

# Evolving Voices

A review of how Dorset HealthCare  
University NHS Foundation Trust  
collects and acts on feedback and  
insight



Healthwatch is the national independent consumer champion for health and social care, established throughout England in 2013 under the provisions of the Health and Social Care Act 2012, with statutory powers to ensure that the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Healthwatch exists in two distinct forms - local Healthwatch, and Healthwatch England at national level.

The remit of local Healthwatch encompasses all publicly funded health and social care services for both adults and children.

Healthwatch Dorset covers the area of the three local authorities of Dorset, Poole and Bournemouth and is delivered by a partnership of three local community organisations - [Help & Care](#), [Citizens Advice in Dorset](#) and [Dorset Race Equality Council](#).

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## Introduction and Background

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[Dorset HealthCare University NHS Foundation Trust](#) is the largest healthcare provider organisation in the county of Dorset. It is a diverse and complex organisation, employing over 5,000 staff and delivering community and mental health services from over 300 sites.

It is also an organisation that we believe is committed to the importance of hearing and learning from its people - most of all, its patients and service users. How that commitment is turned into practice in every part of the organisation is an enormous and daunting challenge. To help it meet that challenge, in 2017 the Trust commissioned Healthwatch Dorset to carry out a review into the effectiveness of current Trust arrangements for systematically collecting and acting on service user feedback and insights, including participation and engagement opportunities.

Our work was carried out in two phases over nine months, using a robust methodology.

Phase 1 involved an overall review of the Trust's current understanding of its "patient and public involvement" opportunities, including what is known centrally about how feedback is gathered, when, where and by whom: a review of how feedback is recorded, analysed, acted on and learned from: and the development of visual roadmaps, identifying current good practice and any gaps.

Phase 2 involved interviewing 38 front line teams to find out how, in practice, feedback is gathered, when, where and by whom: and a review of how teams record, analyse, act on and learn from and engagement and involvement activities.

This review was designed to provide only an overview of patient engagement and involvement across the Trust. Both the Trust and Healthwatch are fully aware that we do not have the complete picture. This report is, therefore, designed to be a discussion document which can help the Trust to understand and reflect on where it is currently and to begin to map out a route which will lead, ultimately, to that

commitment to people's real involvement becoming hard and evidenced reality in every part of the organisation. Indeed, current work the Trust is doing on the "Better Everyday" 3-year transformational programme is already reviewing much of what we have identified in this report and the Trust is still evolving its systems.

There are many examples in this report of the methods and uses of service user feedback, but there are also a number of gaps and areas for improvement, which we include as "Points for discussion".

We hope that the information included in this report will provide some useful evidence and ideas to support the implementation of the Trust's new Participation Strategy and help shift the focus from capturing data about people's experiences to focusing on how their experiences can be used to learn and to improve services.

Both Healthwatch Dorset and the Trust have committed to this report being a publicly available document. We have used the term "service user" throughout to encompass patients, carers and relatives. We would like to thank all the Trust staff involved in this project for their honesty and willingness to share their views and opinions openly.

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## Summary

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1. The Trust undertakes a variety of qualitative and quantitative initiatives to gather feedback, including **Consultation** (asking for views and using them to inform decision making): **Involvement** (service users actively involved in service planning and delivery): **Collaboration** (active ongoing partnerships with service users): and **Empowerment** (shared decision making with service users).
2. At a local level, some teams undertake engagement initiatives and some do not. However, what we found to be common across all the teams we talked to is a great desire that patients and service users should have a voice, be heard and be influential in the design and delivery of services. Most of the barriers to that being the actual case in every locality and service are perceived by staff as being due to practical limitations (e.g. time and expertise).
3. Whilst there is undoubtedly a great deal of activity taking place within the Trust, which can come under the heading of engagement or involvement or participation, there is currently no comprehensive mechanism or system for centrally recording where service user engagement activities are taking place, who undertakes them, how they are logged, analysed and actioned and where changes have been implemented. This information is, therefore, not effectively being used to:
  - Ensure a more coordinated, inclusive, targeted and timely approach to engagement activities.
  - Highlight where gaps in opportunities for engagement exist (maybe for more under-represented or “hard-to-reach” groups).
  - Identify how well some of the current mechanisms are being used by service users. For example, many teams reported in the locality survey and in interviews that comment boxes/books etc. were available but rarely used.

- 6. Raise awareness of the opportunities available for people to have their say in the way they want and appropriate to their circumstances (an embedded & systematic approach which is not a reporting or tick box exercise).
- 4. Not all engagement activities are monitored and tracked. Engagement is not being managed in a systematic way - much of the work is ad hoc. It is not clear how effective some of the initiatives and methodologies are and what constitutes “effectiveness”. Response rates to local surveys/questionnaires are often not monitored. Poor quality methodologies will elicit poor quality feedback.
- 5. The Trust currently does have some degree of central and corporate insight as to how effective current engagement initiatives are in terms of the extent to which service user feedback impacts on and changes working practices, but this is not comprehensive across all areas of the organisation and there are gaps in the information that is used. How feedback is used to influence strategic decision making is not easy to track or audit through the myriad of strategies, committees and reporting structures. From an independent perspective, it is difficult to track where service user feedback is used to monitor the various strategies or where it is explicitly used to assure the Board of service quality.
- 6. Non-Executive Directors undertake regular assessment visits to various sites as part of a patient safety walkabout programme, although it is unclear whether they talk to patients or service users and, if so, how this is logged and actioned. They report back to the Council of Governors’ meeting, either verbally or by a written report.
- 7. The Trust does not appear to have a comprehensive “list” of Members (in general) who may represent patient groups, carer groups, charities and voluntary organisations. This is a potential source of valuable feedback.

8. It is unclear how actual action plans arising from service user feedback link to all the various strategies at various levels in the organisations. Many teams do not produce action plans from the results of feedback.
9. Team leaders and managers have a responsibility to check through feedback of their services on a localised nature although there is no consistent process for how this is done, logged and tracked. There is local empowerment for teams which means they do have the ability to make service changes where necessary but it is not clear when these changes require higher management “sign off”. It is hoped that potential changes to a service would be evaluated for any adverse impact on other services but, again, this is not clear for those changes that do not necessarily require a more formal business case. Any actions not requiring a more formal process are not necessarily centrally logged or known about.
10. There appears to be no systematic evaluation of where constraints and barriers to implementing engagement initiatives exist although work is ongoing in this area and comments from the Trust’s own survey of locality teams highlighted some of the issues front line teams identified, and our team interviews have added to that feedback. Locally, there should be a PDSA (Plan, Do, Study, Act) ethos - teams should start small, make changes, and repeat the cycle although all this may not be fed “upwards”.
11. There appear to be various ways of logging information (from Word documents to Excel spreadsheets) and various ways of analysing data, using it and sharing it. Information is not monitored or tracked. There are various methodologies for undertaking engagement work, from surveys to focus groups. There are many different methods being used to gather service user feedback and we do not recommend a “one size fits all” approach. Mechanisms should be adapted to suit the service user group. Before adopting new initiatives and methodologies there is a need to evaluate what is already being used. As a staff member said in an interview, “Don’t try yet another new idea until we know whether what we’re currently doing works or not”.

