; 5 staff governors; and 14 appointed partner governors. The latter includes representatives from a diverse range of organisations such as The Prison Service, Age Concern, The Racial Equality Council for Staffordshire and representatives from two local PCTs.

The Trust has identified eight key principles to guide its work:

- enhance patient, user, carer and public experience of our services;
- engage and support our clinicians in their front line roles, along with the people who support them;
- improve and develop clinical and managerial processes on a continuing basis;
- strengthen individual and team development to ensure we have the competencies required for a modern organisation;
- to be outward looking, to understand national policies and to influence social changes, involving patients and the public in redesign, development and improvement of our services;
- be flexible in our approach to partnership working;
- devolve responsibility, accountability and authority as close to the patient as possible; and
- develop commercial competence in ways that complement our value base.

In its 2007 submission to the Healthcare Commission, the Trust declared itself fully compliant with the core standards as set out in Standards for Better Health. This includes compliance with Core Standard 17, which requires evidence that "The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services."

Up until 31 May 2007, mental health and learning disability services in Shropshire were provided by Shropshire County Primary Care Trust (PCT) which was established in April 2002. From 1 June 2007 these services transferred to South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

2.2 Patient and Public Involvement at South Staffordshire and Shropshire Healthcare NHS Foundation Trust

In South Staffordshire the Trust has a dedicated PPI team with three staff. Their role is to co-ordinate involvement activities, produce patient information and oversee volunteering opportunities. In addition, there are identified leads for involvement in each of the Trust's directorates. The PPI Manager is the operational lead for involvement in the Trust. In addition to the PPI team described above, the Assistant Chief Executive is the strategic involvement lead and there is a non-executive director PPI champion at Board level.

In Shropshire, there is a dedicated resource allocated to service user and carer involvement comprising two staff in the adult mental health division. However in Learning Disabilities, the role for supporting service user and carer involvement is undertaken by Taking Part, an Advocacy Group, under a contract.

There is also a separate PALS team in South Staffordshire and Shropshire, with responsibility for listening to and acting on patient concerns about Trust services. In March 2004 in South Staffordshire, six Associate Directors (users of Trust services or their carers) were recruited through the PPI team with access to dedicated staff support and resources. There is a Service User/Carer Subcommittee to the Board, with representation from the PPI Team, directorate leads, Service User/Carer Associates and senior management. Since the Trust became an FT, reporting arrangements for the Subcommittee are formally through the Membership Council. Service users and carers are also supported by the PPI team to engage and involve themselves in the work of the Trust and a payments policy supports them to do this.

In Shropshire's mental health services, a group of Service User Consultants are supported to undertake a range of activities related to involvement and are paid on an ad hoc basis in accordance with a payments policy.

2.3 Integration of South Staffordshire NHS Foundation Trust with Shropshire Primary Care Trust²

During the course of the NCI project, South Staffordshire Trust was preparing to integrate with mental health and learning disability services in Shropshire. These services were transferred on 1 June 2007 from Shropshire PCT to South Staffordshire, creating South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

The NCI project took into consideration ways in which an integrated model of involvement could be created to provide consistency of systems and processes.

² Throughout this report, 'Shropshire PCT' specifically refers to the mental health and learning disability directorate rather than the PCT in general.

3. The service improvement work

3.1 Background

The purpose of the service improvement work is to model good involvement practice around an issue or area:

- which is of importance both to the Trust and its staff, as well as to service users/carers;
- where users and carers can be involved in developing solutions to perceived problems; and
- where there are opportunities to build on existing work.

The work is also an opportunity to develop a generic approach to planning and doing involvement, which can be deployed in other parts of the Trust. It is the process of involvement as much as the particular topic which is of importance. During the NCI project, the aim is to plan and initiate a specific piece of service improvement work. The NCI aims to be a catalyst to sustainable work, and the Trust is expected to commit the necessary leadership and resources for successful completion.

