Update on implementation of the PPI Strategy

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Trust Board paper Q

Executive Summary

Context

In April 2015 the Trust Board approved a Patient and Public Involvement (PPI) Strategy. The strategy;

- Outlined the mechanisms by which the Trust communicates and engages with its stakeholders.
- Outlined the ways in which the Trust involves its patients and the wider community in its service development

Updates on this plan are brought to Trust Board quarterly. This is the update for Q1, 2017 /18.

The paper provides an overview of PPI activity since the last PPI update in March 2017. At the March Board meeting, the Board also agreed to receive a revised PPI Strategy. This paper therefore includes the revised strategy as **appendix 1**. The first half of the strategy remains much the same as the original with some contextualisation and scene setting. The Board are particularly directed to the second half of the Strategy which details the refreshed approach to PPI Management and community engagement. A further two appendices are also attached to this paper;

- **Appendix 2** comprises a report by Martin Caple, Chair of the Trust's Patient Partner group on the activity of a new Joint Patient Reference Group
- **Appendix 3** compromises a second report by Martin Caple which provides an overview of Patient Partner activity within the Trust over the last year.

Conclusion

Plans for both the expansion of our Patient Partner group and an increase in community engagement activity are progressing well. These will be supported through the revised PPI Strategy. After a slow start, there is now some momentum building with a newly formed Joint Patient Reference Group. Progress and outcomes regarding this group may be found in appendix 2 of this document.

Input Sought

The Trust Board is asked to note this paper and to approve the revised PPI Strategy. The Board are also asked to consider the issues raised in appendix 2 and 3 of this document and provide feedback to the Chair of our Patient Partner Group.

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	Not applicable]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Not applicable]
A caring, professional, engaged workforce	[Not applicable]
Clinically sustainable services with excellent facilities	[Not applicable]
Financially sustainable NHS organisation	[Not applicable]
Enabled by excellent IM&T	[Not applicable]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Yes]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	**Operational Risk Title(s) – add new line for each operational risk**	**Current Rating**	**Target Rating**	**CMG**
2154	There is a risk that a lack of engagement with PPI processes by CMGs and Directorates could affect legal obligations	12	8	

b. Board Assurance Framework [No]

3. Related **Patient and Public Involvement** actions taken, or to be taken:

This report includes a refreshed PPI Strategy and details the Trust's approach to POI and community engagement. The patient voice is represented in two update papers attached as appendices and submitted by the Chair of our Patient Partner group.

4. Results of any **Equality Impact Assessment**, relating to this matter:

The PPI strategy actively promotes inclusive patient and public involvement which is mindful of the diverse population that we serve. This paper provides assurance that a recent round of Patient Partner recruitment has added to the diversity of that group.

5. Scheduled date for the **next paper** on this topic: [07/09/17 TB]
6. Executive Summaries should not exceed **1 page**. [My paper does comply]
7. Papers should not exceed **7 pages.** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

REPORT BY: Mark Wightman, Director of Communications, Integration and Engagement

AUTHOR: Karl Mayes, PPI and Membership Manager

DATE: 01/06/17

SUBJECT: Update on implementation of the PPI Strategy

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1. Introduction

1.1 In April 2015 the Trust Board approved a Patient and Public Involvement (PPI) Strategy. The strategy;

- Outlined the mechanisms by which the Trust communicates and engages with its stakeholders.
- Outlined the ways in which the Trust involves its patients and the wider community in its service development

1.2 Updates on this plan are brought to Trust Board quarterly. This is the update for Q1, 2017 /18.

1.3 This paper also incorporates three appendices in addition to providing a brief overview of PPI activity over the last Quarter. The appendices are as follows;

- **Appendix 1** comprises a revision of the Trust's PPI Strategy and action plan
- **Appendix 2** comprises a report by Martin Caple, Chair of the Trust's Patient Partner group on the activity of a new Joint Patient Reference Group
- **Appendix 3** compromises a second report by Martin Caple which provides an overview of Patient Partner activity within the Trust over the last year.

2. Revision of the PPI Strategy

2.1 The Board agreed, following the last PPI update in March 2017, to receive a revised PPI Strategy in June 2017. The revisions to the strategy recognise;

- The Board's desire to increase community engagement activity and become more visible across our local communities
- The aspiration to increase the numbers of Patient Partners active within the Trust but to do so in a manageable way
- The desire to adequately support and engage with newly recruited Patient Partners within our CMGs
- A recent reduction in capacity of the PPI Team
- The on-going pressures on CMGs arising from the current financial constraints on the NHS

2.2 Appendix 1 of this document contains the revised PPI Strategy and action plan. In short, the revised strategy retains the Trust Board's commitment to improving Patient and Public Involvement. As such, it seeks to support CMGs to increase their PPI activity while at the same time advocating a closer level of scrutiny. The strategy seeks to increase the numbers of Patient Partners active within the Trust and to get them more involved at service level. It also underlines the Trust's commitment to increasing its community engagement, responding to local need and becoming more "visible" among the diverse communities it serves.

2.3 The key recommendations in the revised PPI Strategy focus on the following areas:

- Increasing CMG ownership of the local PPI agenda
- Developing our Patient Partner model
- Increasing our community engagement
- Developing the E–Partner Programme
- Support for an LLR Joint Patient Group
- Better communication with our volunteers

3. Joint Patient Reference Group

3.1 One of the outcomes from the Trust Board Thinking Day on PPI (August 2016) was to explore the formation of a joint patient representative group. The group would offer disparate patient representative groups and organisations an opportunity to share intelligence and concerns and to present their combined priorities to the Trust. Three meetings have taken place since then to further this aspiration with one of the meetings headed up by the Trust's Chairman. Appendix two of this document has been provided by Martin Caple, our Patient Partner Chair, who is currently also chairing the Joint Patient Reference Group (as it is now known). It shares an overview of the group's activity and identifies key issues and areas of concern. The Trust Board are asked to consider the questions posed in Martin's paper.

Highlights since the last PPI update in March 2017

4. Patient Partner Recruitment

4.1 A recruitment programme for Patient Partners was undertaken this year. The aspiration was to raise the number of Patient Partners to at least 21 by March 2017. Interviews for the Patient Partner role took place in February 2017. As a result, 10 successful candidates will now be offered a place as a UHL Patient Partner. This will bring the total number of Patient Partners up to 24. The new candidates will add further diversity to the Patient Partner group in terms of gender, ethnicity, age and disability.

4.2 Given the relatively large number of new Patient Partners it will be important that they are supported, both by existing Patient Partners and by their PPI Leads and other colleagues in the CMGs. The revisions to the PPI Strategy (Appendix 1) will support this aspiration.

4.3 All new Patient Partners will undertake the Trust’s Corporate Induction. All 10 have been invited to a bespoke Patient Partner induction on June 13th 2017. As such, the newly expanded Patient Partner group will be “operational” by mid June 2017.

4.4 A summary of Patient Partner activity and recommendations by Martin Caple, Patient Partner Chair, may be found in appendix 3 of this document.

4. Community Engagement

4.1 The Trust Board received and endorsed a community engagement proposal in January 2017. The proposal sets out a plan for a quarterly community engagement forum which will be held in community venues across LLR. It also outlines a rolling programme of smaller scale community engagement events and an increased UHL presence at festivals and events. Unfortunately the planned Community Engagement Forum for May 2017 was postponed in response to the embargo on politically sensitive public engagement during the “Purdah” period leading up to the General Election. This first Forum meeting will be rescheduled to July 2017. Details to follow.

4.2 As part of a rolling programme of community engagement the PPI Team have focused recently on some of Leicester’s South Asian Community groups; particularly those representing older people and people with disabilities. The team has also conducted engagement with parents and carers of children with autism and a local Fibromyalgia support group. Details of these engagement events will be shared in “Together” magazine and the PPI team are also developing a means of sharing outcomes from the events on the Trust’s Intranet. Specific issues have also been fed back to relevant teams within the Trust.

