Paper L

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	**Mark Wightman**
Date:	**2 June 2011**
CQC regulation:	As applicable

Title:	**Membership Strategy**

Author/Responsible Director: Karl Mayes PPI and Membership Manager

Purpose of the Report: To seek Trust Board comment / endorsement for the revised membership strategy

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Endorsement	X

Summary / Key Points:

In previous board development sessions as part of our preparation for FT status the board have seen and discussed iterations of the revised membership strategy. Much of the strategy has already been informally endorsed. i.e. the emphasis on segmentation, tiers and engagement and the reduced emphasis on the number of members.

In this iteration we would like to draw the boards attention to the recent work undertaken by the Director of Communications / Director of Corporate and Legal / Prakash Panchal (Non Executive Director, (NED)) and Karl Mayes, PPI and Membership Manager to describe the role of the public Governor in the first 12 months of UHL operating as an FT (pages 15-18).

We would also ask the board to note that (as described on page 32) we are recommending that the role of Patient Advisor ceases at the point at which the Trust becomes a functioning FT with a Council of Governors. To help inform the Board's decision on this point and in response to requests from the Patient Advisors, an evaluation of the PA role has been undertaken and is attached at Appendix 5 (page 45). Still on the subject of the PA role; a number of NEDs met the PA's in April to listen to their views on the proposal and the minutes of this meeting are also attached with this paper at Appendix 3, (page 37)

Recommendations:

The Board is asked to endorse the revised membership strategy, particularly…

1. The proposed role of the Governor
2. The introduction of a tiered membership
3. The cessation of the Patient Advisor role at the point of UHL becoming a FT

Previously considered at another corporate UHL Committee ? No

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR)

The current proposals are within budgets. It is likely that as the Governor/CoG role is developed further that there are resource implications, particularly in the servicing of the functions of the CoG.

Assurance Implications

NA

Patient and Public Involvement (PPI) Implications

Paper L

The paper describes a revised approach to current PPI work and has been subject to comment by Pas
Equality Impact N/A
Information exempt from Disclosure N/A
Requirement for further review?

University Hospitals of Leicester NHS Trust

Membership Development Strategy

June 2011

Contents

1. Introduction

Membership is a means of rewarding and enhancing the connection that people feel with their local hospitals. It provides opportunities for them to be better informed and to contribute to what we do, so that the services we provide are more relevant, fair and appropriate for our local population. University Hospitals of Leicester is currently in the process of applying to become a Foundation Trust. This will not only give us greater financial freedom, and drive an even better quality of services; it is also consistent with, and to an extent driven by, the desire to run patient centred services. In other words, we want to be an organisation that puts our local communities' ideas, needs and experiences at the very heart of what we do. We see active and inclusive membership as vital to this aspiration.

We have been a membership organisation for over five years, and currently have 12,815 public members[1]. These figures compare favourably to neighbouring NHS Trusts[2]. Public members receive regular information from us, in particular, a copy of our quarterly members' magazine. They also receive invitations to events such as our annual public meeting and Medicine for Members sessions which provide an opportunity to learn more about various medical conditions and put questions to our clinical staff. The membership have also been utilised as a consultation body, for example, for our recent Foundation Trust consultation and in the development of our new website.

We wish to develop our membership as a key engagement resource for the Trust and as a means of bringing together some of our most passionate public supporters. However, if we are to understand and respond to the needs and requirements of our service users, it is essential that our membership be inclusive, and broadly representative of the local population. Furthermore, we will need to ensure that it is not simply our membership, but members' *participation* that is inclusive of a diverse range of opinion. It is one thing to assemble a representative membership: it is quite another to ensure that membership involvement is representative. It is only when we achieve the latter that we will be utilising our membership to its full effect.

The following tables provide some statistical data on our public membership in relation to age, gender and ethnicity[3].

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[1] Figures correct as of May 2011

[2] Public Membership figures for local Trusts are;
Derby Hospitals NHS Foundation Trust - 10,250, Kettering General Hospital NHS Foundation Trust - 3,608, Nottingham University Hospitals NHS Trust – 11,000, Northamptonshire Healthcare NHS Foundation Trust - 5,315. Source: Monitor. http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-performance/actual-performance/membership-figu

[3] Ethnicity data is taken from ONS population estimates for 2006, as cited by Leicestershire Statistics & Research Online at www.lsr-online.org.

Age and Gender

0-16yrs	2
17-21yrs	223
22-29yrs	709
30-39yrs	1,270
40-49yrs	1,803
50-59yrs	2,343
60-74yrs	3,555
75+ yrs	1,921
Women	7,876
Men	4,818

Fig 1. UHL public membership figures for gender and age

From the above it is clear that we have more members in the 50+ age groups, which matches the demographic profile of our service users. However, we do want to recruit more younger members to reflect the local demographic profile. The membership structure outlined below will provide opportunities to attract younger people in to our membership. We also currently have better representation from women than men. Again, we will undertake some targeted recruitment to address this disparity.

Ethnicity

Ethnicity: Total Membership	**12,815**
White - British	9,643
White - Irish	130
White - Any other White background	174
Mixed - White and Black Caribbean	33
Mixed - White and Black African	12
Mixed - White and Asian	36
Mixed - Any other mixed background	30
Asian or Asian British - Indian	1,853
Asian or Asian British - Pakistani	104
Asian or Asian British - Bangladeshi	49
Asian or Asian British - Any other Asian background	144
Black or Black British - Caribbean	116
Black or Black British - African	161
Black or Black British - Any other Black background	15
Other Ethnic Groups - Chinese	26
Other Ethnic Groups - Any other ethnic group	21

Fig 2. Ethnic breakdown of total UHL public membership

In terms of ethnicity, our public membership is broadly reflective of the communities we serve. Black and Minority Ethnic (BME) members comprise

21% of our total membership (2680 members), with White British members at 75% (9643 members). However, when these figures are broken down, there is still under representation in some groups (e.g. Chinese and dual heritage groups). To address this, we will be reviewing ethnic representation regularly and putting targeted recruitment initiatives in place where appropriate.

Given the significant demographic differences between Leicester city, Leicestershire and Rutland, the ethnic representation of our public membership will be regularly reviewed in relation to each of these separate areas. When the membership data is broken down in this fashion, representation is still broadly consonant with local population data. However, for the city, we are under represented in relation to White British members by a deficit of 10% when compared with the local population. We are over represented by almost 10% by Asian British – Indian members from the city. Clearly, if we wish to maintain a representative membership we will need to address this disparity. As such we will undertake targeted recruitment and promote membership among White British communities in the city. Recruitment will focus on areas of lower socioeconomic advantage, where the benefits of closer links with the health community are enhanced. Indeed, it is not without irony that communities with some of the highest incidences of premature cardiac disease live within walking distance of the Glenfield Hospital with its national reputation for excellence in cardiac care. We wish to engage such communities and provide better access to the Trust's wealth of knowledge and expertise in this area.

Ethnicity		**% of Membership**	**% of local population**
Total City members	**4,289**		
White - British	2,074	48%	58%
White - Irish	53	1%	1%
White - Any other White background	76	2%	3%
Mixed - White and Black Caribbean	25	0.5%	1%
Mixed - White and Black African	9	0.2%	0%
Mixed - White and Asian	28	0.5%	1%
Mixed - Any other mixed background	16	0.4%	1%
Asian or Asian British - Indian	1,459	34%	25%
Asian or Asian British - Pakistani	87	1.3%	2%
Asian or Asian British - Bangladeshi	28	0.5%	1%
Asian or Asian British - Any other Asian background	103	2.4%	2%
Black or Black British - Caribbean	91	2.0%	1%
Black or Black British - African	138	3.2%	3%
Black or Black British - Any other Black background	13	0.3%	0%
Other Ethnic Groups - Chinese	11	0.2%	1%
Other Ethnic Groups - Any other ethnic group	12	0.3%	1%
Not stated	66	1%	

Fig 3. Ethnic breakdown of UHL public membership within Leicester City

As the tables below show, figures for members living in Leicestershire are again, broadly consistent with the local population data. Indeed, there are no significant gaps for either Leicestershire or Rutland. As such, any membership recruitment activity will need to focus on Leicester City in the first instance. In particular, we will undertake some targeted recruitment among white British communities to address this area of under representation. The membership ethnicity figures will be monitored and reviewed on a regular basis.

Ethnicity		**% of membership**	**% of local population**
Total County members	**7,922**		
White - British	7,018	89%	90%
White - Irish	73	1%	1%
White - Any other White background	95	1.2%	2%
Mixed - White and Black Caribbean	8	0.1%	0%
Mixed - White and Black African	3	0.04%	0%
Mixed - White and Asian	8	0.1%	0%
Mixed - Any other mixed background	11	0.1%	0%
Asian or Asian British - Indian	406	5.1%	4%
Asian or Asian British - Pakistani	17	0.2%	0%
Asian or Asian British - Bangladeshi	20	0.25%	0%
Asian or Asian British - Any other Asian background	40	0.5%	0%
Black or Black British - Caribbean	25	0.3%	0%
Black or Black British - African	22	O.25%	0%
Black or Black British - Any other Black background	2	0.03%	0%
Other Ethnic Groups - Chinese	15	0.2%	1%
Other Ethnic Groups - Any other ethnic group	9	0.1%	0%
Not stated	150	1.9%	

Fig 4. Ethnic breakdown of UHL public membership within Leicestershire

Ethnicity		**% of membership**	**% of local population**
Rutland Total	**580**		
White - British	555	96%	93%
White - Irish	5	1%	1%
White - Any other White background	4	1%	2%
Mixed - White and Black Caribbean	0	0%	1%
Mixed - White and Black African	0	0%	0%
Mixed - White and Asian	0	0%	0%
Mixed - Any other mixed background	3	0.6%	0%
Asian or Asian British - Indian	2	0.4%	1%
Asian or Asian British - Pakistani	0	0%	0%
Asian or Asian British - Bangladeshi	1	0.2%	0%
Asian or Asian British - Any other Asian background	1	0.2%	0%
Black or Black British - Caribbean	0	0%	1%
Black or Black British - African	1	0.2%	0%
Black or Black British - Any other Black background	0	0%	0%
Other Ethnic Groups - Chinese	0	0%	0%
Other Ethnic Groups - Any other ethnic group	0	0%	0%
Not stated	8	1.4%	

Fig 5. Ethnic breakdown of UHL public membership within Rutland

Although we have a large and diverse local membership, we have historically operated a fairly generic membership programme, with the majority of communications being sent out to all members and little targeted work taking place. While there has been a previous attempt to split the membership and identify specific interest groups, this has not resulted in a particularly differentiated membership and as such, it could be argued that our membership has struggled both to establish a clear identity and to respond to the diverse requirements and expectations of its members. There is also, anecdotally, a poor awareness of membership among our staff, despite the fact that our staff automatically become members when they join the Trust. Overall it is fair to say that our membership could be more active and more engaged in the day to day activity of the Trust. Moreover, we could be utilising our membership more effectively as a consultation and engagement resource.