The project steering group at South Staffordshire and Shropshire discussed a number of potential topics for the service improvement work.³ Initial suggestions for the project included developing arts in health or prison in-reach services. However, the group opted to do a piece of work around person centred service evaluation. This choice emerged from concerns about the unsuitability of conventional feedback methods – in particular written surveys – for many groups using the Trust’s services. Various shortcomings were identified for written surveys, including:

- inaccessibility for people who cannot read, write or who have cognitive impairment;
- questions may be based on what organisations want to know, rather than what service users want to tell them; and
- it is not always clear what impact surveys have on the provision and management of services.

The purpose of the work was to develop alternative methodologies for obtaining feedback, to complement written surveys. It focused on two major service user groups: people with Alzheimer’s and dementia (and their carers) and people with learning disabilities.

The steering group agreed that the work needed to ensure that:

- the agenda for, and issues covered by, service evaluation are shaped by the priorities and interests of users and carers;
- feedback methods are used that are suitable and accessible for the users/carers concerned; and

³ The project steering group included local service users, staff, senior managers and others from South Staffordshire and Shropshire.

- appropriate follow up and service improvement is made on the basis of the feedback provided.

The first stage of planning was to identify people to join each of the two project teams and to develop an action plan.

3.2 Current progress

The service improvement work progressed through discussions with key groups and individuals, and at workshops held on the projects at a learning event. Nonetheless, progress in terms of action and output has been slow. In part, this reflects the complexity of co-ordinating involvement work across the newly enlarged Trust area of South Staffordshire and Shropshire. The projects have brought to the fore the issue of how staff and user representatives in previously separate Trusts can work collaboratively to involve service users and carers.

Our observation is that the work is being led enthusiastically, but would benefit from a clear framework for leadership on the ground and strategic direction from the top of the organisation as the integrated Trust becomes established. It was evident from an early stage that there are various people and groups that have a stake in the work, and who could contribute to its delivery. But a systematic project set up process has not been followed which, to date, has hampered progress. This process will be essential for further development.

Previous to the NCI intervention, good work has been done to creatively engage with service users who have Alzheimer's/dementia and learning disabilities. For example, in Shropshire the Older Adults Team replaced their discharge survey with a face to face interview conducted by a trained service user. This has been found to be a very effective way of getting unbiased feedback from older people about their experience of inpatient mental health care. An accessible questionnaire also has been developed in Shropshire for inpatient service users with a learning disability and mental health problems, and work is underway in South Staffordshire to produce an Easy Read dictionary. At present, efforts are focused on gathering together existing good practice as a foundation for the work.

The key factors that have emerged from the service improvement project are:

1. **Staff capacity:** It was not clear to us the extent to which senior managers were empowered to ensure that staff devoted sufficient time to engage with service users and carers on this sort of project. We were told that, across South Staffordshire and Shropshire, there is a wealth of skills and resources for involvement. But there seemed little evidence of mechanisms in place for identifying additional help or resources within the Trust to ensure the successful delivery of involvement work.

- 2. Working with voluntary sector organisations:** An advocacy group for people with learning disabilities in Shropshire indicated strongly that South Staffordshire needs to consider how it works with the local voluntary sector. There are resource implications for voluntary groups in facilitating involvement processes or acting as advocates in a dialogue between service users and health providers. Where the Trust will be approaching voluntary organisations for the first time, communication must be open and honest to ensure clarity of expectation and purpose. Voluntary organisations will want assurances that, where they assist in gathering feedback on local services, the Trust is committed to acting on the findings. A wariness of 'tick box' service evaluation may be countered by upfront assurances that the information collected will be used to improve services, and by making it clear what can be and cannot be changed as a result of user feedback.
- 3. Acting on findings in areas beyond the reach of the Trust:** People may want to give feedback on all the services they use and which collectively shape their experience, not just those that fall under the control of one provider. The Trust needs to be clear with those people that it approaches to provide feedback about which services are within its capacity to change and which are not. But more than this, partnership work is key. At a minimum, the trust must be able to share feedback about other providers and encourage them to act on it. The best solution is solid accountability mechanisms for partnership work and collaboration in the work itself, particularly with voluntary sector partners and other providers with which the Trust engages.

4. The organisational diagnostic

4.1 What we did at South Staffordshire and Shropshire NHS Foundation Trust

As Section 1 outlined, the organisational diagnostic is a multi-method assessment of involvement at an NHS Trust. The box below outlines how we collected data for the organisational diagnostic at South Staffordshire and Shropshire.