12. The Friends & Family Test should be used in all community and inpatient services but in practice not all teams are using it or not using it comprehensively. Friends & Family Test response rates and scores are used in various metrics and dashboards but if the test is not embedded comprehensively these figures will not be accurate. There is still an emphasis on response rates rather than what is actually done with the data.
13. Where focus groups are being run in certain teams they are not necessarily monitored or evaluated. Therefore, it is not possible to ascertain whether they are all being undertaken effectively, all actions implemented and changes to services documented.
14. There is more work that needs to be done to ensure that teams understand the why, what, when and how around patient engagement. Some of the free text comments received from teams who responded to a survey carried out by the Patient Experience & Complaints Team highlight some of the issues and concerns. Having data from service user feedback easily available does not necessarily lead to people using it. There needs to be some kind of incentive - staff need to see that feedback is useful for their own specific service. Staff need to be motivated to ask “what does this feedback mean and what can we do about it?”.
15. The Trust’s new Participation Toolkit could and should include guidance to help develop survey questions or other involvement and engagement mechanisms, understand timings and target groups or work through aspects of data protection, informed consent and ethics. It should aim to enable effective involvement of public, patients and carers. However, staff awareness and training should go alongside the toolkit in order to make it effective and actually used by staff. There is currently no formal training for staff in engagement activities although help, guidance and support is available for team leaders and managers from the Patient Experience & Complaints Team

and the Participation Team. Staff need the necessary skills to undertake engagement work. They need to know how to action results and demonstrate change. Guidance to answer the following questions would be useful:

- What are the objectives of undertaking engagement with patients? Why are you doing it, what do you expect to gain? Gathering general feedback can be informal but if the goal is to measure quality with reliable and valid measures it will need to be more robust. (Just measuring satisfaction will not necessarily provide the sort of information that can be acted on - these type of methods can show where there may be problems but they rarely identify why).
- What is it you want to find out? Targeted work is likely to elicit more useful information than just asking broad spectrum questions. This will also make patients and service users more likely to want to engage.
- Help to “pick the right tool” - sometimes a focus group may be a better way of finding out service user experiences of a particular topic or issue than survey questions. When will you send out a survey? (As discussed elsewhere, timing requests for feedback is important. Collecting feedback at different points in the care pathway can highlight different experiences. It is also known that point of care surveys etc. tend to produce more positive results).
- If undertaking a survey, are the questions checked for variance and bias? Has the survey been verified? Does it require an Equality Impact Assessment?
- How will you check back with service users to find out if changes made from feedback have had a positive impact from their perspective?

16. There is potential for more feedback from external organisations and areas such as primary care (e.g. GP Patient Participation Groups), Citizens Advice, the voluntary and community sector, CCG patient groups and networks, care homes, social care, the voluntary sector, Dorset Partnership for Older People,

MPs etc. There is potential to learn from voluntary sector organisations in terms of how they engage and involve their own service users.

17. There is potentially a wealth of useful verbal patient feedback being missed. However, the new Gather system should allow staff to record this information once all teams are fully aware and trained.
18. There is no comprehensive database of where patients, service users and carers attend, are involved in/with committees, steering groups, working groups etc. It is, therefore, not known if they are provided with adequate training and development or whether they have been recruited for the role or not and whether they are attending as individuals or as representatives of larger groups.
19. Feeding back to service users and the public on what has happened as a result of sharing views and experiences seems to be piecemeal. It appears that no specific groups are sent information unless they have requested it or it forms part of a piece of work, or where the Trust feels they may benefit from the information.
20. It is not clear how the Trust explains to service users and the public the principles which govern how decisions are taken. This is especially relevant where there may be conflicting views or evidence in service user feedback from the larger scale public consultations. Most of the reviewed Trust documents assume patient and public involvement/engagement is a “positive activity” and there is no discussion of how difficult decisions will be handled when service users express different views on desired outcomes or priorities. More needs to be done to manage service user expectations of how feedback will be used.
21. Sharing and learning from service user feedback is undertaken through various routes but it is not clear whether there is a mechanism for tracking whether other parts of the organisation have changed practice due to this learning.

22. Sharing learning and change with patients and service users includes “You Said, We Did” boards in wards, clinics etc., use of Facebook and Twitter (#FeedbackFriday results of Friends & Family), but more could be done to share information with partners, the voluntary sector and members which will assure people that their views are heard and to help them understand how much influence they can have. This would potentially increase involvement by service users in engagement initiatives and reduce “consultation fatigue”.
23. Although there are some excellent examples of co-production, especially in the partnership with [Dorset Mental Health Forum](#), there appear to be few parallels in physical health services. We do have some reservations that, based on the findings from phase 2 and until some of the issues raised are addressed, many teams are not yet at a stage where they could effectively cope with implementing co-design and co-production initiatives.
24. It appears that most patient feedback initiatives have not been designed and produced with the involvement of patients and/or service users. For example, the design of questions for feedback surveys has come from staff rather than from service users.
25. The monitoring of websites and online forums (such as Mumsnet) is done by the Communications team but not actively engaged with. There is potential for gathering more feedback here. Facebook and Twitter are used to share learning from feedback through #FeedbackFriday, although this appears to be only feedback from the Friends and Family Test.
26. Currently, actions taken as a result of comments from patients and the public received through the websites [NHS Choices](#) and [Care Opinion](#) are not tracked, although this is under review.

27. Few teams mentioned receiving any feedback via the online comment forms.

28. From an independent perspective, it is unhelpful that patient engagement and involvement activities are split between the Patient Experience & Complaints Team and the Participation Team, working in different Directorates.

29. There is potential for more benchmarking activity with other Trusts.

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## Recommendations

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In terms of how the Trust moves forward from this point -

1. We recommend that it begins by considering, and drawing up action plans to address, the gaps and areas for improvement which we highlight in the “Points for discussion” in the 7 tables below under the headings:
  - 6 [Friends and Family Test](#)
  - 6 [Surveys and questionnaires](#)
  - 6 [Other feedback methods](#)
  - 6 [Training](#)
  - 6 [Harder to reach people](#)
  - 6 [Action planning, sharing and learning](#)
  - 6 [Barriers encountered in collecting feedback](#)
2. We have included in this report ideas generated by local Trust staff teams, which the Trust could potentially pilot as a way of encouraging and motivating staff and increasing involvement. Through these pilots, the Trust could identify engagement leaders or champions (to include clinicians at all levels) to help reduce the dependency on a central function and the feeling of this work being driven from “top down”. We recommend that the Trust develop such pilots.
3. We have begun to populate a SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats). We recommend that this be taken up and completed in focus groups involving Healthwatch and members of Trust staff.
4. We believe that there would be much to be gained from an independent organisation continuing the interview process which we began in phase 2 of this work and extending it to more (or even all) staff teams. This would enable the Trust centrally to gain more real understanding of what is happening “on the front line”, actively encourage local staff and give them more opportunity to offer new ideas for engagement. We recommend that the Trust make this happen.

5. We recommend that the Trust give serious consideration to bringing together staff who currently work in different teams in different Directorates into one Patient Experience Team in one Directorate. Engagement: Involvement: Participation: Complaints: Compliments: - they are all, and should all be seen as, part of “patient experience”.