5. Emergency Department Tour

5.1 Ballu Patel, Non-Executive Director and the PPI & Membership Manager invited community, faith and voluntary sector representatives to take a tour around the new Emergency Department in April. This gave a range of stakeholder groups an opportunity to comment on the design and layout and to ask questions. Among the groups we engaged with on this were the local LGBT Centre, Somali and Bangladeshi communities, VISTA and the Deaf Forum. The tour provided an opportunity to reinforce the Trust’s commitment to community engagement and desire for greater dialogue.

6. PPI in the Trust’s Cancer Centre

6.1 The Trust’s Cancer Centre runs a Cancer Patient User group which meets every six weeks to explore the experience of patients and to seek their input in service improvement measures. The PPI team have been working with the group over the last couple of months to support its growth. They have also been working with the Cancer Centre to secure a Patient Partner to work specifically with them on their agenda. A Patient Partner should be attached to the Cancer Centre by the end of June 2017.

7. Summary

7.1 Plans for both the expansion of our Patient Partner group and an increase in community engagement activity are progressing well. These will be supported through the revised PPI Strategy which is attached as an appendix to this document.

7.2 After a slow start, there is now some momentum building with a newly formed Joint Patient Reference Group. Progress and outcomes regarding this group may be found in appendix 2 of this document.

Karl Mayes
PPI & Membership Manager
June 2017

Appendix One: Revised Stakeholder Engagement and Patient and Public Involvement (PPI) Strategy

University Hospitals of Leicester NHS Trust

Stakeholder Engagement and Patient and Public Involvement (PPI) Strategy

June 2017

"Patients and their carers should be present, powerful and involved at every level"
Keogh Review report (2013)

1. Purpose

1.1 This document describes how University Hospitals of Leicester NHS Trust will engage and involve the public, patients and its stakeholders in the planning, provision and evaluation of its services. As such its core purpose is to;

- Outline the mechanisms by which the Trust communicates and engages with its stakeholders.
- Outline the ways in which the Trust involves its patients and the wider community in its service development
- Set out the Trust's plans to achieve high quality stakeholder, patient and public involvement over the next 3 years.

2. Strategic outcomes

- Patient and public involvement activity is an integral and valued element of mainstream work, which leads to identifiable improvements in services and facilities and a better experience for patients.
- Changes to services and facilities meet the needs of our diverse service users
- Well informed staff select an appropriate method of patient and public involvement according to the specific context.
- Evaluation of patient and public involvement informs future developments.
- Resources for PPI are assessed and steps taken to secure them.

3. Responsibilities

3.1 The Trust Board is ultimately responsible for ensuring that the Trust meets its legal and policy obligations to deliver the Patient and Public Involvement agenda. The Trust Board is responsible for ensuring that Patient and Public Involvement shapes its own work and that it has been included appropriately in work submitted for Board endorsement or approval.

3.2 Directors are accountable to the Chief Executive for the delivery of Patient and Public Involvement in their areas of responsibility, through the performance review process.

3.3 Clinical Management Groups (CMGs) are central to involving patients and public. They are responsible for implementing PPI in their service areas and facilities.

3.4 Matrons/Senior Nurses have a responsibility for patient and public involvement written into their Job Descriptions. However since patient and public involvement covers all areas, not only nursing, other members of the CMG management team share the responsibility for ensuring appropriate involvement.

3.5 Service Managers, Heads of Operations, Medical Staff and Allied Health professionals should all share responsibility for ensuring that developments in their services are informed through the direct involvement if patients and their representatives.

4. Introduction

4.1 Involving patients and the wider public is not a soft, optional activity. The Trust has a statutory duty to do so; a duty strongly reinforced by the recommendations of the Francis, Keogh and Berwick reports among others. These reports call clearly for “real” patient and public involvement and a cultural change across the NHS to ensure greater openness, transparency and a duty of candour to patients. The Keogh Review (ambition 3), for example, presses for patients to be equal partners in the design and assessment of NHS services, with the patient voice at the centre of the planning, management and evaluation of hospital services.

4.2 Expectations regarding PPI have grown considerably over the last decade. Today’s patients are better informed, have greater choice and are less likely to accept being passive recipients of care in a system they have no influence over. This cultural shift is reflected in the proliferation of fora within which patients and the wider public are connecting with healthcare organisations (e.g. The Trust’s Patient Advisor group and public membership, NHS Citizens, Expert Patients, Healthwatch, the Mercury Patients’ panel partner organisation memberships, PPGs etc.).

4.3 While there is much to celebrate in terms of our engagement to date with our patients, stakeholders and the wider public, there is a good deal more that we can do to ensure the voices of patients, carers and the local population are at the centre of our everyday business. In particular the Trust has a patchy track record of involving patients in its reconfiguration and service development. Where patients have been involved this has tended to come at the end of the process, at a point where they have little opportunity to influence.

4.4 There is a clear benefit to involving patients from the earliest discussions and throughout the planning process. Indeed, where patients witness and are involved in discussions which appraise options and consider clinical and financial constraints they are far better placed to understand, help to shape the discussions and ultimately endorse the outcomes.

4.5 This strategy aims to raise the profile of PPI within the organisation and move us further towards a situation where involving patients is the norm. In particular the strategy aims to strengthen and support a commitment to patient involvement from our CMGs. It sets out measures to provide greater support for CMGs while at the same time increasing the scrutiny of their performance around the PPI agenda.

5. Listening to patients or involving them?

5.1 There is a distinction between *listening* to patients and *involving* them in the development and evaluation of their hospital services. Although the Trust has invested increasing time and resource in to collecting patient feedback, opportunities for patient *involvement* have not kept pace. There are several reasons why this might be the case, ranging from a fear among staff of public challenge, anxiety that involving patients will blow projects off course or delay their completion or a simple lack of confidence around the PPI agenda. Whatever the reasons, the Trust is still some way off the oft quoted aspiration for patient involvement; “no decision about us, without us” (Equity & Excellence: Liberating the NHS, 2010).

5.2 We want our strategy to go beyond being a framework for how we receive and act upon feedback, because we believe the voice of patients should be at the centre of our organisation. Patient feedback provides an important and useful barometer by which the Trust may gauge patient experience and identify key areas for improvement. However, once identified, it is most often the case that actions to address these areas for improvement are determined exclusively by our staff, without the direct *involvement* of patients and the wider public. The diagram below (fig.1) reflects the common response to patient feedback within the Trust. This strategy seeks to move the Trust towards a situation where we routinely have patients and their representatives around the table, making decisions in partnership.

5.3 In many respects the collection of patient feedback is too readily taken as a proxy for patient involvement. This serves to keep “real” involvement at arms length from our strategic activity and the development and evaluation of our services. As such, we are missing opportunities to explore and “co-design” services that best meet the needs of the people using them.

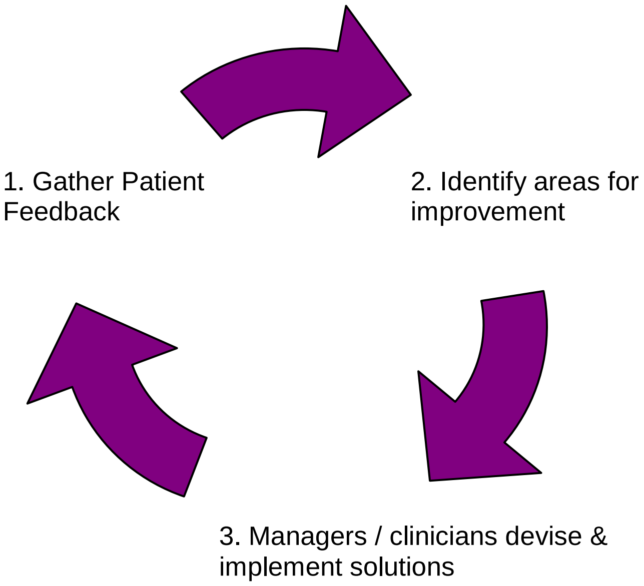

Figure 1. Common pattern of action on patient feedback within the Trust

5.4 To be effective, PPI cannot be carried out as a discrete set of activities which bear little relation to our core activity: rather it needs to be embedded throughout the planning and delivery of our services. Involvement should be the *means by which* we approach this activity. In other words, PPI should not be an additional, “bolt – on” practice that exists separately to where we expend most of our professional energy.