The organisational diagnostic at South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Trust documentation: South Staffordshire sent us their PPI Strategy, minutes of key meetings, User Reimbursement Policy, patient survey results, and Trust newsletters. They also provided copies of gap analyses that had been conducted in advance of the integration with the mental health and learning disabilities division of Shropshire PCT.

Mapping exercise: Some information was provided on involvement activities that had taken place at the Trust over the past six months.

Survey: Fourteen people completed the baseline assessment questionnaire – eight from the South Staffordshire Trust, five from Shropshire PCT and one from a stakeholder organisation.

Follow up interviews: Three telephone interviews were conducted with staff at South Staffordshire – to explore in detail the three key issues that emerged from the survey:

- budgets;
- staff training and development; and
- evaluation and sharing the learning.

Organisational learning event: The learning event was held on 4 May 2007 and was attended by staff, managers, users/carers and other key stakeholders from South Staffordshire and Shropshire. Three workshops were held in the afternoon session: two focusing on the service improvement projects and the third to discuss and validate the findings of the organisational diagnostic.

4.2 The Trust approach to involvement

Our general impression of involvement at South Staffordshire Trust and Shropshire PCT was very positive. Both organisations have embraced the principle of listening and responding to the people who use their services and there is a shared commitment to improving the user/carer experience. There were striking similarities in terms of involvement culture and the way that

involvement practice is situated within the organisation. Leadership and responsibility for involvement is very strongly 'owned' by individual divisions or teams. We found evidence that directorates are taking a strategic approach to involvement by using feedback from users and carers to inform their business planning. This was directly confirmed by one survey respondent, who noted that:

"...service user involvement is mainstreamed into the business planning process for each Directorate" (South Staffordshire respondent).

Another respondent noted that directorate involvement leads have a specific remit to ensure:

"the alignment of directorate priorities and goals (which in turn are aligned with organisational ones) with involvement activities" (South Staffordshire respondent).

This is very different from the centralised approach found in many other Trusts, where involvement is viewed as a corporate or management responsibility. The devolved model at South Staffordshire and Shropshire brings involvement closer to service managers and frontline staff. At its most effective, this has embedded the practice of working with service users and carers into everyday practice.

It is clear that users and carers are being involved at all levels in both Trusts: from providing feedback as part of the development and evaluation of specific services to representation at key meetings and committees where strategic decisions are made and business planning takes place. As one survey respondent commented:

"Most projects and forums will regularly ensure that service users and carers are involved from the outset. For example opportunities are disseminated via the Service User and Carer Sub-committee to the Board" (South Staffordshire respondent).

Many directorates are employing a variety of approaches to find out about the needs and experiences of service users and carers, as well as offering forms of emotional and social support. As one respondent noted about older people's services in Shropshire:

"There are in-patient forums, discharge interviews, focus groups, user groups, care groups, coffee shops, Al's café... There is also a Younger People with Dementia strategy group which is a very active group involving carers, practitioners and managers" (Shropshire respondent).⁴

⁴ Al's Café is a regular social and educational event for people with Alzheimer's and their carers, held in the Shropshire area.

Importantly, both Trusts had made a strong commitment to involvement at the core of their organisations by routinely inviting users and carers to participate in staff recruitment and selection processes. The imperative to support involvement in these complex and technical processes has been recognised. For example, a structured training programme is provided at South Staffordshire to service users with learning disabilities, to equip them for sitting on staff recruitment panels.

Various other involvement mechanisms and processes have been put in place including the following:

- **The User-Carer Subcommittee to the Board in South Staffordshire.** This brings together directorate involvement leads, User-Carer Associates, the PPI and PALS teams and members of Trust management. The Subcommittee reports to the Membership Council, but its Chair is able to take important issues directly to Trust Board. The Chair of the Subcommittee is also a non-executive director.
- **SURF (Service User Reference Forum) in the South Staffordshire mental health directorate.** SURF is a communication forum within the mental health directorate. There are involvement leads (consisting of professionals, service users and carers) in each of the directorate's locality services who attend SURF meetings to share concerns, issues and current involvement activities. This information is routinely communicated to the directorate management team, Trust User-Carer Subcommittee and other relevant bodies (eg the Acute Care Forum).
- **Regular publicising of involvement opportunities in Shropshire mental health services.** A bi-monthly newsletter is produced by the service user involvement team in Shropshire, which includes details of new involvement opportunities.