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## Methodology

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### Phase 1

Phase 1 involved an overall review of the Trust’s current understanding of its “patient and public involvement” opportunities, including what is known centrally about how feedback is gathered, when, where and by whom: a review of how feedback is recorded, analysed, acted on and learned from: and the development of a visual roadmap, identifying current good practice and any gaps.

We wanted to establish what the Trust currently understands is happening or should be happening across the organisation relating to service user engagement and involvement.

1. The Trust’s organisational structure (as at March 2017) was reviewed, to gain a high-level understanding of where information about service user feedback may be known about or used. From this we identified a number of staff whom we considered may have useful information to inform the project. We undertook interviews (face to face and by telephone) with the following:
  - Public, Patients & Carer Engagement Manager
  - Patient Experience and Complaints Managers
  - Lead Quality & Compliance Analyst (Business & Performance)
  - Lead Governor
  - Lead for Recovery & Social Inclusion, Mental Health Directorate
  - Head of Clinical Effectiveness & Audit
  - Head of Regulation & Compliance
  - Senior Public Health Intelligence Analyst
  - Consultant Nurse Eating Disorders/Facilitator Research & Development
  - Senior Communications Officer - Digital
  - Experience & Improvement Manager

- 6 CEO Dorset Mental Health Forum (also Trust Partner Governor/Service User Group Representative)
- 6 Operations Manager, Dorset Mental Health Forum
- 6 Trust Secretary

(Note - during Phase 2 we also interviewed the Medical Director and the Chair of the Executive Quality & Clinical Risk Group).

2. Concurrently with this, and in liaison with the Patient Experience & Complaints Team, we undertook a desktop review of those Trust documents that could provide information relating to how the organisation undertakes engagement with service users. The following documents were reviewed as well as the Trust website (which we found to be out of date in several areas. The site has since been updated).

- 6 Quality Matters newsletters January 2016 to February 2017
- 6 Information collected by the Patient Experience and Complaints Team
- 6 Triangle of Care Report
- 6 Membership Recruitment & Engagement Plan 2017
- 6 Membership Terms of Reference
- 6 Engaging with the Trust Membership & the Public Recruitment & Engagement Plan 2016/17
- 6 WaRP Magazine September 2016
- 6 PPE Team Survey (results as at April 2016)
- 6 Participation Strategy March 2017 final draft
- 6 Patient & Public Panel update draft Terms of Reference V3
- 6 Patient Experience System Specification final 21/12/16
- 6 Patient Feedback Project - N. Waite (2016 Mental Health Inpatient Wards)
- 6 PPEE Q1, Q2 and Q3 2016/17
- 6 Five Year Strategy August 2015
- 6 Quality Account 2016-17

- 6 Draft Quality Account & Report V2 17
- 6 Quality Strategy 2015-18
- 6 Patient Experience Annual Reports 2015-16 and 16-17
- 6 Stages of Excellence Report 2016
- 6 Annual Satisfaction Survey of volunteers 2016
- 6 Complaints Annual Report 2015-2016
- 6 Complaints Overview Apr-June 2016
- 6 Complaints Q2 & Q3 Reports 2016/2017
- 6 PALS Rep sheet
- 6 Clinical Strategy V3 Nov 2016
- 6 Implementing Participation Strategy
- 6 Memorandum of Understanding (with “Friends Of”) 2016 V3
- 6 NHS Staff Survey 2016
- 6 Participation Stakeholders list
- 6 Various Minutes of Trust Board and Council of Governors’ meetings

(Note - During Phase 2 we also reviewed the following documents for additional information and clarification purposes):

- 6 Participation Strategy IN-385 May 17 final version
- 6 Volunteering Strategy IN-542 2017-2020
- 6 Various minutes from meetings of the Quality Governance Committee
- 6 Various minutes from meetings of the Executive Quality & Clinical Risk Committee)

3. We interrogated the documents and asked the same questions of the interviewees to try to establish:

- 6 Current methods used to engage (known centrally)
- 6 What type of feedback is being gathered
- 6 Where feedback is being gathered and by whom
- 6 How feedback is logged and analysed
- 6 How action plans are developed and agreed

- Whether changes to services/procedures/processes are made as a result of feedback received
  - How those changes are tracked, monitored and evaluated
  - How the organisation learns and shares learning
4. From the information we collected, we produced a number of observations and suggested areas for improvement, as well as some potential further questions, issues to be taken forward into Phase 2.
  5. We produced a series of flowcharts mapping out the findings from the Trust's survey of teams (See appendix 4).

## Phase 2

Phase 2 involved interviewing 38 front line teams to find out how, in practice, feedback is gathered, when, where and by whom: and a review of how teams record, analyse, act on and learn from and engagement and involvement activities.

1. The original agreed scope for Phase 2 of the project was to ascertain how information is used and acted on in one locality. Prior to changes to the Trust organisational structure this was to be achieved by interviewing a random selection of teams in the Poole Locality. This locality was chosen as it reflected the majority of services the Trust offers across the organisation and for logistical purposes being in one geographical area. However, during Phase 1 we found that the Trust had already carried out a survey of local teams to establish those that are undertaking local engagement initiatives in addition to the Friends & Family Test. Some high-level analysis of the results identified:
  - Those teams that DO undertake local engagement work and results are shared with the Patient Experience & Complaints Team.
  - Those teams that DO undertake local engagement work and results are NOT shared with the Patient Experience & Complaints Team.

- 6 Those teams that DO NOT undertake local engagement work but some information such as compliments are shared with the Patient Experience & Complaints Team.
- 6 Those teams that DO NOT undertake local engagement work and NO information such as compliments are shared with the Patient Experience & Complaints Team.
- 6 Those teams that did not respond to the survey.

Considering the organisational structure changes and in light of the Patient Experience & Complaints Team survey (see point 4 under [Observations](#)) we proposed changing Phase 2 to undertake interviews with a number of teams (38 interviews, which equates to approximately 10% of the overall number of teams) with local teams - a selection from each of the groups mentioned in paragraph 1 above and covering a wider geographical area (in order to take into account possible east/west differences).

The objectives were:

- 6 to provide the Trust with a better understanding of why some teams undertake local engagement work and some do not.
  - 6 to understand the processes and methods used.
  - 6 to gauge the effectiveness of those methods.
  - 6 to ascertain where teams have experienced any barriers to collecting patient feedback/experience data and
  - 6 to review how teams think engagement activity could be improved in regard to their particular work setting.
2. Teams to be interviewed were selected from each category (see 1.6) but, for comparison purposes, we also deliberately selected a number which, to the best of our knowledge and understanding, undertake the same or similar roles.
  3. In order to gain an in-depth understanding of what happens “on the ground” our interviews were held with all team members (or as many as possible)

which logistically meant us attending team meetings where practical (and also to minimise inconvenience to Trust staff).