6. Aim of the strategy

6.1 The broad aim of this strategy is to ensure that patients and the public are involved and have a strong voice in our core business and strategic and service development. In terms of service development the strategy seeks to move from the diagram (fig. 1) presented above to the diagram below (fig. 2.) which sees patient feedback as a trigger to involve patients and the public in service redesign.

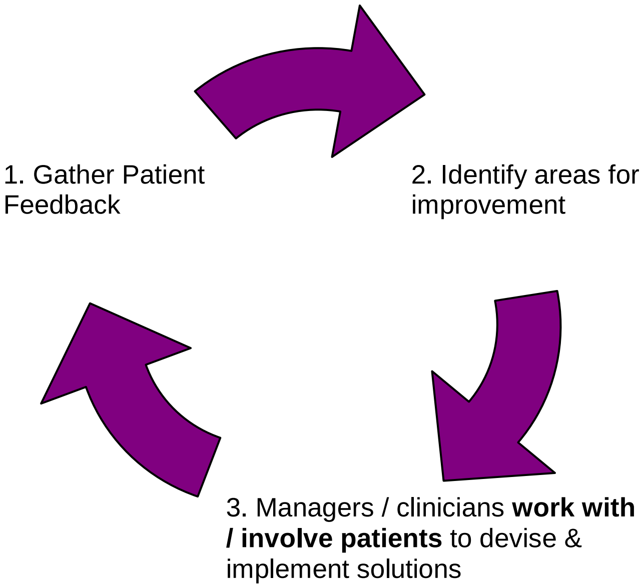

Figure 2. Simple model of involvement

7. Vision and Principles

7.1 To achieve meaningful involvement of patients and the wider public the Trust will honour the following commitments;

Early involvement

Patient involvement is still frequently undertaken at haste, towards the end of a project. As such, it can be little more than a box ticking exercise. If patients are to be meaningfully involved this needs to happen as early as possible and throughout the life of the project. Rather than presenting a *fait accompli* for endorsement, we will make a commitment to “co-design” from the start.

Ownership of PPI by CMGs

For PPI to be meaningful and effective it is vital that CMGs treat it as core business. As such they must adequately resource involvement and actively create opportunities for patients and the public to work alongside them as they develop their services. In this respect it is important that the PPI agenda is not seen as something owned by, and only relevant to nurses.

Empowering patients to get involved

If we wish to see enthusiastic, committed patients who remain engaged with the Trust we will need to support them (through training, development and covering expenses) and ensure that we demonstrate how their involvement has changed our thinking and impacted on service development. Patients and patient representatives who do get involved must be supported, valued and welcomed to the organisation.

Involvement of people with direct experience of our services

Across the UK PPI fora are populated by what we might term “semi professional engagers”. These are individuals who devote a great deal of time to their involvement with health services and as a result gain a nuanced and detailed understanding of the local health economy. Such individuals are invaluable and are well placed to both challenge and to act as a “critical friend”. However, we need to find a balance between such involvement and that of the “ordinary” patient who has a direct and recent experience of our services. As such we must identify ways in which we can recruit and support such patients and provide a range of opportunities for them to get involved.

Managing expectations

Well supported participants in PPI will be clear about what they can influence and what they cannot. Moreover they will understand the important clinical, political and financial drivers that may influence the Trust’s decision making. In this respect we must make a commitment to provide relevant background training for participants to allow them to meaningfully participate in the dialogue we have with them.

8. Definitions: What do we mean by Patient and Public Involvement (PPI)?

8.1 Patient and Public Involvement (PPI) refers to the active participation of patients, carers, community representatives and the public in the design, delivery and evaluation of health services.

8.2 It may be helpful to think of patient and public involvement as one element of a scale of engagement activities. One end of the scale represents simple information giving, while placing decision making directly in the hands of patients is at the other end of the scale. The term “engagement” covers a range of activity characterised by the degree of influence patients and the public may have. The diagram below (fig. 3) provides a summary of the range and nature of public and patient engagement. Activities that “involve” patients in various degrees are indicated by the shaded areas of the diagram.

	Goal	Commitment to the public	Tools (examples)
↑ **Public influence**	**Empowerment** Supporting patients / the public while placing decision making in their hands	We will provide support and information to you and implement what you decide	Working with Voluntary sector / health interest groups, citizens juries
	Collaboration Working in partnership with patients / the public through every aspect of the project including development of alternatives & identification of the preferred solution	We will work together through each step of the process, seeking your advice and innovation & incorporating this in to decisions to the maximum extent possible	Project boards, advisory committees, participatory decision making, patient representatives
	Involvement Working directly with patients / the public throughout the process. Ensuring concerns and aspirations are understood & considered	We will work with you to ensure your concerns & aspirations are directly reflected in our activity. We will provide feedback on how public views have influenced our decisions	Focus groups, workshops, project groups, expert patients,
	Consultation Obtaining public feedback, acknowledging concerns and suggestions. Providing feedback on how public opinion shaped the decision	We will listen to your views & acknowledge your concerns & aspirations. We will provide feedback on how public views have influenced our decisions	Feedback forms, surveys, social media, public meetings, exhibitions.
	Giving Information Providing clear information on services and how they are being developed. (Newsletters, web sites etc.)	We will keep you informed, providing accurate and accessible information	Fact sheets, local media, social media, newsletters, web sites, Open days

Fig. 3. Levels of Patient and Public Involvement (Adapted from Arnstein's "Ladder of Participation" 1969)

8.3 As noted above, all of these activities fall under the general heading of "engagement" and different approaches will suit different activities. For example, if the Trust installs new equipment to speed up the way in which it can dispense medicines it may be appropriate simply to inform the public (e.g. through communications with our membership and through local media). However, if significant changes are being made to a care pathway the project would clearly benefit from the involvement of people who use, will use, or have used the service.

Indeed, the Trust has a legal obligation to involve the public in such circumstances. In practice, patients and the public can become involved in decisions about healthcare and health services at a number of different levels, ranging from the involvement of individual patients and carers in treatment decisions to large scale consultations on national policy.

9. Benefits of PPI

9.1 Involving patients and the public in our service development and delivery brings many benefits; both to the Trust and to the people who use our services. Indeed, in the private sector it would be almost inconceivable to develop products and services without actively seeking the insight of customers. Market research, Mystery Shoppers, customer surveys and focus groups etc are fundamental to successful businesses and reduce risk, minimise dissatisfaction and avoid costly mistakes. In short, any organisation that seeks assurance that it is developing services in a way that is right for the people that use them will involve them in the process.

9.2 Among the many benefits of PPI it can;

- Improve the planning and development of services
- Improve patient satisfaction
- Increase confidence in Hospital care
- Encourage public endorsement of strategic decisions
- Increase public understanding of the complexities of healthcare provision
- Improve decision making by incorporating the perspective of patients
- Encourage a sense of shared ownership
- Avoid conflicts by identifying and addressing critical issues early on
- Build better relationships and communication between hospital staff and service users
- Facilitate better health and more appropriate use of services
- Promote openness and accountability
- Contribute to the development of fairer and more accessible services
- Empower communities to have a say in the delivery of services
- Improve how we respond to people’s needs and values
- Encourage more informed and active patients
- Build Trust and legitimacy
- Build relationships between the Trust and local communities
- Reduce complaints

10. Why is Stakeholder Engagement important?

10.1 The Trust is keen to build stronger and more productive relationships with its stakeholders to understand their needs and ensure that hospital services are optimised for our local population. Stakeholder engagement is essentially about building a dialogue with interested parties, providing timely information and gaining endorsement for projects and initiatives. It is also a means by which we can minimise negative and maximise positive environmental and social impacts. Effective and honest stakeholder engagement is the hallmark of an organisation that is run responsibly. It entails a willingness to listen; to discuss issues of interest to stakeholders and crucially a willingness to be flexible in what the Trust aims to achieve and how it operates as a result of its engagement.