4.3 Strategy and action plans

An involvement strategy plays a key role in coordinating involvement activities across an organisation, setting priorities and objectives and providing a clear plan for future action. Any strategy or action plan needs to outline specific steps for how aims and objectives will be met, whose responsibility it is to undertake the necessary actions, and what the timeframes to achieve these should be. This is also essential in terms of monitoring progress and ensuring accountability in the involvement process. For involvement to be fully embedded into organisational culture and practice, the strategy needs to demonstrate how involvement links with wider Trust priorities and overall business objectives.

A well acknowledged Patient and Public Involvement Partnership Strategy has been developed at South Staffordshire. Since its development, the Trust has gained FT status and on 1 June 2007 integrated with the mental health and learning disabilities directorate of Shropshire PCT. The need to develop a new strategy to take account of changed circumstances has been recognised, and the Trust intends to use the findings from the NCI project to inform this.

The current strategy has ambitious aims, but does not set out a programme of action with specific activities, key performance indicators and timescales. Given this, it is not clear if and how the strategy is being implemented, or how progress against the objectives is being monitored. Without clear indications of how strategic involvement objectives should be translated into action, it is possible that implementation is not systematic and consistent across all parts of the organisation. It appears also that the strategy does not make provision for adequate resources and support for involvement.

Some survey respondents suggested that a Trust wide strategy is not critically important, given that the responsibility for 'doing' involvement is principally at a directorate level and that involvement is mainstreamed. But there needs to be a mechanism for ensuring that divisional activity reflects and contributes to the overall priorities for involvement set by the Trust. There did not seem to be a clear steer from the top of the organisation about how these corporate priorities can be built into directorate planning process (and vice-versa). This was recognised by one respondent, who noted that:

"The principles of involvement are embedded within Directorates and evidence exists that involvement is deployed effectively and communicated. But this is not currently drawn together as one action plan/strategy and probably needs to be – both to share and communicate best practice and direct future strategy in terms of involvement" (South Staffordshire respondent).

4.4 Senior commitment and leadership

A strong and positive involvement culture should permeate all levels of an organisation. Board members, the Chief Executive, senior managers and clinical leaders all have key roles to play in leading, motivating and inspiring staff to engage with patients and the public in their everyday practice. They should lead by example and model a commitment to openness, listening and responsiveness. Staff also need to be valued for their involvement work and the Trust should celebrate success.

It is clear that senior commitment and leadership is strong, visible and appreciated. As one survey respondent commented:

"I believe the culture of involvement is very embedded at senior level" (South Staffordshire respondent).

The survey asked specific questions about senior level support, with respondents able to provide an answer between a low of 0% to a high of 100%. Key findings from these questions are outlined in the box below.

Good evidence of senior commitment and leadership: survey responses

Question: “The Chief Executive and Chair visibly demonstrate their support and leadership of involvement.”

- South Staffordshire respondents gave an average rating of 98%.

Question: “Senior managers and clinical leaders visibly demonstrate their support and leadership of involvement.”

- Respondents across both Trusts gave an average rating of 78%.

Question: “Directorate/team involvement leads support and motivate frontline staff to engage in involvement activities.”

- An average rating of 88% from respondents at South Staffordshire and of 66% from respondents at Shropshire.

Strength and visibility of leadership for involvement was less apparent among senior medical staff. At the learning event, some examples were given of senior doctors who are open to, and supportive of, involvement. However, people also suggested that such engagement was not the norm and that the behaviour of some doctors was a barrier to participative ways of working and involvement.

4.5 Resourcing and support

A coherent strategy and senior leadership are necessary for effective involvement, but they are not sufficient. An organisation needs to build its capacity to undertake involvement that is both successful and sustainable. Proper resources are needed, and staff must have the opportunities and time to do the work. They must also be equipped for the task through training and development. Equally, patients and the public may need support in order to make their contribution. Training and development for staff must be complemented by equivalent opportunities for patients. The issue of reimbursement is also important as it sends a message to those involved about how the Trust recognises and values their contribution.