4. The Patient Experience & Complaints Team contacted all selected teams requesting dates, times and venues for near future team meetings. We then contacted all the teams to arrange suitable appointments.
5. Interviews were semi-structured, audio-recorded and lasted between 15 mins up to approximately 45 mins. The transcribed audio recordings provided the source of data for analysis. Interviews were undertaken by trained interviewers who had received a guidance/interview “pack”, code of conduct and appropriate Disclosure & Barring Service (DBS) checks.
6. At the start of each interview we provided a snapshot of Healthwatch Dorset and our remit, as well as a brief synopsis of the project objectives, and assured everyone that individual team members would not be identifiable. We also advised all teams that they could contact us away from the interviews if anyone felt they wanted to provide further information. Interview questions were as follows, although interviewers could adapt where necessary and appropriate to individual teams (not all questions were asked of all teams):
  - 1) Does your team currently gather feedback from patients (note - interviewers interchanged the words “patient”, “service user”, “carer” as required) about their experiences of your service, other than the Friends and Family Test (FFT)?  
(Additional - if so, can you provide any examples of what you do and how long you have been doing it?)
  - 2) Do you gather feedback from all patients or specific patient groups?  
E.g. a random selection, patients with certain conditions etc?  
(Additional - if certain groups, why those?)

- 3) How do you get patients to become involved?
- 4) If you use more than one method (e.g. surveys and focus groups) do you find you get better responses from one method than others?  
(Additional - if you do use different methods, do you use that feedback in different ways?)
- 5) Who is involved in collecting the feedback?
- 6) Has anyone in the team had training in engagement work?  
(Additional - do you know where to get help elsewhere in the Trust?)
- 7) If you use surveys/questionnaires, how did you decide on the questions used?
- 8) Do you have any budget for patient engagement work?
- 9) How do you gather feedback from patients who may find it harder to do so (those with language barriers, learning difficulties and communication issues)?
- 10) Are there any ethical/confidentiality/data protection issues that you have to consider if you are using surveys etc.?
- 11) How do you analyse the data you collect?
- 12) Do you develop action plans to use the information? (Additional - do you share action plans with other areas of the Trust? Additional - do you get patients involved in designing action plans?)
- 13) Do you have any examples of where patient feedback you have gathered has directly led to changes in what you do? (Additional -

How is the impact of those changes monitored and evaluated?)

- 14) If you have tried to make changes due to patient feedback and not succeeded - what were the obstacles?
- 15) Have you experienced any other barriers to collecting patient feedback?
- 16) What do you think makes for effective engagement with patients?
- 17) In what ways do you think patient engagement activity could be improved in regard to your particular work setting?

The Trust also asked us to ascertain whether any teams were working with Experts by Experience.

7. All teams were welcoming and happy to discuss openly and honestly their patient engagement practices. Some teams also advised that our interview process has given them an incentive to review and reflect further on their engagement work.
8. Although this adjustment to Phase 2 led to a longer timeframe for the project we believe that it has provided the Trust with more valuable information to take forward.

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## Findings and Observations - Phase 1

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The following information is gleaned from the various Trust documents we reviewed or from people we interviewed. We have separated it into feedback mechanisms that are “reactive” (i.e. volunteered directly or through external channels) and those that are “proactive” (i.e. solicited from service users or gained via direct approaches).

### Reactive Mechanisms

#### 1. Complaints

- Managers and Matrons are required by NHS England to demonstrate changes to services following complaints and Patient Advice & Liaison concerns. There is a Lessons Learned pro-forma which is sent to the Patient Experience & Complaints Team.
- Complainants are offered the chance to attend to meet with managers/teams to discuss issues.
- The Patient Experience & Complaints Team offer Complaints Handling & Investigator training for managers. This course is co-produced and co-presented with the Dorset Mental Health Forum/peer support. Other complaint training is being reviewed - e-hub, physical and on-line courses, role specific and mandatory being considered. The Trust also offers the “Delivering Compassionate Care” course which provides support for all staff and has been designed in partnership with service users and carers.
- Weekly complaints reports go to all service leads. Directors receive a RAG report of all overdue and due within 7 days, on a bi-weekly basis.
- Business Team produce Monthly locality/directorate reports (included within the monthly Quality Report) and discussed at the Locality Management Groups.
- Complaints key themes and lessons learned, on a quarterly basis, go to the Quality Governance Committee and Board and are included on local dashboards as well as the Corporate Dashboard (quality metrics).

- 6 Teams share learning from complaints at team and professional meetings. These should be recorded in minutes and lessons learned are sent to the Patient Experience & Complaints Team.
  - 6 Locality teams receive information on lessons learned from complaints in quarterly Quality Reports.
  - 6 A list of where service improvements have been made as a result of complaints is detailed in the Complaints Annual Report.
  - 6 Lessons learned from complaints are detailed in Quality Matters, in the Quality Account and also on the Trust website, although at the time of review the information available was for 2013, [www.dorsethealthcare.nhs.uk/trust/quality/complaints.htm](http://www.dorsethealthcare.nhs.uk/trust/quality/complaints.htm)
  - 6 Complaints Review Group chaired by the CEO includes representatives from the voluntary sector and Healthwatch. A random selection of complaints is reviewed and discussed with relevant teams. There are also focussed thematic reviews (e.g. recently reviewed complaints received from patients in local prisons).
  - 6 Complainants are surveyed post-complaint to gather views on the complaints process using the NHS England Survey (as a pilot). Responses are shared with Locality Managers monthly. These are then shared with teams. Results are reviewed by the Board quarterly through the Dashboard. The Patient Experience & Complaints Team does not monitor actions taken as result of feedback from this survey.
  - 6 Attendance at the regional Complaints Forum (participants include representatives from NHS England Wessex and Dorset Advocacy). The Trust has also led the re-launch of the Dorset health and social services complaints managers group.
2. Patient Advice & Liaison queries can come through email, website, letter or verbally (comments are logged onto Ulysses and monthly reports run). Comments are categorised into “enquiries”, “concerns” and “signposting”.

3. Compliments should be logged on Ulysses and now Gather. The system generates monthly and quarterly reports and some are shared in Quality Matters. They should be used by teams to evidence good practice.
4. Email/Letter/Phone/Face to Face. (Any complaint or Patient Advice & Liaison Service query sent to the complaints/PALS email inbox is sent an automated response.)
5. Social media, Facebook, Twitter, NHS Choices, Trust website etc. are monitored and any comment that needs a formal or more in-depth response is re-directed to the relevant team and the Patient Experience & Complaints Team. Negative comments are forwarded to the Patient Advice & Liaison team, but we saw no evidence that the social media platforms are used significantly for patient and service user feedback. There has been involvement of service users in the development of a new web page for sexual health services. It also appears there are some “local” Twitter accounts managed by local teams. There are protocols in place should teams request an account (they need to have a business case). There are also additional Facebook groups (usually private) for service users to access as support groups/forums (the Communications team administer these but they are edited by local teams).
6. The Patient Experience team also monitors feedback posted on NHS Choices and Care Opinion (previously Patient Opinion) websites and sends generic responses. If a more detailed response is required, the Communications team liaise with the Patient Experience & Complaints Team and the relevant local team. Managers and matrons of the services for which there are postings on NHS Choices are requested to give responses to the comments, and to share these comments with their teams and act on the feedback as necessary. Responses require approval from the Director of Communications and an email is sent to the patient/service user advising a response has been made.