10.2 Robust and successful stakeholder engagement will:-

- Ensure the Trust is more responsive to the needs of its users and local population
- Improve the hospital experience of patients and carers
- Improve communications and feedback with stakeholders
- Gain “buy in” to Trust strategies by stakeholders
- Ensure support for key strategic business developments
- Support the Trust to gain influence to achieve its organisational objectives
- Increase leverage and influence within health and social care markets
- Support the Trust to compete effectively & improve financial stability
- Improve the Trust’s reputation

11. Legal requirements

11.1 Notwithstanding the many and obvious benefits of stakeholder, patient and public engagement, the Trust has a statutory requirement or duty to consult and involve the public. Specifically, under section 242 of the Health Act (2006) we are obliged to ensure that users of our services are involved / consulted in -

a. the planning of the provision of services,
b. the development and consideration of proposals for changes in the way those services are provided, and
c. decisions we make which affect the operation of those services.

This is particularly important if the implementation of a proposal will have an impact on -

a. the manner in which the services are delivered to users of those services,

or

b. the range of health services available to those users.

12. Management of current PPI and stakeholder engagement

12.1 Within the Communications and Engagement directorate the Trust has a clear team structure with which to coordinate stakeholder engagement and PPI, led by the Director of Communications, Integration and Engagement. The Communications team includes a PPI and Membership manager and a Head of Services for GPs. So, for example, the key relationships and communications products / channels with the three Healthwatch organisations, the two Overview & Scrutiny Committees, the Trust’s Patient Partners, Trust public members, the Mercury Patients Panel and local MPs are managed through this team, with support from key individuals including the Chairman and Chief Executive.

12.2 The Trust’s PPI and Membership Manager, supported by a Band 5 PPI & Membership Officer, is responsible for engagement and involvement programmes across the Trust, providing support and advice at all organisational levels. Corporate engagement is managed through the PPI and Membership office, drawing on a range of sources including the Trust’s Patient Partner group, its public membership, engagement with our diverse local communities, Healthwatch and other patient and public representative groups.

13. Patient Partners and PPI within the CMGs

13.1 Since 2001 the Trust has supported a group of Patient Partners (formerly Patient Advisors). Patient Partners are members of the public who provide a patient or carer's perspective on various groups, Boards and Committees within the organisation. They are also involved in patient surveying and act collectively as a consultation group. Patient Partners are allocated to our CMGs and are coordinated there, usually by a senior Matron or the Head of Nursing. These members of staff are known as "PPI Leads" and are also responsible for coordinating and monitoring the wider PPI agenda for their service areas.

14. Trust membership

14.1 The Trust now has a public membership of 16,522 people across Leicester, Leicestershire and Rutland. Although the membership was established in anticipation of a Foundation Trust application, even in the absence of such an application there is still a significant advantage to having such a large membership. Chiefly, the membership puts the Trust in touch with thousands of local people who have expressed an interest in Leicester's Hospitals. As such, it is both an excellent communication channel and a resource from which to draw people to events and engagement opportunities.

14.2 Following a recent cost improvement review, our members now receive a quarterly magazine promoting Trust news and events. The majority of magazines are now sent out electronically. Members are also regularly approached to attend events and engagement opportunities and form the key population from which such roles as Patient Partner are recruited. Members and the wider public are also invited to a monthly "Leicester's Marvellous Medicine" talk, usually delivered by one the Trust's consultants. It is clear that there are many who wish to become more involved with the Trust and there is certainly scope to create more opportunities for this to happen.

15. Patient Involvement Patient Experience and Equality Assurance Committee (PIPEEAC)

15.1 In December 2013 the Trust established a new assurance committee which monitors and encourages CMG performance on Patient Involvement, Patient Experience and Equality. The committee was set up to recognise the close links between these three agendas. A recent review of his committee was undertaken in April 2017. The committee will now devote a quarterly meeting each to the Equality, Patient Experience and Patient Involvement agendas. The PIPEEAC meetings are attended by the seven CMG PPI leads as well as medical and senior nurse representation and other senior staff from the Trust. The Patient Partner Chair also attends these meetings and other Patient Partners will be invited to the quarterly sessions on PPI.

16. Healthwatch

16.1 The Trust has a good working relationship with its local Healthwatch organisations and a Healthwatch representative sits on the UHL Trust Board as a non voting member. Our Chief Executive and Director of Communications, Integration and Engagement meets quarterly in a long standing arrangement with representatives from all three local Healthwatch organisations. The PPI and Membership Manager is also in regular contact with Healthwatch representatives and acts as a point of contact for the Trust.

17. The New Strategy

17.1 This strategy aims to build upon what is already happening within the Trust and to strengthen PPI in our strategic initiatives and within CMGs. We aim to raise the profile and significance of PPI activity throughout the Trust, increase the opportunities to get involved and emphasise the responsibility of CMGs to involve patients in the shaping and development of their services.

17.2 Recommendations in the following areas will help us to achieve these aspirations;

- Increasing CMG ownership of the local PPI agenda
- Developing our Patient Partner model
- Patient Involvement in sub committees of the Board
- Increasing our community engagement
- Developing the E–Partner Programme
- Support for an LLR Joint Patient Group
- Better communication with our volunteers

18. CMG ownership of the PPI agenda

18.1 If we are to generate a step change in patient and public involvement then CMGs must take a central role. The CMG management team are collectively responsible for developing their CMG’s approach, identifying priorities and for the production of an annual plan for involving patients and public. As things stand, CMG performance in PPI (both in terms of the use of Patient Partners and engagement with the wider patient population) is varied across the CMGs. Some CMGs have robust plans to engage patients while others have taken a more *ad hoc* approach which is not always satisfactory.

18.2 As things stand, the resource for PPI at CMG level is, in most cases, their Head of Nursing. Although all of our Heads of Nursing understand the value of PPI they have many other demands on their time and as a consequence they can struggle to devote sufficient attention to patient involvement or to their Patient Partners. Similarly, in the crowded CMG Board agendas there is rarely mention or monitoring of PPI activity.

18.3 Given our statutory duty, rising public expectations and increasing national attention to PPI, CMGs will need to integrate PPI in to their activity as a matter of core business. Moreover, such activity must be adequately resourced.

18.4 We propose the following measures to support and monitor PPI in CMGs;

- **A standing agenda item on PPI at CMG Board meetings**

Although many CMGs do schedule a standing item on “Patient Experience” at their CMG Board or Quality and Safety meetings, these items may or may not cover actual patient *involvement*. There is a danger, therefore, that patient involvement becomes lost or subsumed into the wider discourse around “patient experience”. The PPI team will work with the CMG leads to ensure that this distinction is not lost.

- **Increasing support for PPI within the CMGs**

The PPI team wish to formalise the support they offer to CMGs by mandating quarterly meetings with the CMG PPI leads, Patient Partners in that CMG and a member of the PPI team. The purpose of these meetings will be to identify opportunities for involvement, share good practice in other CMGs, support the development of a PPI plan and provide ongoing development and monitoring around the PPI agenda.

- **PPI leads in each CMG will be required to nominate delegates to coordinate PPI at service level**

Given the pressures on Heads of Nursing to deliver and report across a wide range of agendas it is essential that they identify a named deputy to coordinate PPI at service level and to work with Patient Partners across the CMG. PPI leads will be asked to inform the PPI team of the names of deputies. They will also be expected to encourage the involvement of Service Managers, doctors and other non – nursing staff in the PPI agenda.