The issue of resourcing and support was felt by survey respondents to be the weakest link in the involvement chain. There is a great deal of motivation and emotional support provided to staff for involvement. Dedicated divisional and, in some cases, locality involvement leads signify clear responsibilities for leadership and guidance. But two things are largely missing: a coherent approach to budgeting and to staff training and development.

Most survey respondents and participants at the learning event felt that the budget allocated to involvement was insufficient. There is no ring fenced funding for involvement work, either centrally or in directorates. At directorate level, money has to be found from operational budgets. Consequently, funding is always provisional, dependent on the clinical director's agreement to release money, and contingent on other cost pressures. There is no central PPI budget with which to fund activities such as producing patient information. Instead the PPI team is currently set income targets based on the sale of patient information leaflets. We were also told that this situation compares unfavourably with the pre-FT situation where Patient Associates had access to significant dedicated resources.

People have experienced difficulties securing rooms and basic refreshments to hold events for service users and carers. The integration has also brought the issue of user reimbursement to the fore. South Staffordshire has recently developed a revised user reimbursement policy, developed in line with Department of Health guidelines. The policy outlines activities for which users/carers would be paid for their time, either as a sessional fee or hourly rate. There is no single and consistent approach in Shropshire. In mental health, user 'consultants' are paid a sessional fee and, in some cases, costs for childcare or a sitting service can be covered to enable people to participate. Comments made by service users indicate that parity of payment across the two areas is an important issue, and would be symbolic of an integrated approach to involvement.

We further explored this issue up during a telephone interview with the Trust's Finance Department. One possibility is that directorate budgets are top-sliced to create a ring fenced pot for involvement. This top down measure was felt to run counter to current efforts to devolve control to directorates. Equally, given that some directorates are currently overspending, increasing the directorate budget to create funds for involvement was not considered to be a viable option.

It was suggested that greater flexibility to apportion money for involvement could be achieved through enhancing the prominence of PPI targets into the performance management process. If involvement was defined as a core element of directorate business plans, then involvement leads would have greater leverage to push for budgets to support work when PPI targets are met. While money would still not be ring fenced, it would be more difficult for directorates not to fund involvement work where this directly contributes to their success in performance review. But one possible consequence of this would be to squeeze out other directorate level activities. Without central advice and support as to how to allocate limited funds, this may risk unsettling directorate level budget holders.

Cost pressures on the central PPI team were recognised. It was suggested that the team could make a business case for the next financial year for increased funding to achieve key aims and targets. The Finance Department offered to help them with this.

There are two main issues concerning staff training and development. First, whether and how service users/carers are involved in the induction and training of Trust staff. Secondly, whether performance in, and support for, involvement is built into the staff development process. Service users and carers do get to talk to new staff about their experiences at induction, but involvement is not a consistent feature of further staff training. At the learning event, we were given examples of learning opportunities where staff and service users/carers are working closely together, for example in the area self harm and in the Wellness Recovery Action Planning (WRAP) programme. However, participants felt that more could be done in this area, particularly in relation to clinical staff. This was echoed by one survey respondent, who commented that there is:

“too much assumption that involvement comes naturally – need to explore this as part of induction, KSF development, mandatory training, possibly through a customer care approach” (South Staffordshire respondent).

The survey responses indicated that involvement is not consistently or formally addressed during staff appraisal. We interviewed the Learning and Development Manager at the Trust about this. They talked about the role of the Knowledge and Skills Framework (KSF), which forms the basis of appraisal for nursing staff and allied health professionals. While the KSF covers areas such as service improvement, quality and communication, it does not explicitly include PPI competencies. They also commented that directorates or teams could make more use of feedback from service users and carers to identify overall priorities for staff training and development. These priorities could then be fed into the appraisal process and linked to specific programmes of development for individual staff.