7. Comment Cards, Comment Boxes, Comments Books, Suggestion Boxes in various wards and waiting rooms etc.

## Proactive Mechanisms

1. Friends & Family Test (and free text comments - coded into positive and negative comments). A new system (Gather) for recording and analysing results has recently replaced Elephant. Results are reported in the quarterly Patient Experience Reports which go to the Executive Quality and Clinical Risk Group. The test will be available through texts, email, hand held devices and paper surveys. Additional patient surveys will also be available through the system. There is a formal quarterly internal audit process for the Friends & Family Test (through the Business & Performance Team). The new system will hopefully support action plans at team level with a central oversight. Team action plans are sent to the Patient Experience & Complaints Team for publishing.
2. PLACE (Patient Led Assessment of the Care Environment) - involvement of patients and service users.
3. National Surveys (through the NHS Patient Survey Programme - Patient Surveys Team Intelligence Division of the CQC) including:
  - Mental Health Acute Inpatient Service User Survey and the Community Mental Health Survey (led to a review of services, realignment of resources to ensure more equitable services across Dorset and co-production of pathways and co-development of Team Recovery Implementation Plans).
  - Adult Inpatient Survey.
  - Dementia Carers Survey (results shared and discussed at monthly Dementia Operational Groups and disseminated to Dementia Champions for discussion with teams and to agree actions. Results

are included in the Patient Experience & Complaints Team Annual Report).

4. Consultations - examples:

- Dorset CCG Mental Health Acute Care Pathway Public Consultation (analysed by Bournemouth University).
- Various drop-in events around the county.
- Smokefree premises public consultation.
- Input to the Dorset Clinical Services Review.
- CCG-arranged “You Said, We Did” events.

5. Local Surveys. The Trust expects all teams to undertake some kind of “local survey” at least annually (in 2015/16 171 local surveys were undertaken by 126 services/teams). Results should be collated by individual teams and shared with the Patient Experience & Complaints Team. Example:

- Dietetic service undertook a user satisfaction survey to 83 care homes. Results were shared with the team, other homes and across the Trust (reported in Quality Matters).

6. Focus Groups. Examples of groups and actions are documented in the Patient Experience & Complaints Team Annual Report. Examples include:

- Long Term Conditions Therapy Team - actions resulting from feedback include calling patients to clarify appointments, viewing the possibility of self-referral and issue phone number on discharge.
- Gastroscopy Focus Group - actions resulting from feedback include reviewing whether patients waiting for procedures should be in a different waiting area.
- Dorset Community Brain Injury Service - has a volunteer programme using people with experience of brain injury to facilitate and deliver services with clinicians. They co-produced a fatigue management course and will develop more service initiatives.

- 6 Dorset Community Pain Service - The Dorset Wellbeing and Recovery Partnership facilitated co-produced workshops and Pain Management Course in the Recovery Education Centre. This led to co-review and redesign of Invitation sessions for newly referred patients, co-interview of new pain consultant and co-planning and running of quarterly support meetings in the East.
- 6 Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation - included submission of patient feedback (shared in Quality Matters).
- 6 Palliative Care Carers Forums - one of the actions from this group included reviewing and improving how information was being shared between services.
- 6 Glendinning Ward (mental health rehabilitation) created a new arts and crafts room and had audited the success of its patient led activities program. Activity plans were patient led and designed around personal needs and choices.
- 6 Alderney Hospital has view seeking forum of people with long-term conditions.
- 6 Nursing & Quality Directorate have a Quality Priorities Public Panel.
- 6 Melcombe Day Hospital carers group.

Experts by Experience. (Currently the Trust is working ad hoc with service users, and there is no framework to support safe recruitment and support. Consequently they are creating a programme of 'Experts by Experience' (EbE). We are told that the EbE role will encompass all circumstances where they are working with service users bringing their insight and experience.

7. Other examples of less formal forums and events where patient feedback may be gathered but not necessarily formally logged include:
  - 6 Westminster Community Hospital - Easter service
  - 6 Pulmonary Rehabilitation patients' singing group

- 6 Parkinson's patients' education/exercise group
- 6 Remembrance Day events (Willows Intermediate Care and St. Leonard's)
- 6 Melcombe Day hospital events
- 6 Children's Learning disability service team - Seastone House support group

8. Although not specifically focussed on engagement, Patient Reported Outcome Measures (PROMs) assess the quality and safety of care delivered to patients from the patient perspective. Currently covering four clinical procedures - hip replacements, knee replacements, groin hernia and varicose veins (although this will reduce to two in the near future), PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

PROMs national-level headline data are published every month with additional organisation and record-level data made available each quarter <http://www.hscic.gov.uk/proms> . There is also some work being done around Patient Reported Experience Measures (PREMs), but this is still in its infancy.

9. Staff Induction, training and education includes input from service users and carers (the Trust was nominated for work in this area in the Health Education England Wessex Shine Awards 2015). Service users and carers have been involved in 38 training courses for staff recently.

The Trust has signed up to the Carers' Trust "[Triangle of Care](#)" and made it one of their Quality Priorities. The Triangle of Care has six areas highlighting good practice, against which teams self-assess. To support assessment, the Trust established a steering group led by carers. The group delivers carer awareness training for staff along with quarterly action learning sets.

10. A selection of “patient stories” is shared with the Board on a bi-monthly basis (actions taken as a result of these are documented in the quarterly Patient Experience Report). These are discussed by the Board and a response sent to the patient where appropriate. Actions are reported to the Quality Governance Committee.
11. Real-time hand-held device surveys/questionnaires are being re-introduced with new system Gather.
12. Partnership working with the Patient Association to undertake QUIS (Quality of Interaction Schedule) observations (scoring the interactions between staff, patients and visitors in inpatient services).
13. Bournemouth University undertakes mental health training packages (co-produced with Peer Specialists) for 1st year Paramedic students.
14. There is a library of videos featuring carers/families and staff sharing their experiences following a sudden death that are used in training and feedback for staff (from QA 2014/16 under Patient Safety priority). The Trust reviewed communications with families post-suicide/unexpected deaths and now provide the “Help is at Hand” leaflet for families affected by suicide/sudden deaths.
15. Implementation of Carers’ Passports (stemming from “[John’s Campaign](#)”, which raised the importance of allowing relatives and carers of dementia patients open visitor access when they are admitted to hospital).
16. Stroke Review Service personalised 6-month review (includes service user feedback). One of the actions included providing more information on recovery rates to patients.