- **Training to improve CMG PPI capability**

In the last financial year, the PPI & Membership Manager (with the involvement of Patient Partners and UHL staff) developed a PPI toolkit which has been distributed to CMG leads. It also forms part of the suite of tools which have been made available via the “UHL Way” programme. The toolkit details a range of methodologies which may support PPI and will be used as the basis for ongoing training. Opportunities for training will be taken in the quarterly meetings noted above, in PPI PIPEEAC meetings and on an ad hoc basis as required. A training needs analysis will be undertaken in each CMG, and with our Patient Partner group in order to shape the training programme. Training will be delivered by the PPI team and in some cases supported by our Patient Partners.

- **Monitoring and reporting of CMG performance**

The PPI team and CMG Patient Partners will assess the CMG’s performance around PPI and this will be reported as part of the quarterly PPI update submitted to Trust Board by the PPI & Membership manager.

19. Patient Partners

19.1 To support CMGs in their day to day activity we will expand the numbers of Patient Partners active within the Trust. Recruitment has already taken place over last few months and the PPI team aim to have inducted 11 new Patient Partners by June 2017. This will bring the total number of Patient Partners up from 13 to 24. We will set a threshold of no fewer than 21 Patient Partners attached to the Trust and will recruit to vacancies on an ongoing basis.

19.2 Patient Partners will continue to support CMGs, getting involved in such areas as;

- Service development
- Service evaluation
- Strategic planning
- Patient surveying
- Boards and committees
- Audits (e.g. environmental)
- Focus groups
- Team meetings
- Patient information development
- Staff recruitment
- Complaints reviews
- Reviewing patient experience data

19.3 The Patient Partner group will be managed centrally and recruitment will take place through the PPI & Membership office, as will induction and training of new and existing Patient Partners. However, they will continue to be coordinated at service / CMG level as detailed above.

19.4 CMG coordination of Patient Partners will need to be adequate to ensure that they are guided and supported in their involvement with the Trust. Indeed, without a clear commitment from each CMG to embrace Patient Partners the model will not be sustainable.

19.5 To support Patient Partners the PPI & Membership team will develop a Patient Partner Workbook which will act as a shared document between Patient Partners and CMG leads to record their activity and monitor performance of the CMG. A revised Terms of Reference will be developed for the group as well as a comprehensive induction pack for new Patient Partners.

19.6 The PPI team will explore the attachment of Patient Partners to other areas of the Trust in addition to the CMGs. This will begin with a trial allocation of a Patient Partner to the Trust's Cancer Centre. The Patient Partner will be coordinated by the Trust's MacMillan Lead Cancer Nurse.

19.7 We will raise the profile of Patient Partners within the Trust through an internal communications campaign which will include a simplification of the process of requesting Patient Partner involvement. The PPI team will develop an online form for requesting Patient Partners (both individuals and to consult with the group). The team will also organise Patient Partner profiles which will be displayed in the Trust's Intranet to promote the range of interests and experience of our Patient Partners. This campaign will compliment a poster campaign which was started at the beginning of 2017 around UHL sites and on the Hospital Hopper.

20. Our approach to Community Engagement

20.1 With reference to the stakeholder mapping diagram, the Trust spends most of its engagement time and effort concentrating on those stakeholders with the highest interest and influence (in the top right of the diagram). As such we have regular contact with MPs, our Patient Advisors, Healthwatch and the Mercury Patients' Panel etc. However, we engage far less with the majority of our service users, their families and communities who are located in the bottom left quadrant of our stakeholder diagram. To remedy this we will take steps to improve the relationships we have with faith and community groups and with geographical and interest communities across the LLR region.

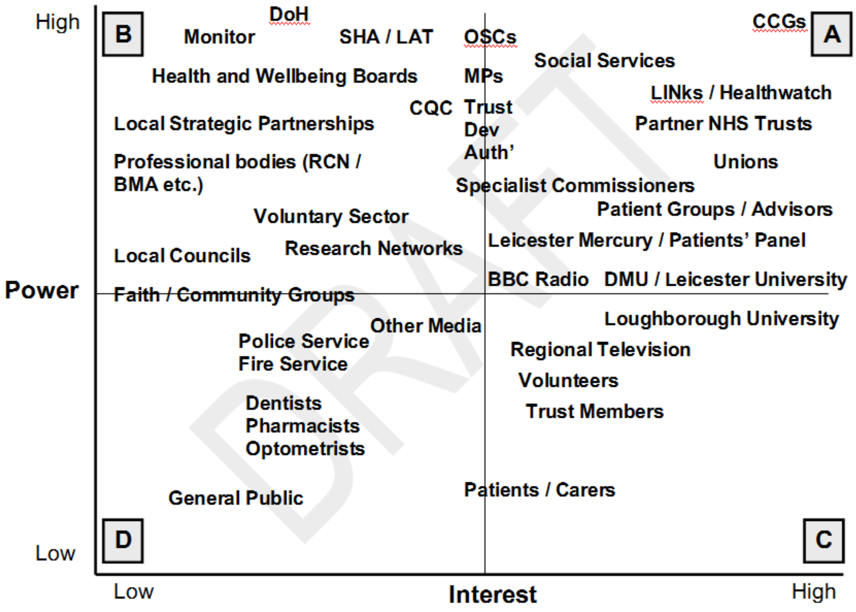

Fig. 5. Matrix analysis of UHL stakeholders

20.2 The diversity of our local population is well documented. Within the city of Leicester, people from Black and Minority Ethnic (BME) communities comprise almost 50% of the population and within the county the BME population is higher than the national average. People from all of our local communities are users of our services. As such, it is imperative that PPI activity conducted by the Trust is inclusive. This extends, of course, not only to people from BME backgrounds but also to people with disabilities, faith groups, Lesbian Gay Bisexual and Transgender (LGBT) service users, rural residents, people from disadvantaged communities and other communities that are less often engaged and consulted.

20.3 Engaging and involving such a diverse population will require different approaches and may also call for extra resource (e.g. interpreters, accessible formats for information etc.). However, given that we provide acute care for the whole population and that "seldom heard" groups often experience poorer health and social circumstances, it is particularly important that we make the effort to engage and involve them.

20.4 For the community engagement section of this strategy we will set out two core elements to help the Trust increase its presence and visibility across the region. Specifically we outline plans here for;

a) a quarterly Community Engagement Forum
b) a rolling series of smaller scale engagement events.

The aim of the larger events will be to enable Board members to be more visible in local communities, to listen to a diverse range of views on our services and promote and publicise the work of the Trust. The smaller events will focus on relationship building, understanding community experience of our services and encouraging greater and more diverse participation in UHL business from the communities we serve.

Aims and objectives

20.5 Public sector engagement is often viewed by communities with a degree of cynicism (e.g. as "engagement for engagement's sake"). It is important, therefore, that we are clear about why we wish to undertake a programme of community engagement. The activity outlined in this paper will seek to achieve the following aims and objectives;

- Listening to the experience of service users and the wider public
- Feeding issues and concerns back in to the organisation.
- Raising awareness of recruitment opportunities in our hospitals
- Encouraging community participation and involvement in UHL (through, for example, our membership, volunteering, Patient Partner group, ePartners etc.)
- Signposting to services, departments and personnel (i.e. PILS / complaints)
- Sharing information and engaging on service developments and evaluation
- Validating what have already learnt about community views and concerns
- Informing our decision making
- Developing an "outward face" for the organisation.
- Consultation on key reconfiguration plans

Principles

20.6 The following principles will guide and inform our engagement activity.

On-going dialogue: Community engagement is as much about building relationships and establishing an ongoing "conversation" as it is about giving information. As such, we will seek to build relationships, trust and networks, particularly among communities with whom we rarely engage.