Notwithstanding the above, if one were to look elsewhere among our local population, it is not difficult to identify many individuals and organisations who are having direct and active involvement in our work; by attending user groups or events, as one of our volunteers, as a Patient Advisor, or as a fundraiser or donator of money to our hospital charity. If we were to integrate these already active and interested individuals in to our membership the benefits to the organisation are obvious. This strategy seeks to move in precisely this direction.

Vision

Put simply, our vision for membership is that it becomes *the* way in which to get involved with our organisation. Whether people just want to be kept informed about our services, wish to participate in surveys and events, or would like to give their time to come and help out in our hospitals, they will be encouraged to do so through our membership. To achieve this we will bring together, under the banner of membership, a number of the ways in which people currently get involved with the Trust.

To accommodate this greater range of engagement opportunities for our members we will introduce a tiered membership structure (for further details see Appendix 1). Three distinct tiers will be created which will recognise and reward becoming incrementally more involved in the work of the Trust. Members will become tier one members automatically, and receive information from the Trust to keep them up to date with its activity. They will also receive invitations to get involved in surveys, patient information reviews, focus groups, co design opportunities and events. Individuals who regularly get involved in such activity will be identified as level two members, and will therefore be eligible to participate in other events and opportunities run by the Trust.

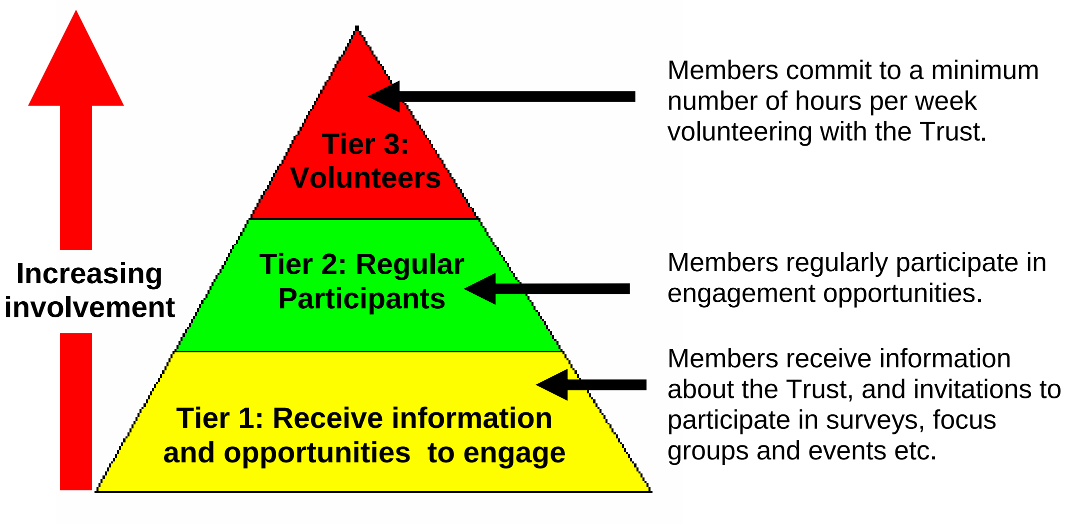


Fig 6. Pyramid chart showing proposed tiered membership structure

Tier three will be the most engaged sector of our membership and will comprise members who volunteer their time to the organisation. We currently have over a thousand active volunteers who give their time in a wide variety of roles; from administrative support or driving the hospital buggy to befriending and mealtime assistance on our wards. Situating volunteers within this structure will ensure that we maintain an active membership, and will provide opportunities to engage more closely with members while they are in the organisation. This move will also greatly improve the visibility of members within the Trust and promote both membership and involvement to our service users and the wider public.

We want it to become a hallmark of our membership that there are tangible benefits from becoming involved with the organisation. As such, participation in the more active tiers will be rewarded. For example, regular participants in tier two will be invited to one – off talks, tours of hospital areas and periodic thank you events. Other benefits for greater participation would include, for our volunteers, access to training and skills development and work experience. For members attached to voluntary sector organisations, we will explore relevant benefits such as access to our staff expertise (i.e. in relation to fundraising), access to meeting spaces, and marketing and promotion opportunities within the Trust.

Our membership will be developed as a key patient and public involvement resource which will help us to understand the needs and experience of the diverse communities we serve. To do this, we will link up staff in our business units with members who have identified an interest in the work that they do. For example, staff within our Women's and Children's Division will be encouraged to build relationships with members who have expressed an interest in our maternity services, or in the activity of our children's hospital. PPI leads in the organisation will be supported to facilitate the groups, providing information and engagement opportunities relevant to their field of work. In addition to groups specifically linked to Clinical Business Units, interest groups will be developed which explore other issues such as disability access, food provision and the delivery of religious and spiritual care.

The introduction of a tiered membership structure will provide an excellent opportunity to re-brand and promote our membership; not only to the local population, but also among our staff. The timing for such a promotion is good: we will only ensure the success of future governor elections, for example, if we begin to pique our members' interest now, and raise their awareness of our move to Foundation Trust and their role in this process (more detail on the tiered membership structure may be found in Appendix 1. of this document).

Our values, aims and objectives

We are building and developing our organisation around five core values. Our membership is no exception to this. Our principal aims for membership are informed by these values.

- **We are one team and we work best when we work together**. As such, we will develop a membership that is accessible, inclusive, and representative of our local population. Through our membership we will work with our members, maximising the number of people actively engaged in the development of the Trust and its activities.

- **We focus on what matters most**. To do this, we will develop membership as a key engagement resource for the Trust, harnessing the experience, knowledge and skills of members to add value to our decision making processes and ensure that we develop services that meet the needs and requirements of the local population.

- **We are passionate and creative in our work.** Through our membership we will seek new and creative ways to inform, update and involve local people in the life of the Trust. We will build and maintain an accurate and informative data base of members to allow us to target people's interests and make sure they get what they want to out of the membership.

- **We do what we say we are going to do.** We will keep our membership up to date about the work of the Trust and ensure they are able to make informed decisions. If we cannot do something for our members, we will explain why.

- **We treat people how we would like to be treated.** As such we will encourage a partnership approach between the Trust, its membership, and other like-minded organisations, using feedback to monitor satisfaction with the quality and experience of our services.

Our objectives for members are that they:

- Benefit from membership
- Feel well informed about the work of the Trust
- Have opportunities to influence the decisions which are taken by the Trust
- Are given feedback and evidence of how their opinions have shaped the work of the Trust
- Feel valued
- Remain interested and involved through a variety of information and opportunities that are relevant to them
- Participate in Governor elections and aspire to be governors

Our Commitment to our Members

We operate for the benefit of members and the community we serve. As such, we will:

- Be open and honest in our relationships with members.
- Be approachable and easy to deal with.
- Take ownership of issues raised by members and feed back on issues raised.
- Respect the views of members and endeavour to ensure they are represented in a balanced and fair manner.
- Provide members with accurate, balanced information to ensure their decisions are well informed.
- Work in partnership with our members and ensure they have the potential to maximise their involvement.
- Allow members to determine the nature and degree of their participation.

As we move towards Foundation Trust we will maintain a well publicised and ongoing membership scheme. This will include:

- A membership community made up of patients, carers, staff, volunteers and the public, aged 16 and over, who live within Leicester, Leicestershire and Rutland
- An accurate and informative members database
- Opportunities for members to make a valuable contribution to the way in which we manage and plan our services.

Members will have the right to:

- Receive regular information such as members' newsletters
- Participate in surveys, workshops, focus groups and other member events
- Once we become a Foundation Trust, elect governors to serve on the Council of Governors
- Stand themselves for election to the Council of Governors

2. What is membership?

We see our membership as a community of interested and supportive local people who wish to be involved in some way in the life of our organisation. Membership builds loyalty, a sense of belonging, and increases awareness of our services. It also offers local people opportunities to become actively involved in service development and in many other aspects of our day to day activity. Such a community is also an enormously useful resource for an organisation such as ours. Membership allows us to listen to and explore the views of our local population to ensure that we provide services that are fair and appropriate to their needs and requirements. Our new Governors will play a significant part in this process.

While the formal requirement to be a membership organisation comes as criteria of Foundation Trust status, "membership" is a fairly broad concept, which gives organisations some flexibility in how it manages its own local programme. In order to maximise the value of membership we need to recognise that membership will mean different things to different individuals. For example, membership may be seen in terms of;

- Receiving information about the Trust
- Receiving discounts and privileges
- Social activities with other members
- Donating money / fundraising

- Participating in the organisation's decision making
- Volunteering
- Responding to questionnaires and surveys
- Attending events
- Accessing training and education

Many people become members to feel that they are in some way "giving something back" following a good experience of our service. In practice, most individuals will understand membership in terms of some combination of the above. If we are to develop a membership that remains relevant to its members, we will need to respond to different sets of expectations, and offer different opportunities for engagement. A "one size fits all" approach runs the risk of losing appeal, leading to members losing interest and becoming less active. Our plans for maintaining an interested, active and engaged membership may be found below.

3. Defining the membership community

Our catchment population is Leicester City and the counties of Leicestershire and Rutland where just over 960,000 people live (based on 2006 mid year population estimates).

Our membership is made up of a number of "constituencies", with two main categories of member:

- Staff
- Public, patient and carers

Members of one constituency may not join any other constituency, so our staff members are not eligible to join as a public, patient or carer member.

Staff

The staff membership will be broken down in to four job types:
- Medical and dental staff
- Nursing and midwifery
- Other clinical staff
- Administrative and support staff

Staff membership will be open to:
- Staff who have a permanent contract of employment
- Staff on a fixed term contract of employment lasting at least twelve months

- Staff with an honorary contract of employment of at least twelve months or who have exercised functions for the Trust for at least twelve months including as a volunteer.

Staff automatically become members, unless they indicate that they do not wish to. We will work together with our Human Resources team to ensure that our staff members who retire will be given an opportunity to rejoin as a public member. In order to manage our communication with staff members more effectively we will transfer our staff data to our membership database. This will enable us to monitor engagement and target communications. Over the first year of this strategy we will develop a communications plan to increase awareness of membership among our staff, and to promote the role they could play in our new council of governors.