During telephone follow up interviews, we were told about two ideal opportunities to take this work forward:

- **The Learning and Development Manager will be developing a set of organisational expectations and standards around the KSF dimensions.** The aim is to simplify the KSF and apply it so that it meets specific workforce needs of South Staffordshire and Shropshire, and to develop Trust-wide standards of evidence to show that KSF indicators have been met. For example, listening and responding to patients might be one measure used to demonstrate competency for the communication dimension.
- **The Performance Development Team is reviewing mechanisms for service user and carer input into the performance review processes.** The team's review includes how feedback from users and carers is used in business planning, as well as how users and carers can be involved in six monthly performance review processes. The team will be working with the Service User-Carer Subcommittee on this project.

4.6 Roles and responsibilities

The foundation of a strong involvement infrastructure is having well defined roles and responsibilities for staff at all levels of an organisation. This leads to clarity of purpose and approach, less duplication of effort, and stronger governance and accountability arrangements. It should also be clear who is responsible for 'doing' involvement, and who is responsible for ensuring that the organisation takes action based on the feedback it receives. Linkage and communication between those concerned is important.

At South Staffordshire there is a clearly identified operational lead (the PPI manager), strategic lead (the Assistant Chief Executive), and leads in each of the Trust's directorates. We did not see specific evidence of equivalent professional leads for involvement in Shropshire, but in mental health a service user is the part time involvement coordinator (30 hours per week). Board meeting minutes show that involvement is routinely taken to and considered at this level. In the survey, a question was posed about whether it is clear who does what in terms of involvement at all levels. While Shropshire respondents scored this item with a low 15%, the average rating was 86% in South Staffordshire. We were told that Shropshire PCT had taken a hands off approach with the mental health and learning disability directorate. For example, there had been relatively little Board involvement in the governance of the directorate. This may be one reason for the lower ratings given by Shropshire respondents to this question.

Our concern is that the structure for involvement at South Staffordshire and Shropshire – with regards to roles, responsibilities and accountabilities – seems based on particular committed individuals, rather than being formalised and embedded into a system. We were left with the impression that the structures may need to be strengthened in order to withstand organisational changes and the departure of enthusiastic senior champions, such as the outgoing Chief Executive.

During the organisational diagnostic, there was hardly any discussion about the role of the Membership Council or member governors. Neither did anybody suggest how the Council might be better integrated into governance structures in the integrated Trust or connect with the Local Involvement Networks (LINKs) that will be established shortly in each Local Authority area.

4.7 Partnership working, equalities and diversity

Partnership working in involvement can help to:

- share expertise and capacity across organisations, promoting greater efficiency;
- prevent duplication of effort and combat 'consultation fatigue' in the local population;
- share best practice, learning and contacts;
- build new relationships and networks;

- contribute towards improved co-ordination across service providers; and
- engage with a diverse range of people in the local community.

Both South Staffordshire Trust and Shropshire PCT have developed relationships with a range of external organisations (statutory and voluntary), but there was disagreement among survey respondents about the extent of collaborative working. In Shropshire, the involvement of people with learning disabilities is co-ordinated by the independent advocacy organisation *Taking Part*. There is a joint commissioning post across the PCT and Local Authority for this user group.

Both Trusts are making reasonable efforts to involve and get feedback from a wide range of people, although there was felt to be room for improvement. There is a commitment to listening to all voices equally, as illustrated by the focus on inclusion in service improvement work. Yet a number of people suggested that the Trust could do more to involve children and young people.

4.8 Evaluation and sharing the learning

Gathering and disseminating information about the outcomes of involvement work is essential. It contributes to a positive culture of involvement, demonstrates to the staff and users/carers involved that they have genuinely made a difference, and can be a useful lever in securing support for future activities. But organisations should not wait until the end of an activity to assess how well they are delivering improvements. Integrating involvement into performance management arrangements ensures that progress is regularly monitored. This creates an important accountability framework, as organisations can determine whether they are meeting their involvement objectives and goals.

It was easy to find examples of good practice in both South Staffordshire and Shropshire. However, many people felt that much more could be done to share this good practice across the organisation and to communicate the impact of involvement work to those who use the Trust's services:

"[We need] more specific examples of how involvement has made a difference" (South Staffordshire respondent).

"[There are] not many instances of parading our successes" (Shropshire respondent).

"[The Trust] does need to improve the overall communicating of best practice" (South Staffordshire respondent).