Listening: It will be a key objective in our community engagement activity to create an environment in which we can genuinely listen to the issues and concerns of community groups.

Learning: We will actively seek a better understanding of the composition of local communities, how they function at a neighbourhood level and their aspirations in relation to our Hospital services. This will include the identification of poorly met and unmet needs.

Involvement and empowerment: We will empower and encourage individuals to become involved in the development of new policies and service changes.

Inclusivity: We will pay attention to "easily ignored" groups and communities; particularly those who are known to have poor health outcomes. We will employ a range of methods to ensure that our engagement events are accessible, culturally appropriate and worthwhile for participants.

Feedback: We will make a firm commitment to provide timely feedback to participants in our engagement activity.

Defining “communities”

20.7 Our region is well known for its diverse ethnic communities and these communities will certainly form a key focus for our engagement. However, we will work with a much broader understanding of the term “community” which will include people linked to a particular locality as well as “communities of interest”: groups of people who come together through a shared experience. As such, our community engagement will include women’s, LGBT, sports and disability groups, faith communities, disease specific groups and social and philanthropic communities such as the WI and Rotary Clubs.

Methods

20.8 The methodology for the smaller events will need to be flexible enough to accommodate the needs and preferences of our diverse local communities. We will speak with local groups who work with or involve people from minority ethnic communities, for example, and discuss how people prefer to be involved. Often, informal methods of engagement work best. For example, small discussion groups which are relaxed and more sociable have proven popular and effective. We will seek to identify individuals who have influence and respect in local communities (e.g. local councilors, chairs of community organisations, professionals and religious leaders). Where relevant (e.g., when speaking with women’s faith groups), we will pay attention to the gender of staff conducting the engagement.

20.9 Where possible we will engage with existing groups, allowing us to meet in familiar and established venues. This may take the form of a slot on a group’s agenda or joining a social gathering. We will also identify opportunities around religious festivals such as Diwali, Eid and local cultural events such as Pride, Carnival and the Leicester and Loughborough Melas. During the course of this engagement there will be scope to develop partnership working with our NHS partners and with local Healthwatch organisations.

20.10 As part of our community engagement activity we will explore how UHL Staff might act as conduits to local community groups, associations and clubs etc. This will help to involve our staff in community engagement and to further value the diverse backgrounds of our employees. We will also encourage our Patient Partners to get involved by engaging with their own communities and networks and facilitating at engagement events.

Quarterly Community Engagement events

20.11 The larger quarterly events are, in part, a response to the relatively low turnout at the Trust’s Public Engagement Forum meetings and the limited diversity of its participants. It is anticipated that the establishment of a regular UHL event in localities across LLR will broaden the diversity of people with whom the Trust Board engage as well as increasing the numbers of participants at such events.

20.12 From our previous community engagement activity certain key themes regularly surface, namely;

- Community representatives have said that the Trust ought to be more visible in local community settings and not expect participants to always come to our hospital sites to engage.

- We are often asked about job and work experience opportunities in the Trust. There is also a general lack of awareness of other ways in which to get involved with UHL (i.e. as a Patient Partner, ePartner, volunteer or member).

- Participants often expect health checks and advice to be available when the Trust has a presence at community events.

20.13 With the above in mind we will relocate the Public Engagement Forum in to community venues. With a greater emphasis on listening to community views, the meetings will be fronted by two or three members of the Trust Board, supported by;

- Human Resources representatives who would provide information on the range of career opportunities within the Trust as well as work experience and shadowing opportunities.

- The PPI team, who would promote a range of ways in which members of the public may get more involved with the Trust (membership, Patient Partnership, events, ePartners, Engagement Forum, volunteering etc.)

20.14 We will also explore the feasibility of providing health checks and advice at these events. This may be something nursing and medical staff and students could get involved in. It may also present an opportunity to work with partners, for example Public Health, smoking cessation services etc. The format of the events will be tailored to specific audiences but will include a presentation by Board members or senior staff, followed by an opportunity to listen to the concerns of participants and respond to queries.

20.15 The core aims of this approach would be to provide opportunities for the Trust to be more visible and responsive to local communities, particularly those with whom we do not often engage. It also sets up opportunities for the Trust to engage on specific issues and projects as they arise.

20.16 This represents a new approach for the Trust and one which is untested. As such, it is proposed that the format is trialed over one year with quarterly events. During the year, variations on the style of event may be tested to determine the most advantageous format. Potential community settings would include;

- Localities with significant BME populations such as the St Matthews, Belgrave Road, Highfields and East Park Road areas.
- Rural localities across Rutland and the County.
- “Communities of interest” such as the Leicester LGBT community, deaf community and other disability groups
- Voluntary sector venues
- Faith communities and places of worship

Community mapping

20.17 The PPI and Membership Manager will ensure that a comprehensive and up to date community database is maintained. This will entail a community mapping exercise in which community influencers and "gatekeepers" are identified. The database will also include voluntary and community sector groups, "grassroots" community groups, health and condition specific groups, religious organisations, community development workers, specialist bodies (the Race Equality Council, disability groups etc) and community social groups.

21. Developing the E–Partner Programme

21.1 In recognition of the fact that many people now prefer to interact online and to provide new avenues by which we may enter in to dialogue with our public members we will re-invigorate our e-Partner activity. Earlier in 2017 the PPI team recruited over 250 new e- Partners. These individuals were drawn from our public membership and agreed to receive extra information to comment on regarding the Trust. E-Partners may review information and participate in discussions online about a wide variety of our services.

21.2 A reduction in the capacity of the PPI team has meant that our ePartners have been an underutilised resource to date. However, the team will explore alter5native ways in which to service this group of members and their existence will form part of a new PPI awareness campaign which will be supported by the communications team.

22. Support for an LLR Joint Patient Group

22.1 In August 2016 the Trust Board held a "Thinking Day" which focused on PPI. Among the participants were representatives from nine local patient groups. One of the key actions to come out of the Thinking Day was to provide support for these groups to meet on a more regular basis to share concerns and issues and to create opportunities to present a consensus view to the Trust. After three initial meetings, one of which was chaired by the UHL Chairman, the group is beginning to gain momentum and has agreed to meet Bimonthly in the first instance.

22.2 While the Trust recognises the independence of this group, we would like to offer some administrative and venue support for their meetings. We will also report the collective views of the group via the PPI & Membership Manager's quarterly report to Trust Board.

23. Better communication with our volunteers

23.1 The Trust supports approximately 1,000 volunteers who are engaged in a wide range of support activity within the Trust. By definition, our volunteers are "active citizens" who come with a unique perspective and close knowledge of our services. The link between volunteers and the Trust's public membership is already acknowledged in the fact that all volunteers are asked first to become members of the Trust in order to progress their volunteering application. As members, volunteers are offered regular invitations to get more involved with the Trust. However, more could be done to harness the views and participation of this group. The PPI and Membership Manager will work with the Trust's Volunteer Services Manager to explore the most effective means of tapping in to the volunteer community.

24. Summary

24.1 The revised strategy and accompanying plan seek to support CMGs to increase their PPI activity while at the same time maintaining a closer level of scrutiny. The strategy seeks to increase the numbers of Patient Partners active within the Trust and to get them more involved at service level. It also underlines the Trust's commitment to increasing its community engagement, responding to local need and becoming more "visible" among the diverse communities it serves.

Action Plan

Below is the year one action plan to deliver this strategy. The plan will be evaluated annually and, with the involvement of our Patient Partners, other patient groups and stakeholders, a plan will be agreed for the following year.