Public, Patients and Carers

Members of the public, as well as patients of the Trust and their carers, family and friends, can join one of the following public constituencies;

- Leicester City
- Leicestershire County
- Rutland County

Fig 7. Map showing the electoral boundaries of Leicester, Leicestershire and Rutland

Representation

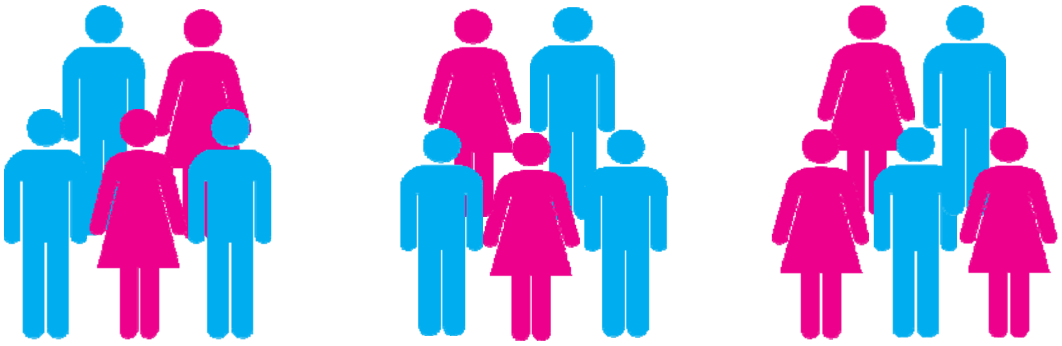
We will strive to maintain a membership that reflects the diverse communities we serve. We currently have a public membership of 12,815 people, the composition of which we will regularly compare with census and other local population data to ensure it is broadly representative. We expect some diminution of membership numbers in the months leading up to Foundation Trust application. However, we wish to maintain a membership of around 10,000 local people, and will be working to ensure that members are well distributed across the constituencies, and that representation in relation to age, ethnicity, gender and disability reflects the local demographic profile.

4. The Council of governors

The Council of Governors will provide an important means of connecting the Trust to its patients, staff and local stakeholders. As such, they will directly represent local interests within our governance structure to ensure that our performance may be held to account. Our Council of Governors will consist of 38 seats in total. 20 of these will come from the following constituencies:

Leicestershire	12 public governors
Leicester City	7 public governors
Rutland	1 public governor

Five seats will be taken by elected members from our staff constituency and a further thirteen seats will be allocated to nominated members from other stakeholders with whom we work in partnership (for example local councils and Universities). Members will vote for governors to represent them on the Council of Governors. All public members are eligible for nomination as a public governor. As required by law, the Trust’s Chairman will also Chair our Council of Governors.



20 elected patient, public and carer representatives

5 elected staff representatives

13 representatives from partner organisations

Fig 8. Breakdown of the Council of Governors.

Role of the Governor

Governors will be responsible for supporting and monitoring the Trust's performance in the following ways;

- Providing advice and guidance to the Trust to help it carry out its business consistent with the needs of our members and the wider community.
- Participation in the development and supervision of the Trust's Annual Plan.
- Appointing / removing our Chair and Non-Executive Directors
- Determining the remuneration and allowances and other terms of office of our Chair and Non-Executive Directors
- Approving the appointment of our Chief Executive
- Receiving our Annual Report and Quality Account
- Appointing / removing our Auditor
- Ensuring we operate within our legal framework
- Maintaining a presence on operational groups to ensure that members' views are represented in our service development initiatives

The Council of Governors will meet on a quarterly basis and will meet with the Trust Board twice a year. Governors will also be expected to attend additional meetings throughout the course of the year (for example, to participate in operational groups in the Trust) and to devote time to engaging with their constituency members. Governors will not be paid, but will be paid expenses to ensure they are not financially disadvantaged in the course of their duties.

Inclusive engagement with members

The introduction of Governors will present a great opportunity for the Trust to be more responsive to local needs and requirements. As such, in addition to the responsibilities outlined above, our Governors will be expected to develop effective ways in which to engage with our membership. Governors will be a conduit to our members and will need to ensure that they are in a position to properly represent their needs and concerns. Indeed, strong Governor and membership relationships will allow the Council of Governors to act as the Trust's “eyes and ears” in the community, and will therefore constitute a valuable resource which will inform the ways in which our services are delivered.

The Trust will promote the forthcoming elections in, and actively encourage candidates to come forward from our diverse local communities. In this way we hope that our elected Governors will broadly reflect the profile of the local population. However, irrespective of how representative or unrepresentative the final composition of the Council of Governors ends up, the Trust will articulate to *all* Governors that they have a responsibility to reflect the full diversity of views that exist within the local population. As such, Governors will be required to take steps to ensure that they understand the demographic profile of their constituency and develop their knowledge of, and interaction with, specific communities, groups and voluntary sector organisations. Governors will be expected to act as guardians of the public interest and to ensure that the activity of the Trust does not disadvantage particular individuals or groups. This responsibility may only be discharged if Governors actively explore the issues that face, for example, local BME communities, disabled people or service users from faith communities.

The Trust will support Governors to engage with their constituents by;

- Promoting the role of Governor to our membership
- Developing members networks
- Hosting events that bring members and Governors together
- Encouraging links with voluntary sector and community organisations
- Developing links with volunteer members in the Trust
- Good use of media (newsletters, web sites, “New Media” etc.)
- Providing Diversity Training for Governors
- Facilitating access support for Governors (i.e. interpreters where required)
- Maintaining effective support systems for membership
- Maintaining a representative membership base

Benefits of Governor Involvement

In preparation for the Governor role, the Trust’s Director of Corporate and Legal Affairs and its Director of Communications and External Relations led senior staff in a workshop where they were asked to consider both the value of Governors and how their particular service would work with them. Perceptions of the potential impact of Governors were overwhelmingly positive, although it was clear that expectations are high. A number of managers looked forward to fresh pairs of eyes coming in to the Trust to provide an objective perspective on our performance. Among the benefits that Governors were anticipated to bring to the Trust were;

- **Strengthening the PPI agenda in the Trust.** The election of public governors was seen as an opportunity to formally bring community knowledge and expertise in to the Trust so that it better understands the needs of the local population. Equally, governors were seen as having a significant role to play in promoting a better understanding of the Trust and its services within local communities. The development of stronger links with the Trust's membership was also seen as a positive way of ensuring that local views informed our service delivery.

- **Improving patient experience.** With their links to membership (including our new member volunteers), understanding what is important to local service users and their relationship with the Trust Board, it was felt that Governors would be in a position to positively influence activity around the experience of our patients. Indeed, our Governors will be taking a keen interest in patient experience data and reviewing activity which aims to improve it.

- **Improving accountability.** The Governor role was welcomed as an opportunity to monitor the performance of the Trust. Senior staff in the organisation specifically noted their expectations their expectation that Governors would take an interest in our performance in quality and patient safety agendas. In general, the Council of Governors as a collective was thought to represent a new and significant voice for patients, staff and stakeholders within the Trust which would effectively hold us to account and ultimately improve Trust performance.

- **Developing links with external bodies.** Governors' links to other regional and national governor networks were expected to bring benefits to the Trust. The closer involvement of our stakeholders was also seen as an important aspect of the new governance arrangements.

Governor Training

We recognise that our governors will require guidance and training to fulfil their role and we will allocate resources to do this. Governor training will begin before our elections in the form of "Governor Awareness" sessions, which will introduce the role to potential candidates and provide opportunities to meet with members of the Trust Board and learn more about our organisational structures and the broader context in which we operate.

Once our governors have been elected we will establish regular training and development sessions to promote a fuller understanding of the organisation and of Governor roles and responsibilities. Governor training will begin with a comprehensive induction programme, which may include opportunities to shadow members of staff and learn more about the day to day running of the Trust. The induction will also provide new Governors with an introduction to the NHS and in particular the impact of recent legislative changes to the way in which it operates. Throughout the programme Governors will be encouraged and supported to understand the Trust's relationship to other stakeholders and the range of legal obligations it is obliged to meet. Governor induction will also provide opportunities to develop thinking in relation to member engagement. To support this objective, Governors will also be provided with training in relation to the PPI, Patient Experience and Equality agendas within the Trust.

Our Governors will be encouraged to identify areas of the Trust's activity that particularly interests them. This will allow us to develop a bespoke training and support package which will allow Governors to participate effectively and in an informed manner in these areas. Governors will also be subject to mandatory training requirements which will be fulfilled in the first instance by attending the Trust's corporate induction programme.

5. Resourcing Membership Development

We have appointed a Patient and Public Involvement and Membership manager, who takes day to day responsibility for membership development and is the main point of contact for members. The Trust has always planned for additional support to manage the membership and election process and the intention is to recruit to a support post which has had ring-fenced funding. This post will become increasingly important once our 20 public Governors are in post and begin to develop their interaction with the Trust membership.

An effective database of members will be central to good management of our membership. In order to gain greater control of our membership data and to reduce the costs of housing and managing that data, we recently changed supplier. Earlier in the year we served notice to Capita and have commissioned MES (Membership Engagement Services) to supply us with a system which allows us to better manage our membership data. The database also allows us to build more detailed profiles of our members' interests, and will be capable of producing the reports which are required by Monitor and measuring membership representation in comparison with the general population. As our application for Foundation Trust status progresses, we will need to commission the Electoral Reform Service to organise and run our elections for our Council of Governors, which includes providing members with the information they will require to engage in the process.

Adopting a tiered membership structure will naturally have resource implications. In particular, the move to such a model will require significant data input to the member database and administrative support to manage such a restructure. There are also resource implications for the promotion and marketing which will be required to make the new structure a success. This strategy also advocates a more frequent programme of events, which again will have both human and financial resource implications. Administrative support would greatly assist this process.

A breakdown of estimated costs may be found below. It should be noted that these costs are already part of the Trust's overall Communications budget, with the exception of a Band 4 position, the funding for which is currently ring fenced.

Non Pay Costs	
Membership Database (+set up and support costs)	10K
Promotion, printing, postage and stationary (including members' magazine)	56K
Governors' election process (non recurrent)	70K
Events	5K
Subscriptions and Courses	25K
Pay Costs	
PPI and Membership Manager (Band 8a)	51K
Membership and Engagement Support Officer (Band 4)	24K
Total	**241K**

6. Building the membership base

We have a well established membership comprising both public and staff members. While the focus over the last three years has been to build our membership base, with public membership figures now standing at 12,815 our focus will shift towards building a more involved and engaged membership. Having said this, we do not wish our public membership levels to drop below 10,000 and will actively recruit members when necessary, both to maintain numbers and address areas of under representation.