At South Staffordshire, there are a number of mechanisms in place to disseminate information about involvement work. These include a recently introduced service user and carer newsletter *Involvement Matters*, the Service User-Carer Subcommittee which regularly brings together directorate

involvement leads, and an annual Celebration Day. It is unclear whether these existing mechanisms are working effectively, or if additional ways of sharing and celebrating good practice are needed.

The diagnostic also suggested that the Trust could be more systematic and consistent in the evaluation of involvement activities. The Clinical Audit Team at South Staffordshire supports directorates in monitoring and evaluation activities, and has compiled a database of audit projects with user/carer feedback or involvement. The database stores information on the outcome and impact of clinical audits. Ensuring that this team is able to support Shropshire based services is important, as is further consideration of how evaluation can be built into all involvement work at the Trust so that improvements in service quality and experience can be shown consistently.

5: Recommendations and next steps

5.1 Recommendations

Our work with South Staffordshire and Shropshire has identified much to be positive about. There are many examples of good involvement practice, a strong organisational culture of listening and responding to users/carers, and a willingness to make the necessary changes for improvement.

There are a number of organisational challenges that have major implications for Trust-wide involvement. These include the integration with Shropshire PCT Mental Health and Learning Disabilities Directorate and the need to develop and adapt FT governance arrangements to incorporate a wider geography of services. Externally, there are going to be changes in national arrangements for involvement. These include the introduction of LINKs and stronger duties to involve and consult under Section 11 of the Health and Social Care Act.

In order to be fit for the future, it is our opinion that the Trust needs to consider developing its approach to involvement in two ways:

- 1. Move from an informal to a formal structure for involvement.**
Involvement at South Staffordshire is largely dependent on the support and leadership of committed individuals. For sustainable PPI, the Trust needs a strong involvement infrastructure which can endure organisational changes and external challenges.
- 2. It needs to move from a devolved to a shared model of involvement.** There is a danger that the current direction of travel could result in the complete transference of responsibility for doing and resourcing involvement to directorates. Senior managers voice a strong commitment to the principle of involvement, but must take this a step further by sharing responsibility for achieving this in practice.

To achieve these changes, we suggest that South Staffordshire and Shropshire Healthcare NHS Foundation Trust considers implementing the following four recommendations:

Recommendation 1 Develop an integrated and coherent involvement strategy

South Staffordshire and Shropshire currently lacks a practical blueprint for involvement. Without this, the Trust cannot be assured that involvement is sustainable. The integration with Shropshire PCT provides an ideal opportunity to rethink the Trust's current PPI strategy. The new one has to be sustainable and embedded in structures and processes.

The integrated strategy should be underpinned by principles, such as the sharing of responsibility for involvement, rather than the current reliance on

devolvement to directorates that may be unsustainable in the new environment.

The strategy should set out specific actions, expected outcomes and agreed timescales. It should be integrated into performance management arrangements to measure ongoing progress and outcomes and be a core aspect of all staff induction. It should also assign specific responsibilities for involvement at directorate, team and individual levels and for key decision making bodies (eg the Board, the Service User-Carer Subcommittee).

Particular challenges include making sure the right support and opportunities are in place. There should be reconsideration of the role of central PPI support and the resources required to support directorate based work. There must be increased clarity about the role of the Membership Council and more targeted support for member-governors so they are able to fulfil their responsibilities.

Finally, based on comments from a number of survey respondents, the new strategy should outline how the Trust will increase the involvement of children and young people. We would suggest that an audit of how the Trust currently involves children and young people should be conducted as the basis of further development.

Recommendation 2 Ensure that the right policies are in place to support involvement and collaborative working

A solid involvement strategy should be underpinned by policies which support and enable its successful delivery. Clearly stated and consistently implemented, such policies would also be a vital part of an integrated approach to involvement across the newly enlarged Trust.

The issue of financial reimbursement for users taking part in involvement activities is important as it sends a message those involved about how the Trust recognises and values their contribution. Following the integration, the Trust must ensure it sends the same message to all by establishing parity of reimbursement for all involved users/carers. A reimbursement policy has been developed by South Staffordshire. This may need to be reviewed to ensure it meets the needs of the integrated Trust, but swift implementation should be the goal.