	Priority	Actions	Target date	Responsibility
2017 / 18				
1.	**CMG ownership of PPI**	• Standing agenda item specifically focused on PPI is delivered by Patient Partner at CMG Board / Quality and Safety meetings	September 2017	CMG GMs & PPI Leads
		• CMGs to nominate a delegate to coordinate PPI at service level	July 2017	CMG PPI Leads
		• Conduct Training Needs Analysis with all CMGs	December 2017	PPI Team
		• Review of KPIs in quarterly CMG (PIPEEAC) reporting template	July 2017	PPI & M Manager
		• Quarterly meetings with PPI Team / Patient Partners / CMG PPI Leads established an diarised in for 1 year	September 2017	PPI team / CMG Leads
		• Each CMG has a clear plan of PPI activity for the coming year	September 2017	CMG PPI Leads
		• PPI Team to develop tools and process to evaluate PPI activity within CMGs	February 2018	PPI team
2.	**Patient Partners**	• Recruit and induct (through both Corporate and local inductions) > 21 new Patient Partners	July 2017	PPI team with support from Patient Partner Chair
		• Allocation of all new Patient Partners to CMGs	July 2017	
		• Develop Patient Partner workbook	June 2017	
		• Develop new Terms of Reference	June 2017	
		• Develop Induction Pack for new Patient Partners	June 2017	
		• Review and develop new Patient Partner role outline	July 2017	
		• Secure a patient Partner to be attached to the UHL Cancer Centre	July 2017	
		• Identify second trial area within the Trust to attach a patient partner to.	March 2018	
		• Develop an awareness raising campaign for Patient Partners, to be promoted via internal communications channels.	August 2017	
		• Develop Intranet presence of Patient Partners including profile information and Patient Partner request form.	August 2017	
		• Establish database to monitor and track Patient Partner	July 2017	

		activity in the Trust • Review the structure and format of Patient Partner meetings in light of the expansion of the group	August 2017	
3.	**Community Engagement**	• Establish and promote quarterly Community Engagement Forums for 20178/18 • Mandy Johnson to coordinate Board attendance at the Community Engagement Forums • Patient Partner group to identify attendees and contribute agenda item for each meeting • Review and maintain community stakeholder database • Establish programme of "outreach" community engagement • Identify calendar of local events / festivals / fairs etc / establish costs for participation • Liaise with HR team regarding opportunities to promote job / career advice	August 2017 / on-going August 2017 / on-going on-going August 2017 / on-going on-going July 2017 ongoing	PPI team M. Johnson Patient Parnter Chair PPI Team PPI Team PPI Team PPI Team
5.	**Develop the E-Partner role**	• Incorporate promotion of ePartners to UHL staff as part of Patient Partner comms campaign (see above) • Recruitment of > 300 ePartners • Minimum of one engagement opportunity for ePartners every 2 months • ePartnership to be promoted via social media	August 2017 March 2018 March 2018 March 2018	PPI Team
6.	**Support for the LLR Joint Patient Group**	• Establish dates / venues for future meetings • Provision of administrative support to service meetings • Quarterly reporting of collective views via the PPI Update paper to Trust Board	July 2017 on-going Quarterly	PPI Team / Joint Patient Gorup Chair

Appendix Two: Report by Martin Caple; Chair, Patient Partner group

Joint Patient Reference Group

Report by Martin Caple, Chair, Patient Partner Group
Thursday, 1st June, 2017

Purpose of Report

1. The purpose of this report is to inform the UHL Board of the progress made since the Board Thinking Day in August, 2016, which focused on patient and public engagement, on the various patient groups sharing their key issues. It will outline some key common concerns that have recently been identified where the Board's views are sought.

Background

2. The Thinking Day last August was facilitated by myself and David Henson, (Healthwatch), and attended by Board members, senior staff within UHL and representatives of 9 patient groups in Leicester, Leicestershire and Rutland as follows:

- UHL Patient Partners
- Healthwatch Leicester City
- Healthwatch Leicestershire
- Healthwatch Rutland
- The Alliance Public and Patient Partnership Group
- UHL Equality Advisory Group
- BME Communities Organ Donation Link
- Leicester Mercury Patients' Panel
- Better Care Together PPI Group

3. Apart from raising key issues of concern for patients and suggesting solutions a key aim of the day was to encourage a closer working relationship between the patient groups so they shared information and raised issues with UHL collectively.

4. Since August, 2016 David and I have consolidated the issues and actions from the Thinking Day and circulated them to everyone who attended. I provided a report with an update on these matters to the Quality Assurance Committee on 22nd December, 2016. We have also arranged three separate meetings where representatives from the above 9 patient groups were invited, with a view of progressing the aim of a shared information forum. Karamjit Singh, Chairman, attended the second meeting in March this year.

5. After a slow start, at the third meeting on 25th April, 2017, some agreement was reached on how we would operate and we did identify some common issues of concern.

Outcome of meeting on 25th April, 2017

6. The meeting was chaired by me and the following attended:-

Malcolm Woods and Margaret Taylor, (both Alliance Patient and Public Partnership Group)
Katy Wheatley, (Leicester Mercury Patients' Panel)
Jennifer Fenelon, (Chair, Rutland Healthwatch)
Evan Rees, (Chair Better Care Together PPI Group and Healthwatch Leicestershire)
Karl Mayes (UHL PPI and Membership Manager)

7. We have called ourselves the Joint Patient Reference Group.

8. The main issues of concern shared by us all can be summarised as follows:-

A) Cancellation of operations and the cancellation of elective care

There is an understanding of the pressures facing UHL, in particular in relation to the Emergency Department and the lack of beds, but we would appreciate information on the following:-

i) What steps are being taken to improve the situation?
ii) What is being done to explain to people why their surgery is cancelled and is there a right of representation about that decision?

B) Signage at the Leicester Royal Infirmary both within the hospital and outside to show the entrances.

It is acknowledged that changes to the signage have been made recently, (with the new ED in mind), but newcomers to the hospital still find it difficult and confusing to find where to go.

i) Is there an overall plan to improve the situation? If so, what is the timescale?
ii)What is the Board's opinion on the situation?

C) Choose and Book (E referrals).

It is felt that the "Choose and Book" system is confusing to patients and not all GPs use it effectively. There are difficulties in getting appointments at UHL.

i) We would be grateful for clarification on how the system operates both in theory and practice as it affects UHL.

D) CQC Inspections

There are concerns about the quality of the inspections generally across CCGs and UHL. Some CQC personnel lack knowledge and their reports contain factual errors which require amendment, which is time consuming for staff of those bodies inspected.

After discussion we felt that raising these matters further may best come from Healthwatch and Jennifer Fenelon has agreed to consider the way forward..

E) Day to Day issues.

From the minutes a number of issues are documented where suggestions are made to improve the patient experience on a daily basis: ie better stocked waiting areas, food on wards, more flexible visiting times, a twinning system between patient groups/charities and specific wards/departments.

We will pursue these matters with Karl Mayes and other relevant staff within UHL.

Conclusion

9. A further meeting of the Joint Patient Reference Group is planned for late June or early

July when representatives from the same 9 patient groups have been invited. However, in the future the intention is to invite other patient groups too from both specialist patient forums within UHL and community patient organisations. The proposed model is to have an overarching Joint Patient Reference Group that gathers and debates the key patient issues affecting UHL and forwards them to the UHL Board so responses and outcomes can be disseminated back to the Group. It will mean existing patient groups will maintain their identity but have the opportunity to widen their remit and bring together joint issues of concern.

10. The UHL Chairman, Karamjit Singh has indicated that there will be another Board Thinking Day in August this year when the focus will again be on patient and public involvement. Clearly a focus of that session will be an update on last year's event and the progress of the Joint Patient Reference Group. In addition it is suggested that the Board may wish to use that event to address the concerns and questions outlined in paragraph 8 above.

11. In the meantime the Board is asked to:

a) note the progress that has been made in bringing patient groups together; and

b) comment on the specific issues raised in this report and the specific proposal in paragraph 10 regarding the Thinking Day.

Martin Caple
Patient Partner Chair
June 2017

Appendix Three: Report by Martin Caple; Chair, Patient Partner group

Patient Partner Summary Report - April 2016 to May 2017

Background

1. The purpose of this report is to outline the key activities and progress achieved by Patient Partners in the past 13 months, together with information on the way forward.