Following the public consultation, and the acceptance of the proposals for the Council of Governors, we removed 1,025 out of area members from the database. The Board felt, and it was agreed through the consultation process, that only residents from Leicester, Leicestershire and Rutland should be eligible to stand as Governors.

Individuals eligible for membership of our staff constituency automatically become members after upon signing their contract employment, unless they indicate that they do not wish to be a member. We believe this strengthens the existing involvement of staff in the organisation, and sends out a clear message about the value we place on staff being actively involved in shaping our future.

There is still work to be done with the staff membership group. Our intention is to work with HR to extract the details of staff (these are only basic details such as name, DOB, staff group and ethnicity) from ESR and merge them into our membership database so that we may communicate and engage them more easily. This will of course allow us to record those staff who opt out of being a member and therefore will be unable to stand for election.

To maintain our membership we will:

- Offer membership to everyone in the qualifying constituencies

- Provide a simple, accessible, well publicised process for becoming a member
- Recognise members as a valuable resource in the planning and delivery of services
- Take advantage of our events as a means of promoting membership

Once appointed, we will encourage our Governors to become involved in member recruitment. Upon approval from the Secretary of State (which is anticipated in 2012), we will call for nominations to the Council of Governors and will hold governor elections. Within the first twelve months of operation as a NHS Foundation Trust the Council of Governors will be asked to take an increasingly active role in developing the membership base.

With the support of the membership manager, governors will assess shortfalls in terms of representative membership and formulate action plans for targeted recruitment. Governors will be supported to become champions for recruitment within their constituencies.

The Council of Governors, within the first 12 months, will:

- Identify initiatives for raising the profile of membership with staff, patients and communities
- Seek to maintain a membership that is representative of the diverse communities we serve, identifying under represented groups and exploring relevant recruitment strategies
- Keep patients, staff, local communities and the wider public informed about our work in order to promote understanding, partnership working and the recruitment of new members
- Review support arrangements for membership

7. Managing Active membership

As noted above, encouraging members to become more actively involved with the Trust and in the development of services are key aims for our membership. There are a number of ways in which we might achieve this. Indeed, we need to provide a wide variety of opportunities to become more involved in the Trust to make sure we reflect the diverse needs and interests of our members.

To encourage active members we will:

- **Improve the data we hold on members**, and canvass them to identify specific areas of interest, and to complete equality monitoring data. This will allow us to target specific sections of the membership with relevant information, opportunities and requests. Members will be encouraged to identify which tier of membership they would like to sign up to (see below).

- **Instigate a tiered membership structure** (see Appendix 1). Tiering the membership will enable us to bring together and harmonise a number of disparate ways in which people currently become involved with the Trust. Under a tiered model the following opportunities will be mediated through the membership:

- Volunteering
- A new patient feedback volunteer role
- Participation in focus groups
- “Co-design” opportunities
- Responding to questionnaires and surveys
- Participation in interest groups and networks (see below)

All members will be situated in tier one of the membership automatically. However, they will be encouraged to become more actively involved with the Trust, incentivised through access to events and opportunities within the Trust.

- **Develop networks of members** with specific interests, linking them in to relevant services and initiatives. These Networks will be developed and facilitated by our PPI leads, who will be given access to relevant groups and networks of members. As such, CBUs will be able to develop closer relationships with our member groups. Networks may link in with existing voluntary sector groups. Member networks may include:

    - Maternity
    - Cancer and Haematology
    - Diabetes
    - Research
    - Children’s Hospital
    - Renal
    - Cardiac
    - Older People
    - Religion and Faith
    - Food
    - Disability Access

PPI leads will be asked to hold relevant workshops and events for members. They will also be expected to develop questionnaires, surveys and focus groups aimed at getting the members perspective on different aspects of our work.

- **Provide opportunities for members to gain new skills and knowledge.** We will endeavour to give members opportunities to gain knowledge and skills. These opportunities will be incremental and related to the tiered membership. For example;

- Members will receive regular copies of the Trust Talk for members' magazine and be invited to attend the medicine for members events;
- Members will also be offered opportunities to participate in the design and assessment of some of our services;
- As part of their volunteering role, tier three members will have access to training opportunities delivered within the Trust, as well as opportunities to develop skills in such areas as customer care, first aid and IT.

- Bring members into closer contact with the Trust through **regular events**. In addition to the Medicine for Members programme, we will offer opportunities throughout the year for members to come in to the hospital and meet our staff and get involved in the work of the Trust. As such we will host guided tours of the hospital and offer health screening as well as opportunities to participate in our Annual Public Meeting.

- **Develop a clear promotional strategy to raise awareness of membership**. We will review the content of the Trust Talk for Members magazine, to reflect the tiered membership model and the contributions that members are making to the Trust. We will promote the roles members are playing and the impact they are having by establishing promotional displays in hospital reception areas and producing posters and electronic media campaigns.

- **Use IT / new media effectively**, for example, by setting up a Members Facebook Group to interact with members and promote recruitment, particularly among younger people. We will explore the possibility of establishing a "Members' TV" or video section on our website, which features short films about what motivates members to get involved. We will also explore the benefits of a members' online forum.

- **Encourage individuals to take up membership with affiliation to voluntary sector groups.** This will establish better links with networks of local people. In the first year in which this strategy is implemented we will explore incentives such as the provision of meeting spaces, or space to display art or promotions for voluntary sector groups.

- **Create a network of local "corporate members"** with whom to develop mutually beneficial links. For example, local arts venues and retail partners.

- **Maintain and expand our "Medicine for Members" programme of talks**, using these events as a means of engaging with members on other relevant issues (for example reviewing patient information and participating in consultations).

The Council of Governors, within the first 12 months, will:

- Encourage the contribution of members in the planning and delivery of services.
- Lead by example, demonstrating active participation in the day to day business of the Trust
- Work with CBU leads to promote constructive working relationships and dialogue between public members and our staff.

The Council of Governors, within the first 18 months will:

- Map the level of involvement and influence of members in the planning and delivery of services, and utilise the results to inform the membership strategy in the future
- Review the effectiveness of this strategy in encouraging a more engaged and active membership.

8. Communicating with Members

It is essential that we establish appropriate and meaningful two way communication with our members. We will ensure that we use effective communication methods to encourage active membership and ensure that the information we make available to members is appropriate, regular and user friendly.

To make sure we communicate with our members we will;

- Develop a new welcome and introductory pack for members reflecting the tiered membership and opportunities to become more involved.
- Linked to our Communications strategy, we will establish an effective communication plan for members. This will use existing communication channels and seek to develop new ones. These will include a minimum of four newsletters per year, email communications and a dedicated section on our website for members, regularly updated with news and items of interest to the membership.

- Seek feedback from members on the content and nature of our communications to make sure we communicate in a manner that is most relevant to them.

- Organise membership events, presenting items of interest to our members, for example, innovations in care or changes in clinical practice

- Maximise the use of electronic communication to ensure that communication with members is as cost effective and efficient as possible. As such, we will regularly remind members to provide email addresses where possible.

The Council of Governors, in the first 12 months, will:

- Identify ongoing initiatives which can be used to inform the wider public about our Trust

- Evaluate the success of the communication plan from member feedback

The Council of Governors, in the first 18 months, will:

- Evaluate and review the communications plan

9. Playing a key community role

As a membership organisation committed to being a good corporate citizen, we will endeavour to ensure that we contribute to the communities we serve. Indeed, as noted above, we are keen that individuals and organisations receive some tangible benefit from their involvement with the Trust. Our aim is to encourage interest in our hospitals, raise our local profile, raise awareness of our services and promote good relationships, particularly with our local communities and voluntary sector organisations. Given the extraordinary diversity of our local area, we will strive to be inclusive in our activity, and mindful of the differing needs and requirements of the population.

To ensure we play a key community role we will:

- Develop and encourage positive links with local voluntary and community organisations, for example, by promoting membership and building dialogue about access to and experience of hospital services.

- Ensure that we provide feedback to community groups about the ways in which their feedback has influenced our service planning and delivery

- Explore ways in which we can provide a benefit to local communities, for example finding space to exhibit community art, run promotions, or providing low cost meeting venues.

- Develop stronger links with community arts programmes to widen their audience to our membership and improve dialogue between the Trust and its diverse population.

- Establish a staff volunteering programme which will match our staff with organisations that they can hep with their skills and knowledge (see above).

- Ensure that our membership is inclusive and reflective of the communities we serve by targeting specific groups for recruitment and to ensure that people who need more support to participate are able to do so.

- Reflect local communities in our publications and on our website.

- Investigate opportunities to work in partnership with local communities.

- Use opportunities to build positive public relations in local communities to promote the aims of the Trust.

The Council of Governors, in the first 12 months, will:

- Investigate opportunities for the organisation to participate in partnership working across the local communities

- Use opportunities for public relations in our local communities to promote our aims and objectives.

The Council of Governors, during the first 18 months, will:

- Review the level and success of partnership working

- Identify local communities that have not been so involved, and which the Trust needs to focus its engagement on

10. Working with other membership organisations

The population served by the University Hospitals of Leicester NHS Trust naturally receives services from other public sector partners. As such, it is important that we work together with these organisations to promote consistent messages about membership and the value of public involvement. We also wish to minimise duplication in our consultation and engagement by working in a more joined up way with other membership organisations.

We will work together with other membership organisations by meeting regularly with local and regional partners to share best practice and identify joint working opportunities. As the NHS landscape changes, and some membership organisations are phased out, we will work closely with these organisations to explore how we might support their membership through the transition.

11. Evaluating Success

The aims and objectives of this strategy will be reviewed by the Membership Manager annually and remedial plans will be put in place to address any unmet aspirations. Members' feedback will also form part of this annual review. Once the organisation becomes a Foundation Trust we will ensure that the Membership Strategy is owned by the Council of Governors. To do this we will:

- Invite the Council of Governors to take ownership of the strategy and review and update it on a regular basis.
- Present regular reports to the Council of Governors on membership numbers, diversity, activities and involvement

The Council of Governors, during the first 12/18 months will:

- Keep the strategy under review, ensuring that it meets its aims and remains meaningful and relevant to the membership.
- Present a report on the progress of the strategy to members at the annual meeting
- Invite members feedback on the aims and content of the strategy and success of the communication plan

12. Membership recruitment to date

We have been a membership organisation for over five years. The vast majority of public members were recruited in two rounds of targeted direct mail. This helped us achieve a mass of public members from which we could seek to grow the membership using network marketing and word of mouth rather than the expensive (but successful) direct mail route.