17. Partnership working with Dorset Mental Health Forum includes proactive work with service users, relatives and carers:

- The Dorset Wellbeing & Recovery Partnership (WaRP) (between Forum and Trust) includes workshops, reflective sessions and learning sets. It aims to promote principles of wellbeing, recovery and co-production in order to transform people's expectations of mental health services and how mental health is perceived.
- Complaint Handling and Investigator Training course.
- ImROc ([www.imroc.org](http://www.imroc.org)) Implementing Recovery for Organisational Change in mental health. The learning sets, attended by both NHS staff and peers encouraged each of the teams to share processes and good ideas. More learning sets are to be undertaken (facilitated by the WaRP).
- Child & Adolescent Mental Health - peer specialists are active in Pebble Lodge - co-production of safety planning and learning sets (review of current practice and development of action plans to support recovery ethos in Nightingale House). Co-production and co-delivery of Transitions course for young people.
- Co-produced Safety Plans were an innovation developed on Harbour Ward and are now being adopted by other wards across acute services. The Safety Plans focus on co-ownership of the plan; on what safety means for the individual, validating their perspective; encouraging people to develop distress tolerance skills (with support from peers); taking responsibility for their own safety (developing through levels of engagement); and positive risk taking. This has seen some important personal outcomes for people and a reduction of incidents. Safety Plans have now been incorporated into RiO via My Crisis Plan for all inpatient services and a training package has been co-produced with clinicians, peers and DHC Learning and Development.
- Co-produced crisis plans. This workshop was co-produced between 5 peers who had used Crisis and 5 staff from the Crisis Team. Identified

what risk and safety meant to individuals and to services, what people wanted at different stages of their crisis and what sort of communication fostered emotional safety. Developed a way of care planning that acknowledged that when people are in crisis, they are not necessarily able to develop a crisis plan, but they may have information that they wish to share and that is important to them. The Crisis team have taken this on board and are starting to see results, including an increase in completed Care Plans.

- 6 The Recovery Education Centre (REC) offers courses which fit to an educational framework around Recovery and Wellbeing - based on the principles of co-production and co-delivery between the expertise of lived experience and professional expertise- recovery skills workshops (aimed at people in inpatient or crisis services and offer 30-45 minute sessions that focus on managing distress and how to best use the services that are available.)
- 6 Peer Specialists work directly with mental health teams in the Trust.
- 6 Hidden Talents (learning from staff with lived experience of mental health) - actions include production of a booklet and film, peer support and a Recovery Education Centre course “Sharing your Experience”.
- 6 Intensive Community Recovery Education - Bournemouth East Community Mental Health Team co-produced a new community group with peer specialist experience for people not necessarily getting the most from services.
- 6 Carers’ Project. The Carers’ Project in partnership with the Trust and the Forum, collates views of carers across Dorset by visiting carers’ groups and reporting back on carers’ experiences of services, so that the Trust can respond more effectively to carers’ needs. The Carers’ Project with support from the Trust’s Carers officers also delivers events for carers across Dorset.
- 6 The Forum and the Carers’ Project have been working together to develop Peer Carer roles. Staff at Forston Clinic and St Ann’s have

started to provide carers' teas for people to drop in and get support. These areas of work are developing into carers being able to offer peer support, including a telephone line set up for carers who want to talk to someone who has been through similar situations. The plan over the coming year is to extend this project and develop the Peer Carer role.

- 6 Co-producing development areas with peers and the team themselves, acknowledging strengths, building commitment and creating ownership. A version of the ImRoc Team Recovery Implementation Plan (TRIP) is used by the team to map their assets and discuss their approaches and share ideas. Teams rate themselves against the criteria, such as Collaborative Care Planning, Offering Choice and Control, Wellbeing of Staff and so on. Scores used to discuss areas of strength and areas that could be developed within the team. Shapes how they can introduce peers into the team and for the team to identify Recovery focused practice and activities that they may wish to develop.

## In process of development by the Trust:

18. Implementation of an experience insight dashboard to triangulate staff and patient feedback from the Friends & Family Test.
19. Raising awareness of what Membership is about - for Governors and Members. Re-launch of an e-newsletter for Members and establishing a programme of engagement activities to include topic-based health talks, seminars, focus groups, open days, listening events or “surgeries” and an online Member poll 2/3 times per year.

20. Reviewing how the Trust can better support organisations such as Access Dorset to be more involved in the Trust.
21. Refresh of the Patient and Public Quality Improvement Panel (within the Nursing and Quality Directorate), the objective being to ensure there is a patient and public voice in the oversight and scrutiny of the Trust's quality improvement initiatives. The Panel will review and comment on outcomes of a selected number of quality priorities, the clinical audit plan and actions taken following quality improvement initiatives. The aim is to "drill down" to test whether patient and public engagement and collaboration is embedded in services. The Panel will report to the Executive Quality and Clinical Risk Group, Board and Council of Governors.
22. Development of a Participation Working Group that will monitor and support the new Participation Strategy and associated Implementation Plan (reviewing how to embed co-production across the Trust). The Group will include services users, carers, third sector and public representatives. This group will report to the Board.
23. Development of proactive work with the Leagues of Friends, including a new Memorandum of Understanding.
24. Reviewing the work of Trust volunteers and developing further roles. (Potential to train volunteers to undertake aspects of "Enter & View" work or to act as engagement "Champions"). There are 196 volunteers, not including those in Leagues of Friends. A 2016 survey asked them about their experiences of being volunteers for the Trust and has been used to inform the new Volunteer Strategy.
25. Sign-up for the Quality Mark for Elder-Friendly Hospital Wards. As part of the assessment patients and their carers/family members will report their experience of the quality of essential care provided on the ward.

26. NHS England is developing a new survey for complaints - the Trust is involved in the pilot.
27. Improving ways to share lessons learned from complaints and patient Feedback with services users.
28. The Patient Advice & Liaison Service process has been reviewed, including how enquiries are recorded and analysed - the Trust is developing a web based system (the first phase will be recording of information) and identify how the team can capture common themes and identified learning and how this can then be shared with staff to ensure sharing of learning. The team will concentrate on comments coded as “concerns”.
29. The Patient Experience & Complaints Team will undertake a Patient Advice & Liaison audit and will contact a cross section of people who have used the service to check that their concerns have been adequately dealt with and to ensure that people do not feel they have been treated differently as a result of raising their concern.
30. Continuing regular reviews of the existing Complaints process, and identify any areas for improvement (including developing a web-based reporting system).
31. Continuing to review the Friends and Family Test programme, focusing on those areas that have poor update and decline in responses. Larger programme of work being undertaken to encourage local input of data and ownership of feedback.
32. Developing a systematic approach to reviewing comments, identifying themes and working with teams to collate and centrally record changes as a result of the feedback received.

33. Developing stronger links with Business and Performance Partners / Quality Assurance Team and increasing involvement in the development of Patient Experience Outcome Measures so that more meaningful reports and information is being shared throughout corporate and clinical teams and reduction of duplication/repetition of work.
34. Reviewing wider patient experience surveys, which teams are undertaking surveys and which are not and identifying changes made as a result of feedback received.
35. There is potential in the future to be involved with Patient Centred Outcome Measures (PCOMs) - a relatively new concept which involves putting patients, and their families and carers, at the heart of deciding which goals are most valuable for individuals with a range of health conditions, rather than clinicians deciding what is best.