Evaluation and sharing the learning is another area where work is needed. There is a considerable amount of good practice at the Trust, but also a sense among staff that this isn't always gathered and shared to best effect. A key part of capacity building for involvement is to make staff aware of existing good practice within the organisation, and help them build on this in their own work.

The first step should be to assess what resources are already available within the Trust to support evaluation. The Trust also needs to consider how it can provide information to staff about resources that are available and how they

can be accessed. There is already considerable in-house expertise in the Clinical Audit Team. It is extremely unlikely that this team would be able to directly support all involvement activities at the Trust, but instead could develop a set of guidelines and provide generic tools for evaluating outcomes. This would help to ensure that information on the impact of involvement is consistently and routinely collected.

The service improvement work has uncovered some of the challenges of working in partnership with voluntary sector organisations, particularly for the first time in the Shropshire area. South Staffordshire and Shropshire recognises the considerable value to partnership working, but needs to formalise and establish clarity in its relationships with voluntary organisations to ensure success. To this end, it needs to develop core principles for effective partnership, and should use the opportunity to consult the local voluntary sector about how they can work more effectively together.

Recommendation 3 Build capacity by integrating involvement into staff training and development processes

A strategy and supportive policies are necessary for successful and sustainable involvement, but are not in themselves sufficient. South Staffordshire and Shropshire also needs a workforce that is equipped for the task. Integrating involvement in staff training and development is the key to this.

We identified a number of opportunities for the Trust to take this issue forward. In particular, the KSF development project by the Learning and Development Manager, and the joint initiative to enhance involvement in performance management by the Performance Development Team and Service User-Carer Subcommittee. These provide a focus for considering how capacity for involvement can be further developed through workforce development and business planning arrangements.

We recommend that South Staffordshire and Shropshire formally integrates involvement into the staff recruitment and development process. There are two main methods for achieving this, both of which could be implemented at the Trust. First, staff appraisal could include setting individual involvement targets and the identification of training and support needs to achieve these. This links to the KSF project, which could look at how involvement competencies can be defined and mapped onto existing job descriptions.

Second, users and carers could be directly involved in performance appraisal – of individual staff members, teams and directorates. There are a number of issues to be considered here, which could be looked at as part of the Performance Development Team's work on this subject. For example, how will user/carer feedback be contextualised and weighed against other types of evidence? And what mechanisms are needed to ensure accountability to users/carers in the review process?

Recommendations 4 Establish clear arrangements for project planning and management

There are many merits to the model of involvement at South Staffordshire and Shropshire, where responsibility for planning and doing involvement is at directorate level. But this model may also lead to difficulties in developing Trust wide projects, which require collaboration of different service areas and coordination between these and the central PPI team. This may be one reason for the slow progress observed in the service improvement work

South Staffordshire and Shropshire should utilise a standardised approach to project initiation and arrangements for ongoing project management. A project initiation document should prompt for a project leader, team members, and user/carer representatives. Teams need to think in advance about what the overall aims and expected outcomes of the project are, and have clear agreement about the timescales in which specific activities should be completed.

The recommendations above indicate ways in which South Staffordshire and Shropshire can address areas of weakness in its strategic support for involvement. Additionally, the Trust should also use the service improvement work to address these areas in practice. This would require teams to think now about what staff training and development needs might be, and consider how they will gather and share the learning from their projects. A method for building strategic issues into service improvement work would be the ideal outcome.

Finally, the Trust should consider investing in involvement projects that have a strong developmental emphasis. A small amount of money could be used to set up a seedcorn fund, to support involvement projects which aim for improvement at both strategic and service improvement level. This would be a demonstration of the Trust's commitment to involvement, and would encourage projects that promote wider sustainability and impact.

5.2 The next steps

This report has outlined the findings and recommendations from our work at South Staffordshire and Shropshire. The next steps are for the Board to consider the findings and decide how to respond to the recommendations. In the meantime, there is a need for the Trust to continue work on the service improvement project, and share their progress with the NCI. The NCI team will identify opportunities to share learning from the work and will return in one year to evaluate progress.

In the meantime, the NCI would like to wish the Trust the best of luck in its efforts to turn involvement into everyday practice.