More recent membership drives have been targeted to help us fine tune the membership base and ensure that it is demographically representative. For example we knew that young males were under represented and so we worked with colleges, universities and local football and rugby clubs (Leicester Tigers and Leicester City FC) to encourage young men to become more involved in their hospitals.

Over the last year, we have not been actively recruiting members, although we do still receive a steady flow of requests from online and membership leaflet sources. The Trust membership is also promoted as part of a joint working initiative with the local health community.

As part of our aspiration to harmonise support for the Trust through the membership, we will work with the Leicester Hospitals charity to promote membership to local fundraisers. In this way we will aim to raise awareness of the membership and its benefits to people who are already keen to give something back to the Trust.

13. Plans for Future Membership Recruitment

We now have a public membership of 12,815 people which is broadly representative of the local population. Anecdotal evidence from other FTs indicates that about 15% of members are lost per year. As a result to just maintain our current position we will need to recruit about 100 members a month. We have taken a decision to concentrate on activating our current membership rather than aiming for greater numbers. As such, in the run up to our Foundation Trust application, we will not embark upon a formal recruitment drive, but sincerely hope that this strategy will encourage a more active, involved and engaged community of members. As noted above, it is our intention to maintain a membership of around 10,000 members, and for our membership to be both inclusive and representative of the local population. As such, an exception to this approach will be made when recruitment will address under representation.

14. Summary

This strategy has set out the way in which we will draw into our membership local people who are interested in, and support the work of the Trust. By bringing together and rewarding our most passionate local supporters, we will encourage a membership community that will work with us, shape us, challenge us and support us as we navigate the future landscape of healthcare in the UK.

The tiered membership structure proposed here should result in a clearer and more prominent identity for our membership. Encompassing our existing and future volunteers will ensure that membership is more visible in the organisation, which will in turn provide strong evidence of local engagement as we move to Foundation Trust status. A tiered approach to membership also represents a clear “ladder of engagement” for members, culminating in the hands-on volunteering of time to the organisation.

Above all, we wish to develop a membership that is inclusive, representative, and which provides many different opportunities to get involved with the Trust.

In this way we hope to understand the breadth and diversity of patient and public opinion and ensure that these views inform the delivery of our services.

Appendix 1. Tiered Membership and Member Involvement

As noted above, it is our intention to establish a tiered membership structure which will harmonise some of the disparate means by which people may get involved with the Trust. The following opportunities will be mediated through the new tiered membership structure:

- Volunteering
- A new patient feedback volunteer role
- Participation in focus groups
- “Co-design” opportunities
- Member questionnaires and surveys
- Participation in interest groups and networks (see below)
- Communication with Governors

Three tiers or options are proposed. These will represent incrementally active levels of engagement. Once this strategy is approved by our Trust Board, the Communications department will develop a branding and marketing plan to promote the newly configured membership both to members and the wider population. At this point, the working titles of the tiers will be changed to reflect the overall branding.

Among the anticipated benefits of this tiered membership structure are:

- Greater consistency and harmony regarding the ways in which individuals become involved with the organisation

- Greater clarity regarding the purpose and benefits of membership

- A clear “ladder of involvement” which will encourage and reward greater engagement with the Trust

- Greater commitment and loyalty to the organisation among the local population

- Clearer identity for membership and better “brand awareness” among staff and in the local population

- Higher visibility of member involvement within the Trust

- The ability for the Trust to target members more effectively for engagement and involvement initiatives

- Services that more effectively place the user at their centre.

The three tiers will be organised as follows:

Tier one: Receiving Information and opportunities to engage

All public members will be placed in this tier automatically. Tier one members will be given access to special offers and other opportunities through NHS Discounts and will receive information about the Trust as well as opportunities to get involved in surveys, focus groups and events etc. To encourage greater involvement from Tier one members, the members' magazine will be reformatted to reflect activity in the membership tiers. As such, the magazine will carry features about volunteering opportunities and the positive impact members can have on the organisation and how their participation is influencing service delivery in the Trust. The revised magazine will carry opportunities for all members to become more involved with the Trust.

Tier two: Regular Participant Tier

Tier two members will still retain the benefits of level one, but will be recognised and rewarded for more regular participation in the Trust's engagement opportunities. As such, members who participate in a minimum of five activities in a year will be given access to dedicated events and talks which are aimed at this more active layer of members. Activities would include participation in surveys, focus groups, interest groups, events or consultations etc. More active members will be identified from our Members database.

Tier 3: Volunteer Members Tier

Tier three creates a sector of the membership for people who wish to commit to a minimum amount of time per week volunteering in the organisation. To establish this tier, our current volunteers would be asked to join the membership (many are already members). It is possible that some existing volunteers may not wish to become members. As such, we are likely to operate with a legacy of some non-member volunteers. However, once this strategy is implemented, we will require all new volunteers to first sign up to our membership in order to be eligible. Although the requirement for volunteers to be members of the Trust will not alter the infrastructure of volunteer management, it will send out a clear message that we have an active and engaged membership, many of whom regularly volunteer their time to support the work of our hospitals. Such an initiative would place membership front of house, and improve both its visibility and tangibility as well as allowing us to better evidence the level of engagement and involvement our members have.

Our volunteer service experiences a higher demand for volunteer placements than it can fulfil. As such, recruitment is a challenging process to manage and is currently run on a "first come first served" basis. Moreover, there is a high attrition rate among younger volunteers who wish to gain work experience, but often do not continue to volunteer with the Trust long after joining. In such cases, considerable resource is put in to recruiting, CRB checking and training the individual with a relatively poor return for the Trust. As things stand, potential volunteers are asked to wait until the next recruitment opportunity, at which point they are invited to try and get through by telephone to the volunteer office to progress their application. If they are unsuccessful, they are asked to try again in subsequent months. As such, potential volunteers can spend several months waiting before they are considered for volunteering in the Trust. During this period they will have no formal involvement with the Trust.

With the introduction of volunteering as a function of membership, individuals will be required to have been a member of the Trust for a minimum of four months. In this way, before they are considered for volunteering, they will be offered a range of opportunities to become involved in our membership activity and learn more about us, as opposed to simply waiting for their application to be considered. Indeed, as potential new volunteers serve their requisite time as new members, they are more likely to be motivated to participate in surveys etc. This will harness their will to engage, and provide fresh opinion to our patient and public involvement activity. Such an entry in to volunteering should encourage greater commitment among volunteers, particularly younger people, where there has been a higher drop out rate. A minimum time period prior to volunteering should also help to stagger the volunteer recruitment process, and result in a fairer and more manageable process.

Segmentation of Tier three

Within Tier three, members will be encouraged to identify specific skills and interests, which the Trust can support through training and development. Areas of interest may include:

- Fluency in another language / language support
- Mealtime assistance
- Gardening
- Hospital greeter / way finder
- Database and admin skills
- Fund raising
- Spiritual support (Chaplaincy volunteers)
- Collecting patient feedback
- Hospital buggy driving
- Befriending

Specific role outlines reflecting these areas of interest will be developed by our volunteer support team. Such an approach also provides opportunities for the Trust to develop new volunteer roles. For example, we will create a new patient feedback volunteer role outline which will provide members with an opportunity to get more involved in collating and understanding patients' experience of our services. More detail of this role may be found below.

The role of Patient Advisors once Governors are elected.

The Trust has always been committed to engaging and involving lay people in its business and eight years ago created the role of the Patient Advisor. This role is similar to that of a Foundation Trust Governor and was a way for us to embed this type of approach in to the daily business of the Trust. We currently have Fourteen Patient Advisors. Over the years, they have brought a lay perspective to some of our key decision making forums. Indeed they have arguably acted as “proto governors”, preparing the Trust for the contribution and challenge of members of the public in every area of our business.

Once we become a Foundation Trust, our governors will assume many of the functions currently undertaken by our Patient Advisors. At this point the Patient Advisor role in the Trust will cease, making room for the new governor role. The timeline for this move will be consistent with that of our Foundation Trust application. As such, the Trust’s Patient Advisor role will continue until such times as our Foundation Trust application is successful and we have appointed our governors.

Patient Advisor Evaluation

The Trust’s current Patient Advisors have expressed concerns regarding the cessation of their role once we achieve Foundation Trust status (a summary of their responses to this proposal may be found in Appendices 3 and 4). Following an initial consultation with the Patient Advisors, it was agreed that the Trust conduct an evaluation of the role (the full results of this evaluation may be found in Appendix 5 of this document).

Overall the evaluation demonstrated that the Patient Advisor role has contributed positively to the work of the Trust over the last eight years. However, it also suggested that the current model was not always effective in terms of bringing the broader patient’s perspective in to the day to day activity of the Trust. For example, several respondents remarked upon the lack of cultural diversity and ethnic representation among the current Patient Advisors.

As part of the evaluation, respondents were asked to rate the impact they felt Patient Advisors had had in the various aspects of their role. From this exercise, the highest value was given to the gathering of patient feedback. Patient Advisors were also felt to have had a significant impact in the development of patient literature and in their participation in observational audits (these aspects have been incorporated in to the proposed Patient Feedback volunteer role). Patient Advisors were recorded as having the least impact on Boards and Committees (even though the evaluation showed that this was where they were perceived to have had the highest level of involvement). Lower impact was also reported in Patient Advisors’ contribution to policy development and in their input in to training.

Respondents were asked to identify an example of where Patient Advisors had positively contributed to the improvement of Patient Experience. 20 out of 43 respondents completed this section of the evaluation. Most of the responses again referred to their role in obtaining patient feedback and participating in observational audits. Patient Advisors were also reported as contributing to work on privacy and dignity, and in one response, acting as a patient advocate. Contributions to work on end of life care were also noted.

The evaluation then invited respondents to make any additional comments they wished. Again, the positive contribution that the Patient Advisors have made to the Trust was expressed. A number of respondents said that they were a valuable resource to the Trust, and that they had been very supportive in their interactions with CBUs. However, several respondents suggested that Patient Advisors did not adequately represent patients or the local population and were concerned that the current model effectively excluded wider patient and public views from our service development activity. Moreover, some responses suggested that the current incumbents had been in post for too long, and that this had affected their capacity to be objective. There was also a suggestion that the current model permitted CBUs to underachieve in relation to their PPI obligations. As one respondent put it, the organisation "will use a Patient Advisor "to tick the box of patient / public involvement / engagement and shy away from contacting patients that have recently used their service and who would be able to give more and better feedback".