## Observations

1. The Trust undertakes a variety of qualitative and quantitative initiatives to gather feedback, including:
  - Consultation** (asking for views and using them to inform decision making)
  - Involvement** (service users actively involved in service planning and delivery)
  - Collaboration** (active ongoing partnerships with service users) and
  - Empowerment** (shared decision making with service users).
2. There are many examples in the various documents reviewed, (and subsequently from team interviews) of where actions have been implemented and changes to services undertaken due to feedback received (see Appendix).
3. Information in the Quality Strategy provides details of where and how service user involvement fits into performance measures. This includes how team and directorate level reports feed into Dashboards, Annual Quality Priorities, Quality Objectives and Strategic Goals all under the 5 Year Strategy. Monthly reports from the Patient Experience & Complaints Team are sent to Locality Directors and quarterly to the Executive Quality & Clinical Risk Committee. The Annual Patient Experience Report is sent to the Board and includes examples of changes to services due to feedback received. From our outside perspective it is unclear why patient experience measures are directed to the Executive Quality & Clinical Risk Committee (responsible for clinical governance) and not to the Executive Performance & Corporate Risk Group (responsible for monitoring non-clinical corporate performance), although it seems that the two groups have the same membership so there may be an implied understanding that the same information goes to both groups. The Corporate Dashboard includes indicators relating to patient feedback on:
  - Friends & Family Test response rates and results.
  - Whether service users feel involved in their care (from questionnaires on hand-held devices).

- Whether service users feel safe (in Community Mental Health services and data taken from the patient safety thermometer and also from discharge surveys). Note we would question whether the use “do you feel safe” measure is effective as an overarching measure of patient experience in the dashboard.
- Complaints and Compliments data including results of the satisfaction surveys of complaints handling.
- CQUIN schemes re supporting carers of dementia patients (through the Dementia Carers Survey) and the CQUIN for Child & Adolescent Mental Health Transition and for John’s Campaign.

Additional note regarding the “Stages of Excellence” methodology used to undertake an assessment of progress towards the Strategic Goals in 2016. We would question the validity of some of the evidence used e.g. “League of Friends” is listed as evidence that “local people have mechanisms through which they can influence Trust business” we found little actual evidence that “League of Friends” act as a conduit or mechanism for local people to influence Trust business.

4. As already mentioned, at the beginning of 2017 the Patient Experience & Complaints Team undertook a survey of all locality teams (just over 300) to ascertain whether they are undertaking local surveys or service user engagement initiatives other than the Friends & Family Test. As at April 1st the response rate was 52%. Of these, 55 teams were undertaking some kind of service user feedback initiative and results of 22 of those initiatives are shared with the Patient Experience & Complaints Team. The Team are aware that there are potentially more local initiatives that they have not been informed of.
5. There is guidance on the Trust intranet for undertaking service user engagement initiatives and those local surveys that are sent through to the Patient Experience & Complaints Team are evaluated.

6. Learning from service user feedback and sharing good practice is done through various methods such as:

- The Patient Experience Annual Report (includes results of engagement work, themes and trends identified and highlights actions and improvements taken in response to feedback).
- In the Trust Quality Matters newsletter and on the Intranet.
- Through monthly Quality Reports.
- The Annual Staff Awards and monthly “Heroes” awards.
- Learning events and roadshows for staff (23 events in 2015/16 covering 400 staff plus 15 half day (learning from serious incidents events)).
- Through the annual Quality Account.
- Through the annual Quality Improvement Conference (patient stories and learning from complaints).
- Feedback is shared at staff 1-to-1 meetings.
- Some wards and teams use “You Said, We Did” boards.
- Community Hospital Matrons share learning together at regular meetings.
- The Ulysses system generates automated reported for Patient Advice & Liaison Service enquiries and compliments and feeds into the Dashboard.

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## Findings and Points for Discussion - Phase 2

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Phase 2 involved interviewing 38 front line teams to find out how, in practice, feedback is gathered, when, where and by whom: and a review of how teams record, analyse, act on and learn from and engagement and involvement activities. This section uses several general headings extrapolated from the interview questions to draw together the findings from those interviews into a series of themed areas. From this information we have then drawn more general summaries and suggestions for Points for discussion (referencing the findings and observations from Phase 1 where necessary).

### 1. Friends and Family Test

- 1.1. Service users using inpatient wards/clinics appear to have easier access to the Friends & Family Test than more transient service users such as those using walk-in services or Minor Injuries Units. Staff also find it easier to ensure service users have the opportunity to complete a Friends & Family Test form in these areas. Response rates appear to reflect this.
- 1.2. Many teams give out Friends & Family Test forms sporadically or use different processes for giving them out even within teams. For example, the Community Pain Service chooses a couple of days where all the team are in the same place and all service users can receive Friends & Family Test forms. In the east, however, it is given out at each pain management group and on discharge (possibly still sporadically).
- 1.3. Many teams were displaying Friends & Family Test feedback data (response rates, pie charts etc) on reception/waiting room “You Said, We Did” notice boards.

- 1.4. Some teams were not aware of or not using alternative Friends & Family Test formats such as easy-read. Learning Disability teams do use easy-read but still expressed concerns over the use of the Friends & Family Test for some of their service user groups.
- 1.5. Some teams did not give out forms as they felt it inappropriate for their service user group (End of Life, for example) or those whom they felt are vulnerable, very ill, very elderly frail or their condition, in the opinion of staff, would likely prevent them from being able to complete it.
- 1.6. Some teams only give out forms “as and when” they remember.
- 1.7. Certain teams working with other areas (for example, Diabetes Nurses who work with practice nurses) do not have control over which service users receive a Friends & Family Test form and do not see results (in this case practice nurses select the service users to give the test to).
- 1.8. Many teams expressed concerns over service users becoming overwhelmed with Friends & Family Test and other requests for feedback, especially those using multiple services and “frequent users”.
- 1.9. Some service users receive a Friends & Family Test request at the initial point of contact, some at various stages of the care pathway, some at discharge, some post-discharge or at follow-up appointments, and sometimes at all of these. The test can also be incorporated into other more service specific surveys/questionnaires also increasing the possibility of duplication/overload. Some teams kept lists of who had received a form in order to stop service users being overwhelmed.
- 1.10. Many teams voiced frustration with the Friends & Family Test in terms of not being able to use the results to make service changes (if the feedback is anonymous or does not give a reason for a poor rating).

- 1.11. Many teams felt the “word clouds” they are given from the results are meaningless - just picking up most used words - and also meaningless to service users if used on “You Said, We Did” boards.
- 1.12. Teams working with children advised that the Friends & Family Test is not child or young-people friendly, so it is not used very often.
- 1.13. Some teams advised they “have to stand with or over” service users to get them to complete a form, which reduces its anonymity and potential subjectivity. This is especially relevant to teams such as District Nurses/Community Nurses and Health Visitors who take the test to the service user’s own home. They often bring the completed form back with them. Staff advised “it’s embarrassing and feels like we’re fishing for compliments” or “how can the service user be honest and really tell us what they feel when they know we can see what they have written”. These teams are often reluctant to promote the Friends & Family Test for these reasons.
- Note: we were advised that teams know clinicians who actually complete the forms for service users while they are with them.*
- 1.14. Many teams felt that forms should be given out from “central” or by an independent person to help increase response rates and assure service users that responses will be anonymous (for example Health Visitors/Nursery Nurses said it may help for forms to be given out by Children’s Centre staff who are seen, by service users, as being more independent).
- 1.15. Many teams felt that the Trust places more emphasis on response rates than on what is actually done with the feedback. Some felt “chased” to increase response rates.