Summary of the main points in this Report

2. The role of Patient Partners has developed over the past year and we are continually involved, not only in CMG issues, but increasingly corporate activities across the Trust and potentially work outside UHL in the community and more involvement with other patient groups.

3. We provide advice and constructive comment on patient related issues both at a practical day to day level and at a more strategic level, based on our knowledge and experiences within UHL and from our work and life skills.

4. Eleven new Patient Partners will be appointed in June and this is an exciting and challenging time for everyone, particularly those people with a key role in patient and public involvement.

5. Our current patient related concerns affecting UHL are outlined in this report and we would be interested in your comments on those issues.

6. In future with more Patient Partners we suggest that more opportunities should be taken by UHL to seek our collective views on key issues.

Looking back in the last Year

7. There are now 13 people undertaking the role of Patient Partner and they are attached to a specific Clinical Management Group, (CMG), as below:

- Khudeja Amer-Sharif - CHUGGS
- David Allen - ESM
- Martin Caple - ITAPS
- Mary Gordon - ITAPS
- David Gorrod - RRCV
- Michael Griffiths - CSI
- Lena Kotecha - ESM
- Anthony Locke - RRCV and MSK/SS
- Jo Mitchell - CHUGGS
- Pragnya Patel - ESM
- Geoff Smith - CSI (until Feb, 2017) - now corporate activities
- Rosemary Stokes - Women’s and Childrens
- Stephanie Tate - Women’s and Childrens

8. Whilst much of the work is focused in the CMGs there is a growing tendency for Patient Partners to be invited to participate in initiatives, projects and committees that cross all or several CMGs. On average each person undertakes 6 sessions, a month, (a session being half a day).

9. Patient Partners meet every 6 weeks as a group to share information and speak to senior staff. Mark Wightman and Karl Mayes attend these meetings and latterly Ballu Patel, Non-Executive Director, has also attended and has indicated he will do so in future. I speak to Karamjit Singh, Chairman, on a regular basis to share information and he also attends our Patient Partner meetings periodically.

10. Listed below is a summary of the main activities of Patient Partners both within CMGs and on corporate cross cutting UHL issues in the last 13 months:-

- Members of UHL strategic committees, (ie Integrated Finance, Performance and Investment Committee, (IFPIC), Quality Assurance Committee, Safeguarding Committee, Infection Prevention Committee, Charitable Funds Committee and Education Committee).
- Attendance at CMG Board, Quality and Safety and Infection Control meetings.
- Participate in interviews for nursing posts, Complaints Manager and Freedom to Speak Up Guardian post.
- Attend confirm and challenge planning events.
- Facilitate patient focus events.
- Involved in GMC inspection
- Visit Birmingham Heartlands Hospital with Board members and senior staff to look at their excellent work in reducing A and E waiting times.
- Visit New Cross Hospital Emergency Department, Wolverhampton with Board members and senior staff.
- Attend Planned Ambulatory Care Hub meetings and devise a research questionnaire for service users.
- Attend Research and Development Committee
- Involved in “secret garden” project at Glenfield Hospital
- Review of Ophthalmology facilities and procedures.
- PLACE visits
- Attend Listening into Action events.
- Member UHL Nutrition Committee
- Member PIPEEAC meetings
- Participate in surveys at LRI entrances to assist access and signage arrangements.
- Safety Walkabouts
- Consult with 3 classes of 8/9 year olds at a County school regarding the new Childrens’ Hospital and feedback to the Project Board.

- Attend Trust Board meetings.

- Member of Patient Information Group forum.

- Involved with outside consultants with staff to improve pre-admission and theatre procedures.

- Participate in examining complaints files as part of Independent Complaints Panel.

- Involved in dementia strategy meetings.

- As a group undertake research across all CMGs in to the knowledge and awareness of the Carers Charter and in a separate exercise to assess how patient information is managed across the Trust.

- Member of Pharmacy 7 day Service TTO Project.

- Member of UHL Way Sponsor Group

- Undertake PLACE assessments

11. As can be seen from the above list, which is by no means exhaustive, increasingly Patient Partners are being asked to be involved in activities that are not CMG related but cross over in to several CMGs or are UHL related. Undertaking these activities and working in CMGs, particularly if new to the role, requires support, some background knowledge, brief training and an on-going commitment to ensure Patient Partners can be fully effective.

Work outside UHL in the Community

12. The refreshed PPI Strategy gives a greater focus on community engagement and two Patient Partners have already undertaken such work. It is hoped that more Patient Partners will do this in a planned way with UHL staff in the future.

Work with other Patient Groups

13. Following the Board Thinking Day last August, which focused on patient and public involvement, efforts have been made for all patient groups to meet and share their concerns and issues. I chaired a meeting of such a group, (called a Joint Patient Reference Group), on 25th April, 2017 where progress has been made. A separate report from me on this topic is on today’s agenda.

Current Issues of Concern affecting Patients

14**.** Current issues of concern affecting patients for Patient Partners are primarily:-

- The continuing trend of operations being cancelled, (sometimes several times).
- Some cancer targets still not being met.
- The effect on performance in the new ED.
- Sustainable Transformation Programmes (STPs) - more detail as to how it will affect UHL and CMGs and how and when Patient Partners and other patient groups will be consulted.
- Concerns over the new radiology contract as it affects both staff and patients.

Whilst we are aware of some action on these matters it would be helpful if Patient Partners could receive more detail from relevant staff at one of our forthcoming meetings, particularly with new people commencing in the role shortly.

Appointment of new Patient Partners

15. Eleven new Patient Partners will commence in mid June and the allocation of Patient Partners will then be as follows:-

CSI - Michael Griffiths, Janina Smith and Peter Newman
CHUGGS - Khudeja Amer-Sharif, Jo Mitchell and Paul Baker
ITAPS - Martin Caple, Mary Gordon and Natu Patel
MSK/SS - Anthony Locke, Keith Allen and Fazila Shahzad
ESM - David Allen, Lena Kotecha, Pragnya Patel and Anna Severwright
RRCV - David Gorrod, Anthony Locke and Lynn Pearson
Womens and Childrens - Rosemary Stokes, Stephanie Tate, Jane Wilson and Julia Wise St Ledger and Aysha Salim

As previously mentioned Geoff Smith now undertakes specific corporate activities and is not attached to a CMG. In addition the Cancer Centre have requested a Patient Partner and the name of this person will be finalised shortly.

Each new Patient Partner will be mentored by an existing Patient Partner(s).

Infrastructure to support Patient Partners

16. Karl Mayes and his team in Communications oversee and support Patient Partners from a central point and, within CMGs, each Head of Nursing, (who have responsibility for patient and public involvement), liaises with them and agrees their work programme. As I have previously reported across UHL more time is given to Patient Partners in some CMGs than others; an issue that is being addressed.

17. The recent removal of the scale 3 post in the PPI team, as part of cost improvement savings, is of concern to Patient Partners particularly as to the possible consequences and risks to the future delivery of the PPI Strategy.

Looking to the Future

18. In addition to their personal skills Patient Partners bring their work and life experiences to the role and these attributes means they can bring a particular expertise to an issue or project.

19. To date we mainly act as individuals in the role and I think more opportunities could be made by UHL to seek our collective views as a group on key issues, particularly with 24 people now involved.

Conclusion

20. This is an exciting time with nearly double the numbers of Patient Partners than hitherto and with strong support from CMGs and the PPI team we are hopeful that our role will be enhanced and extended in UHL.

Recommendations

21. This report is submitted for the information of the Board and further regular reports will be submitted every 3 months. With regard to specific actions in the future we would like the Board to consider:-

a) seeking the collective views more regularly of all Patient Partners on key issues; and

b) providing feedback to us on the current patient issues of concern, as outlined in paragraph 14 above.

Martin Caple
23rd May, 2017