In summary, the evaluation made clear that Patient Advisors have been, and continue to be a supportive and valuable presence in the Trust. In particular their activity in relation to obtaining patient feedback and participating in observational audits was well noted. It was also clear, however, that many did not consider this model to be effective in terms of bringing the diverse perspectives of our local service users in to the day to day activity of the Trust. The independence of such long serving Patient Advisors was also questioned. With the forthcoming elections and appointment of Governors, it is arguably time that the Trust explore alternative ways in which to involve patients and the public in its work, while retaining what has been most valuable about the Patient Advisor role. As noted above, the lay perspective and involvement that we have sought from Patient Advisors will become the remit of Governors. However, the functions that are not covered by Governors will be largely taken up by the new Patient Feedback Volunteer role (below).

Patient Feedback Volunteers

Although it is proposed that the Patient Advisor role will no longer exist once our governors are in place, as noted above, the Trust is keen to retain the beneficial aspects of their role; and, indeed, the knowledge and experience of its existing Patient Advisors. To this end, we will create a distinct patient feedback volunteer role within the volunteer tier of the new membership structure. Individuals currently acting as Patient Advisors will be invited to consider this new role, which will act as an "ear to the ground" in each of our CBUs. From our recent evaluation of the Patient Advisor role, respondents attached the greatest value to their involvement in collecting patient feedback, the development of patient literature and their contribution to observational audits. Through this new role we hope to retain and develop these valued functions. Indeed, Patient Feedback Volunteers, being more numerous, and more diverse in background, will arguably expand the face to face patient contact that is currently undertaken by Patient Advisors. The role will also maintain a dedicated presence in each of our CBUs.

In order to ease the transition between Patient Advisors and Governors, it is recommended that the Patient Feedback Volunteer role be formally established before the Governor elections. As such, recruitment to the role will commence in the autumn of 2011. Opportunities to be interviewed for this role will be given to our existing Patient Advisors and active volunteers as well as our broader membership.

The Patient Feedback Volunteer role will be primarily concerned with collecting and understanding the experience of people using our services and representing these views to our staff and governors. As such, these volunteers will participate in patient surveying and solicit other forms of feedback from service users. Patient Feedback volunteers will also take part in observational audits, another Patient Advisor role that evaluated particularly well. Opportunities to take on this new role will be extended to our membership. This will encourage wider representation than is currently the case for our Patient Advisor group.

As the numbers of patient feedback volunteers grows, so too will their collective value as an engagement group for the Trust: as a group, patient feedback volunteers will be in an excellent position to provide an overview of patient views and experience so that this may inform service delivery and development in the Trust. As such they will represent a significant resource for our staff and governors alike. Patient feedback volunteers will be coordinated by the Trust’s nominated PPI / Patient Experience leads in each CBU. They will primarily support patients to participate in our Patient Surveys and work to gather informal feedback, both from patients and relatives as well as other volunteer members within the Trust. The information gathered will be fed in to the Trust by PPI / Patient Experience leads at the bi-monthly Patient Experience Meeting. Governors will also be invited to attend this meeting, but it is envisaged that Governors may also wish to meet with Patient Feedback Volunteers during the year to better understand the experience of patients in the various CBUs (the Patient Feedback Volunteer role outline may be found in Appendix 2).

Appendix 2: Patient Feedback Volunteer role outline

Volunteer Role Outline

Voluntary Job Title: **Patient Feedback Volunteer**

The Patient Feedback Volunteer will support the Trust to gather information on the experience of patients using our services. The role will involve speaking with patients, supporting the Trust's patient survey and other activities aimed at gathering patient feedback.

Hospital Site: LGH/ GGH / LRI

General Information:

Patient Feedback Volunteers will act as a resource for, and be coordinated by PPI / Patient Experience leads in each of the organisation's Clinical Business Units. As such, they will be expected to meet regularly with their PPI lead to discuss patient experience feedback in their areas. A minimum commitment of 3 hours per week is required for this role. Selection will be by interview.

Task Outline: Assisting patients to fill in the UHL Patient Survey, enabling those who may otherwise be unable to participate to complete it. and supporting wards to meet their quotas.

Helping to facilitate patient involvement activity (e.g. focus groups / patient experience days)

Collating patient feedback and reporting this to the CBU lead

Maintaining a visible presence in the CBU to enable patients and relatives to provide informal feedback relating to the patient experience

Acting as a point of contact and actively encouraging other volunteers to provide feedback on matters relating to patient experience

Participation in audits (e,g, observational audits, dignity audits, environmental audits etc.)

Administering local *ad hoc* surveys

Participation in the development of patient information (as a group, and soliciting feedback from patients)

Person Specification	
Essential	Desirable
Must be over 18 years of age	Customer service experience
CRB Clearance required	Experience as a patient at UHL
Literate and Numerate	Computer literate
Good communication skills	Ability to speak another language
Must be an active UHL volunteer	Ability to analyse data
Good people skills	
Ability to act on own initiative	
Able to act with empathy and provide reassurance	

Training needed/given: Induction training

Optional training (where required)
Patient Survey training
Audit training
PPI training (to conduct focus groups etc.)
UHL Recruitment training

N.B. 1) Volunteers will not undertake any tasks for which professional training is required.
2) Not all volunteers will be happy to perform all of the duties listed.

Volunteers should not use the hospital computer system without training and prior agreement of manager.

Volunteers will not have access to patient records either on paper or computer system.

Lifting and moving of patients must not be undertaken by volunteers on wards, or in hospital departments.

Volunteers are not permitted to assist with the administration of drugs.

Appendix 3.

MINUTES OF A MEETING OF THE PATIENT ADVISERS WITH THE UHL CHAIRMAN AND NON-EXECUTIVE DIRECTORS HELD ON MONDAY, 4 APRIL 2011 AT 2:00 PM IN CONFERENCE ROOMS 1A&1B, GWENDOLEN HOUSE, LEICESTER GENERAL HOSPITAL

Present:
Mr M Hindle – Trust Chairman
Mrs K Jenkins – Non-Executive Director
Mr P Panchal – Non-Executive Director
Mr I Reid – Non-Executive Director

Patient Advisers:
Mr D Allen – Patient Adviser
Mr F Baker – Patient Adviser
Mr P Burlingham – Patient Adviser
Mr M Caple – Patient Adviser
Mr R Dick – Patient Adviser
Mr J Foden – Patient Adviser
Mr D Gorrod – Patient Adviser
Mr A Locke – Patient Adviser
Mr K Russell – Patient Adviser
Mr G Smith – Patient Adviser
Ms R Stokes – Patient Adviser
Ms J Wells – Patient Adviser

In Attendance:
Mrs H Majeed – Trust Administrator

Apologies:
Mr R Kilner – Non-Executive Director
Ms J Wilson – Non-Executive Director

NO.	ITEM	LEAD OFFICER	ACTION DATE

1. INTRODUCTION

The Trust Chairman advised that the Trust was committed to achieving FT status by April 2012. The purpose of this meeting was to listen to concerns from Patient Advisers in relation to the proposals regarding the future of their role when governors would be elected and UHL became a FT. It was noted that a report on ‘Governors and Membership’ was scheduled to be presented to the Trust Board in May 2011.

2. BRIEFINGS FROM ATTENDEES

The Trust Chairman opened discussion and requested views from attendees:-

(a) Ms J Wells, Patient Adviser expressed concern that the communication in respect of the future role of Patient Advisers had been “appalling”. The Trust Chairman gave an apology and commented that lessons would have been learned through this process.

(b) Mr D Gorrod, Patient Adviser stressed that for effective Patient and Public Involvement (PPI), there needed be an informed input. He had undertaken some basic research and expressed concern that the Governor structures would not enhance PPI. He noted that duplication existed and suggested that patient experience should not be a tick-box activity. He recognised that Patient Advisers had failed to address diversity of the community.

(c) Mr G Smith, Patient Adviser advised that he would not be standing for the Governor role. He noted that PPI had dropped considerably in UHL and Trust Board had not reviewed the PPI strategy for the last three years. He advised that Patient Advisers were keen to support constructively the aspirations of UHL to become a FT. The experience of the Patient Advisers would benefit the Trust. FT status would not only bring benefits but also changes and he expressed concern that the work of Patient Advisers should not be lost in transition. He suggested that the role of the Patient Adviser should run alongside Governors and Patient Feedback Volunteers at least for a year prior to a decision being taken. He highlighted that the recently appointed Patient Advisers had been disadvantaged and there was a feeling that the new way of working (as part of a larger PPI strategy) which had been approved by the Trust Board in 2008 had never been fully implemented.

(d) Mr F Baker, Patient Adviser advised that he came into this role as an experienced patient but he would not be standing as a Governor. He suggested that due to the amount of challenge, a phased handover would prove useful.

(e) Mr M Caple, Patient Adviser noted that each Patient Adviser worked differently but good and bad practice themes were shared with the team. However, a formal evaluation of the role had never been undertaken previously. He advised that the Director of Communications and External Relations had agreed for an evaluation to be done in order to capture what had worked well. He stressed the importance of undertaking this as soon as possible. The outcome from the review might then be used as the basis for the role description of Governors and Patient Feedback Volunteers.

(f) Mr D Allen, Patient Adviser highlighted that he had been in this role for 2 years and a volunteer for 3 years. He considered that his suggestions were genuinely listened to and felt that he was given and earned a lot of respect through this role. He worked 3 days a week in this role and would be disappointed if it ceased. He expressed concern that Governors would not be able to dedicate sufficient time and undertake much of the work of Advisers.

(g) Mr P Burlingham, Patient Adviser noted that change was an opportunity for improvement. In order to maximise opportunity and minimise threat, there was a need to take stock noting the need for self and team evaluation. There was need to look into the feedback volunteer roles in other FT Trusts. He sought information about the experience of the PPI and Membership Manager in terms of liaising with Patient Advisers and suggested that a Facilitator would prove useful. There was a need for open and transparent feedback and involvement of people who could make valuable suggestions.

(h) Mr A Locke, Patient Adviser advised that Patient Advisers had been looking into things that they did differently. He noted some of the Patient Advisers were involved with other hospitals and regional groups and they brought back the experience from those hospitals/groups into UHL. There was a risk that this might be lost if their role was ceased. It took time to get the confidence of staff and involvement in working groups came with experience. Patient Advisers raised any issues/concerns to the members of the Trust Board (through the Board-level sub Committees were they had been appointed as non-voting members). He expressed concern that Governors and Feedback Volunteers would take time to build experience and recognition.

(i) Mr K Russell, Patient Adviser advised that the common theme was that they were all committed to improving patient care, acting as ‘critical friends’ and providing feedback and a patient and public view to the Trust on any key issues. As most of the Patient Advisers were users of UHL facilities, they were able to provide genuine feedback. He sought clarity on whether the role of the PPI and Membership Manager was a budget holding role.

(j) Mr R Dick, Patient Adviser queried whether Governors would be able to speak-up. He expressed concern that Governors met only six times a year and they would not be as committed as Patient Advisers.

(k) Ms R Stokes, Patient Adviser advised that every Patient Adviser worked in a particular Division/CBU and had loyalty and did their best for that Division. She queried whether Governors would be able to provide service to this standard. Ms J Wells, Patient Adviser commented that staff were appreciative and thankful for the work they did (specifically in relation to work done in respect of patient questionnaires).

(l) Mr J Foden, Patient Adviser queried whether the ceasing of this role was a cost-cutting exercise. He advised that their role was very cost-effective (as they operated for expenses only) and beneficial to UHL. He questioned whether the Governors’ role would prove cost-effective. All advisers were driven by commitment to contribute to improve PPI and patient experience. He noted that the comments from staff on his contribution had increased his enthusiasm. He acknowledged the changes but strongly recommended that an overlap was essential and the Patient Adviser role should not be ceased as of 1 April 2012.

3. FEEDBACK FROM UHL NON-EXECUTIVE DIRECTORS

Mr P Panchal, Non-Executive Director commented that the meeting was positive and requested Patient Advisers to contact him, as required.

Mrs K Jenkins and Mr I Reid, Non-Executive Directors commented that they were disappointed that the communication to Patient Advisers in respect of their future role had not been appropriate. Mrs K Jenkins noted that patient experience was the focus of UHL’s strategy and the way forward was to get it right.

Mr I Reid, Non-Executive Director thanked the Patient Advisers for their valuable comments and advised that the Trust Board would be considering their experience and input.

The Trust Chairman noted that the value that Patient Advisers brought into the Trust was clear and beneficial.

4. FINAL COMMENT BY MR M CAPLE, PATIENT ADVISER

Mr M Caple, Patient Adviser expressed concern that the key elements of PPI would be missed to the detriment of patients and the reputation of the Trust highlighting that the Patient Feedback Volunteer role would not be able to replace the Patient Adviser role. He was appreciative of the contributions from the Director of Communications and External Relations and PPI and Membership Manager.

The meeting closed at 3:25pm

Hina Majeed,
Trust Administrator

Appendix 4: Patient Advisor Comments on the Draft Membership Strategy and Trust response.

Background

In November 2010 the Patient Advisors were asked to review and comment upon a proposal which formed part of the Trust's Membership Strategy. The proposal anticipated the election of governors once the Trust achieves Foundation Trust status. It was argued that the new governor role would be similar to that of a Patient Advisor, particularly in terms of providing a lay perspective and challenge on decision making fora and Boards in the Trust. As such, the proposal suggested that the role of Patient Advisor cease upon the election of Foundation Trust Governors.

It is acknowledged that the new governors will not fulfil all of the roles that Patient Advisors currently undertake, particularly in relation to face to face patient contact and gathering patient feedback. As such, the proposal went on to identify a new volunteer role which would capture these dimensions of Patient Advisor activity and provide additional support for Patient and Public Involvement and Patient Experience activity at CBU level. The working title for this new role is "Patient Feedback Volunteer". When considered alongside the new governor role it was felt that the Trust would be in a position as a Foundation Trust to retain and in some cases improve upon the beneficial activity formerly provided by Patient Advisors.

We currently have fourteen Patient Advisors: some more active than others. As it stands, Patient Advisors receive a sessional rate of £20 per half day for their time plus travel expenses. The group comprises 12 men and 2 women, with no Black and Minority Ethnic (BME) representation. Patient Advisors have given considerable service to the organisation and are precisely the kind of active, interested and involved members of the public that we seek to encourage through our membership. This proposal is not intended to disregard either their contribution, or their desire to remain involved with the Trust.

Rationale for the proposal

As noted above, the proposal is driven primarily by our obligation to adopt legally prescribed Foundation Trust governance arrangements, in which the views of patients and the wider public are represented at Board level by elected public governors. Since the activity of governors in many ways duplicates the activity of Patient Advisors, it was felt that once the Trust achieved Foundation Trust status it should concentrate on developing an informed and active Council of Governors and wind up the Patient Advisor role. Indeed, the co-existence of the two groups would arguably undermine and confuse the new governance arrangements.

The issues that Patient Advisors raised and the Trust's response may be summarised as follows:

1. Patient Advisors have been operating for eight years and, therefore, have built up enormous experience, influence and credibility, which it would be a shame to lose.

Patient Advisors have indeed built up considerable knowledge and experience during their time in post and the Trust is keen to explore ways of retaining this. Indeed, our Patient Advisors demonstrate precisely the kind of interest and commitment that we would like to encourage in our general membership. As such, over the coming months we will be exploring opportunities which Patient Advisors may wish to consider. Naturally their experience would stand them in good stead to fulfil the role of governor and since all Patient Advisors are already members of the Trust, this option will be open to them. We will also establish a new Patient Feedback Volunteer role, which will suit individuals with an interest in exploring patients' experience of our services.

2. There needs to be greater clarity regarding the Patient Feedback Volunteer role and the way in which this will report in to the Trust.
The Patient Feedback Volunteer role will entail supporting the UHL patient survey, as well as soliciting other forms of patient feedback (for example, involvement in focus groups and local patient involvement initiatives). Patient Feedback Volunteers will support and report to the PPI lead in each CBU. As such, issues and concerns may then be fed in to the Patient Experience / PPI bi-monthly meeting. Patient Feedback Volunteers will meet periodically as a group. Once Governors are elected, it is envisaged that they will be represented at these meetings to ensure that issues raised are fed directly to governors (the Draft role outline for the Patient Feedback Volunteer role may be found in Appendix 2 of this document).

3. The proposal has not been subject to a full consultation.
Given the inevitability of governors and their role as lay representatives once we become a Foundation Trust, the proposal has not been subject to a full scale consultation. However, it has been shared with the Patient Advisors, alongside the membership strategy within which it sits. Patient Advisors were asked to review and comment on the proposal before it goes to the Trust board. Their comments will be shared with the board and will therefore be factored in to its decision making process. The proposal has also been shared in draft form with the Trust Executive team, and with Non – Executive Directors, all of whom have been asked to comment prior to the proposal's presentation at Trust Board. In addition to this, and to provide more information upon which to base a decision, an evaluation of the Patient Advisor role has been carried out with the assistance of the Trust's clinical audit manager (see below).

4. There is a need to evaluate the Patient Advisor role.
Since the appointment of Patient Advisors over eight years ago, there has been no formal evaluation of the role. As such, with the support of our Clinical Audit team an evaluation has now been undertaken, the results of which may be found in Appendix 5 of this document. The evaluation will help the Trust to capture those aspects of the Patient Advisor role that have worked well. This information will be used to refine our Governor and Patient Feedback Volunteer activity in the coming months and years.

5. Elected Governors will not function as well as appointed Advisors.
The Foundation Trust model comes with a legally mandated structure that we are obliged to adopt. This includes the appointment of elected governors. As such, while we acknowledge the concerns Patient Advisors have voiced *vis a vis* elected versus appointed representatives, the Trust remains committed to this model. Clearly we recognise the imperative to support and train governors and to publicise the opportunity to stand so that we attract able and representative candidates when the time comes. We envisage Patient Advisors drawing on their experience to support the preparation of potential governors for their role.

6. Is this is a cost saving measure?
As we are all aware, the need to examine every area of expenditure is acutely relevant at the moment. However, the proposal to move away from the Patient

Advisors model was prompted by our move to Foundation status and the concomitant election of governors.

7. Should Patient Advisors be retained for a transitional period once governors have been elected?
As noted above, Patient Advisors have a significant role to play in the lead up to the election of governors. However, once governors are elected, the proposal is for the Patient Advisor role to cease. At such times, lay representation and scrutiny will come under the remit of governors. To ease the transition, it is recommended that the new Patient Feedback Volunteer role be established ahead of our Governor elections in January 2012.

8. Should Patient Advisors be retained on the four main UHL committees if they are shown to have been effective?
Although it is proposed that the Patient Advisor role will cease, the Trust will still be subject to its legal obligations to involve the public in its service development activity. As such, it will need to explore other means of meaningfully involving patients and the public. Whether this translates to Governor presence on Board Committees or on groups and work streams that feed in to these committees will be a matter for the Trust to eventually determine as it finalises its FT Governance proposals, taking in to account both legal requirements and Monitor guidance. Governors, although unlikely to sit on these committees, will nonetheless receive reports of their activity in the course of their role.

9. The Trust should research the experience of other Foundation Trusts to see how a Patient Advisor model may work in conjunction with Governors.
Through its membership of the Foundation Trust Network, the Trust is in touch with existing and aspirant Foundation Trusts, and will indeed be taking an interest in their governor roles, and how these interact with other forms of lay representation.

In the Patient Advisor responses to this proposal, specific mention was made of both Sheffield and Birmingham Foundation Trusts, who, it was suggested, operated with both governors and patient groups which were broadly analogous to our Patient Advisors. Birmingham has a Patient and Carer Council, who provide support in relation to the patient experience of their services. In some respects, this group acts as a PPI forum for the Trust. Unlike our Patient Advisors, members of the group do not sit on formal decision making forums, although they are represented on some working groups. Since the election of Governors in 2005, Birmingham have retained their Patient and Carer council, and now some Governors sit on this group to ensure their views are represented to the Board.

Until they became a Foundation Trust, Sheffield had a group of volunteer lay representatives who provided a patient perspective on some working groups. However, with the election of governors, they have ceased to promote the role and are not recruiting new members. One or two active members of the group have been retained as volunteers, and the rest have been encouraged to remain active through the Trust membership. Formal lay representation is now sought through their governors.

Clearly each Trust will take its own decisions about how it supports Governors and the nature of alternative patient and public involvement. The model this Trust proposes sees Patient Feedback Volunteers working with PPI leads in each CBU to explore the patient experience in their areas. These views will be represented to governors, and to the Patient Experience and PPI meeting via the PPI leads. In addition to this, PPI leads and Governors will be encouraged to develop links with the membership to gain a broader public perspective on our services. We will continue the dialogue with other Foundation Trusts to learn more about how they have managed the election, training and support of governors, and which other methods they have used to involve members in their service development.

10. The proposal to close down the Patient Advisor role represents a lack of commitment to the Patient and Public Involvement agenda in the Trust.
Contrary to this assertion, this proposal arguably provides an opportunity to breathe some life in to the Patient and Public Involvement (PPI) agenda in the Trust. Patient Advisors themselves have acknowledged that they are sometimes asked to sit on Boards and working groups to “tick a box” and satisfy requirements to involve patients and the public. There has been some frustration among the group that their views are not always sought or reflected in the outcomes of the groups they sit on. When the role was first created, UHL were arguably ahead of their time. However, expectations regarding patient and public involvement have moved on since then and the proposal seeks to reflect this.

The existence of this role over the last eight years has meant that many UHL staff now look no further than the Patient Advisors when they wish to involve members of the public in their work. As such, Patient Advisors have become synonymous with and represent the sum total of PPI in many areas of the organisation. Indeed, it could be argued that the involvement of Patient Advisors has had the unintended consequence of precluding wider patient and public involvement. This is of particular concern when one reflects upon the lack of diversity among the group and their potential influence in key decision making processes. With the increasing focus on meaningful involvement of our service users it is arguably time that the Trust move on from this model of engagement and explore other ways of working with our membership and the wider public to develop services that are right for our local population.

Appendix 5. Results of the Patient Advisor Evaluation Survey

Method

- Electronic survey sent to PPI / Patient Experience Leads, Divisonal and CBU leads and those with whom Patient Advisors have worked most closely (names supplied by the Patient Advisors)

- Responses requested within 2 weeks of email being sent with link to survey.

- No demographic data was collected on either the P.A or responder.

- Data received and analysed by UHL Clinical Audit manager.

Results

A total of 43 valid responses were received and analysed

Part 1

Responders where asked to assess the involvement of P.A on 13 key activities listed in the P.A job descriptions with their area. If the responder had observed that the PA had been involvement in that activity they were then asked to rate the impact of the P.A on the activity (on a scale of 1 to 5 where 1= No/Low impact, 5 = High impact). Both of these elements were then ranked from highest involvement / impact (rank 1) to lowest (rank 13). The results of the analysis are shown in table 1

Table 1

	Responses							
Question: In your area - has your Patient Advisor (PA):	**Yes**	**No**	**Not observed**	**% PA involvement**	**% PA involvement (where observed)**	**PA Involvement rank (1=highest 13=lowest)**	**If yes - average PA Impact score (on a scale of 1 to 5 where 1= No/Low impact, 5 = High impact)**	**PA impact rank (1=highest 13=lowest)**
Q1 participated in performance reviews relating to Patient Experience?	21	12	10	49%	63.6%	7	3.52	4
Q2 provided advice on the content of Training courses?	4	25	14	9%	13.8%	13	2.75	12
Q3 participated in Focus groups on behalf of the CBU?	19	9	15	44%	67.9%	4	3.42	8
Q4 attended ward visits / rounds?	21	13	9	49%	61.8%	8	3.33	9
Q5 been involved in developing policies?	14	17	12	33%	45.2%	10	3.00	10
Q6 been involved in developing action plans based on feedback from complaints / patient information liaison service?	14	18	10	33%	43.8%	12	3.50	5
Q7 attended Divisional / CBU Board meetings?	26	6	10	62%	81.3%	1	2.77	11
Q8 provided guidance to staff on involving patients and the public?	20	13	9	48%	60.6%	9	3.45	6
Q9 been involved in gathering patient feedback?	21	10	11	50%	67.7%	5	4.00	1
Q10 commented on Trust policies?	20	9	13	48%	69.0%	2	2.70	13
Q11 participated in Observational Audits?	17	9	16	40%	65.4%	6	3.71	3
Q12 been involved in developing patient literature?	20	9	13	48%	69.0%	2	3.85	2
Q13 been involved in developing / planning your annual PPI work plan?	12	15	15	29%	44.4%	11	3.45	6

Responders where asked if P.A has been involved in any other activities – those provided (from the 16 responses) were as follows:

Involved in committee meetings
They have attended divisional time out days, helped develop divisional strategies, and have helped at staff interviews.
Main contributions have been internal validation panels for cancer peer review, support and advice on patient information, helping to facilitate focus groups
Formulation of new letters inviting patients to attend outpatients. Also closely involved in planning of Patient User Day to obtain feedback from patients on how they rate the services they received. Also presented at Outpatients Conference in Nov. 2010
Infection Control meetings
Not many however this may be due to the fact that I don't have direct contact with the patient advisor but feedback from the CBU’s confirms my opinion.
Infection control meetings
Attends conferences
Very supportive to staff and helping to improve all staff approach to patient experience
Attending CBU management team meetings
Our patient advisor has worked with is on patient polling, individual patient interviews and advice about all forms of communication. He has also been involved in feeding the results back to staff as well as drawing up and completing the action plans. He
Interviewing. RT2C conference and steering group. walk rounds with management. Helping in ascertaining what the patients want from their experiences, observational reporting. help with the PEAT inspection
Patient adviser accompanied bed manager for a day and reported back observations and made some suggestions
attends infection control
Interview panel member
Undertaken development of quality metrics and auditing/review OPD postcard feedback/active participants within the multi disciplinary Divisional quality forum/active participation to develop patient feedback/help to engage volunteers/worked very hard

Part 2

The next section of the survey asked responders a series of questions and they asked to respond on a scale of 1 - 5, where 1 = Not at all and 5 = Greatly). An average rating for each question was calculated and is shown in table 2.

Table 2 Question	Rating (on a scale of 1 - 5, where 1 = Not at all and 5 = Greatly)	No of scores
Q15 In your opinion, in general, how well do you feel the role of Patient Advisors is understood by staff in the Trust?	2.55	40
Q16 In your opinion, to what extent have the patient advisors encouraged the involvement of other patients and members of the public in the work of the Trust?	2.43	40
Q17 How satisfied are you that Patient Advisors give their own personal views rather than representing patients and the wider public?	2.88	40
Q18 Other than your Patient Advisor, how confident do you feel in involving patients and the wider public as part of your PPI programme?	3.65	40
Q19 To what extent do you feel that Patient Advisors have been utilised in the Trust, simply to "tick a box" in relation to PPI?	2.85	40

Part 3

The responders were then asked where there P.A had an agreed work plan in your work area?

Only 4 stated ‘yes’, 13 responded ‘No’ and 22 said that they didn’t know if there was a work plan for the PA in their area.

Part 4

Could you please give an example(s) of where Patient Advisors have positively contributed to the improvement of Patient Experience in your area?

20 responders were able to give examples and these were as follows:

privacy and dignity, end of life care,
In service review/reform. Observational audit-feedback to staff.
The PA was heavily involved in assisting one team to collect patient feedback. The PA carried out 1 to one sessions with patients attending clinic for direct information gathering.
Given assistance to frail older patients who may not normally have been able to complete a patient survey
following a complaint about a ward an attitude of staff, call bells etc pt advisor did observations on ward at various times throughout day which were inputted into the action plan
See comments in box above. Patient advisors have been extremely useful in improving patient experience within our CBU.
Focus group around changing practice
I have never seen a patient advisor in my area
Performed interviews with patients leaving department and fed back to staff resulting in changes in service delivery
Can focus meeting onto what matters to the patient rather than to the organisation.
Our patient advisor has shadowed staff and done face to face interviews with patients and then helped us draw up action plans. One particular problem was persuading staff to ask the patients what they wanted to be called. The staff were very resistant to
Walk rounds and speaking to our patients and feeding back. Observing the environment and helping to make changes from lay person's eyes. Very open and honest and clam, lovely gentleman.
Advise only
This depends upon the skill of the patient advisor; some will contribute and remain objective when giving contributions regarding improvements. In this instance this is vital and very useful for the improvement of the service.
ward visits
the PA has been able to be an effective advocate for the patient in some difficult situations
Been involved in the collection of patient experience data as well as the development of other tools to collect information
Focus groups, Obtaining patient experience comments though assistance with completing patient polls
Development of improved privacy and dignity in imaging.

Finally responders were asked to make any addition comments:

variable competence and input which is dependent on individuals
A valuable resource
I have to admit that I believe that areas around the organisation will use a PA to tick the box of patient/public involvement/engagement and shy away from contacting patients that have recently used their service and who would be able to give more and better feedback.
The PA in my area has made attempts to get involved in the CBU board and business planning sessions however they have not been invited to attend on a regular basis and I think this is because their overall input is not yet fully appreciated or understood by all managers within the Trust. As such I think the current role is under utilised and not as effective as it could be.
Whilst some of the patient advisors i have worked with do try to give a broad perspective form a patients point of view, others do tend to offer their own opinion rather than that of the wider public. As many of them have been advisors for some years, it can be argued that they have become institutionalised and have lost some objectivity. That said there are a few individuals who remain true to the role
the success of this role is dependent on the right person in post
The patient advisor role has been extremely supportive to the CBU especially given the context of the cancer agenda and PPI
Generally I feel that their role was a good one when first introduced however there are several issues. They are not representative of the community. They don't represent the wider public and are only offering their view of the world.
We find the input from a patient advisor invaluable. It is extremely difficult to achieve our desired input from other patients and the public
Useful to have PPI but depends greatly upon the individual as to the contribution and experience this offers.
I have found the personal input from the Patient advisor extremely valuable
Base many interactions on their own experience and do not always come across as consulting regularly with patients and their familys. a lot of personal experience evident. The group are not representative of the population as a whole. i would like to see more young people and ethnic group advisors
Sadly my own experience i have found some pt advisors want to put forward their own views which may not always be the view of the patients they are representing. Attending meetings they may not have any back ground knowledge regarding a topic, i think when taking on this kind of role there should be some amount of understanding, even if they visit an area, dept and talk to pt, staff. it also appears that they seem to want to try to catch the staff out, using power in appropriately the role can be misused.

I think the role has been valuable but wonder whether they become part of the Trust rather than an independent voice.
the PA has been particularly useful in assisting patients with pt polling, observational audits and the development of patient information
I think may be the role needs to be relaunched and have a Divisonal lead that directs them. I have to admit I am not too sure if I have a specific one I should use for the CBU as I think we have 3 for the Division. It might be they have an area of expertise we could work with them on.
My experience of working with the patient advisors so closely has been a new experience for me over the last 12 months. As with all things some are better than others and some have at times a very narrowed tunnel view of what it really is like to deliver some ideas within a NHS environment. Despite this though I have found them to be very helpful and willing and have supported our Divison in many developments
Intensive Care is a difficult area to support, but I don't know who my Patient Advisor is, do we have one?
I think that some patient advisers try hard to fulfil their role but others seem to have their own agenda. The Patient Advisers do not seem to be representative of the population or the patient base