- 1.16. Some teams used to carry out service specific surveys/questionnaires before the Friends & Family Test and felt they were more appropriate to their team. Many were unaware of the new Gather system and the possibility of adding service specific questions to the Friends & Family Test.
- 1.17. Some teams felt they needed more help, advice and support to understand why response rates were low. For example, Wimborne Minor Injuries Unit had 41 responses from 600 service users but were unsure why. However, Swanage Minor Injuries Unit have increased their response rate with the use of text. Staff felt lack of stamped, addressed envelopes or Freepost doesn't help.
- 1.18. Staff feel #feedbackfriday (Twitter) is a good way to share results of the Friends & Family Test but the comments published are nearly always positive (note: we checked Twitter for December 2017 - of 137 #feedbackfriday tweets posted all comments were positive), and that it would be good to share some of the negative comments and what changed and improved because of them.
- 1.19. Teams using tablets felt it made a big difference in terms of saving time inputting paper forms and also helped with anonymity.
- 1.20. Some integrated teams (for example, Community Matrons) expressed concerns that service users may respond negatively to a Friends & Family Test due to issues with social care rather with health care but the test does not distinguish.

## Summary

Even though the Trust describe the Friends & Family Test as being “embedded in community and inpatient services” (Quality Governance Committee meeting minutes 18th May 2017 item 075/17) we found that not all service users are given an opportunity to feed back using the test and it is inconsistently used across the 38 teams we interviewed. Some teams randomly select service users, some target certain service user groups, some service user groups do not have access (or are not given access) for various reasons, the anonymity of the test is compromised in some environments and many teams do not feel they are able to action service changes from the data. The opportunity for service users to be overwhelmed with requests is also a potential issue.

However, we are aware that the new Gather system should improve implementation and usability of the Friends & Family Test and provide teams with more usable data. We acknowledge that some of the Discussion Points below may be incorporated into the reviews and ongoing work mentioned in points 32 and 33 (under “In process of development by the Trust).

## Points for Discussion

### Points for Discussion - Friends & Family Test

Where the test is not being given to those “harder to reach” groups is it likely to be biasing results?

Many teams were unaware of being able to add service specific questions to the Friends & Family Test and were unaware of Gather in general. We acknowledge that the system has only recently been introduced and the Patient Experience & Complaints Teams are working to ensure all teams have full knowledge and training. Will this be incorporated into the review?

What can be done to reduce duplication for service users who use multiple services? Maybe under the larger review (point 31)

Staff perception is response rates are more important than using feedback. How can the Trust counter this especially when responses rates, rather than service improvements, are the metric used in the Board Dashboard?

If some teams are randomly or sporadically giving out the test to service users or targeting different service user groups within similar teams how does this affect understanding and accuracy of response rate analysis and ability to make useful comparisons? Example - Community Mental Health (Older People) Dorchester don't give out the test but make reference to it in letters whilst Community Mental Health (Older People) Blandford & Shaftesbury give the test to service users on initial contact, periodically during the care pathway and on discharge as well as at end of group sessions.

Could more use be made of #feedbackfriday to share the negative comments and what the Trust did in terms of "You Said, We Did"?

For teams that work out in community settings where tablets would be useful, are there any implications for areas with bad Wi-Fi connectivity?

Would it be useful to undertake a further survey of teams in 12 months time to ascertain how the perception of the Friends & Family Test has changed due to implementation of the Gather system?

## 2. Surveys and Questionnaires

- 2.1. Surveys and questionnaires vary in format, "branding" and quality, which can be confusing for service users especially those using multiple services.
- 2.2. Service user surveys and questionnaires are sometimes designed by the teams themselves with little or no support or help, or by staff (and in some cases placement students) who may have little or no training or expertise. Some have relied on previous questionnaires or those used by

other teams or organisations with potentially no understanding of their suitability.

- 2.3. A variety of collection methods were being used such as Excel, Ulysses, and Gather.
- 2.4. Some surveys and questionnaires have been designed (and verified) with help from the Patient Experience & Complaints Team (for example, Podiatry). Some teams are in the process of development new surveys and questionnaires with the help of the Patient Experience & Complaints Team or are working on new initiatives such as use of email to request feedback.
- 2.5. Most surveys and questionnaires seem to be paper-based but very few also have an accompanying stamped, addressed envelope. Teams felt this has detrimental effect on response rates.
- 2.6. Some paper-based surveys and questionnaires do allow service users to respond via email.
- 2.7. Survey and questionnaire administration and subsequent analysis is often done within teams, often by administration or support staff who may not have the appropriate training and expertise.
- 2.8. Some teams said staffing issues often affect consistency of data input and analysis or even whether responses are collated or analysed at all. For example, the CHI-ESQ Experience of Service questionnaire used by Child & Adolescent Mental Health Bournemouth & Christchurch is currently being sent out but not analysed. This questionnaire should be given to all service users, but it depends on the clinician and whether the service user drops out of treatment. Clinicians give it to service users after sessions, leave the room, then collect it (does this put pressure on the

service user?) - alternatively the questionnaire can be sent to the service user's home with a stamped, addressed envelope.

2.9. Some teams use profession-specific surveys and questionnaires that also include patient experience data, for example:

- Child & Adolescent Mental Health Delphwood advised they use Session Rating Scales for practitioners to reflect on their professional relationship with a service user (appears to be used adhoc by clinicians but more regularly for those in training).
- Community Mental Health (Older People) Blandford & Shaftesbury advise they use a PROM (Patient-Reported Outcome Measure) ReQoL internally which has 10 informal questions asking service users about 10 aspects of their consultation.
- Bournemouth Learning Disability team advised they undertake Care Programme Approach (CPA) Health Reviews and carers assessments that capture feedback with feedback methods determined by the service user.
- Poole Learning Disability team use "Early Indicators of Concern" to review care with service users. Feedback is also provided to framework providers and commissioners.

2.10. Some teams advised that they did not know the response rates to their service specific surveys and some advised that they did not know what happens to the results of surveys.

2.11. A few teams could not see the point of doing surveys as they "never tell us anything we don't already know".

2.12. Some teams undertake phone surveys, for example Shaftesbury Intermediate Care.

- 2.13. A few teams undertake follow-up calls to survey responders if the response warrants it and they have contact details of the service user.
- 2.14. Very few teams who had service specific surveys and questionnaires knew if they had been designed taking into account the needs of harder-to-reach service users or those with additional communication needs. Very few teams advised that their surveys were available in other formats such as easy-read. However, some Learning Disability teams (e.g. Poole) have created their surveys using their knowledge and experience of what works best for their service user group.
- 2.15. Many teams did seem to follow up issues and trends from surveys and questionnaires where they were being analysed, but sometimes not in a timely way.
- 2.16. Some teams advised that responses to surveys and questionnaires go to senior clinicians and/or “higher management” to deal with but they are uncertain what happens to the data or how it is evaluated.
- 2.17. A few teams were frustrated that previously useful service specific surveys and questionnaires had been superseded by the Friends & Family Test.
- 2.18. Many teams were unsure when surveys go out to service users or whether they go at the right time. For example, it may be better to request feedback post-discharge rather than at discharge or at follow-up sessions. Some service users are never discharged (for example, those using Leg Ulcer services, so this team realise surveying on discharge misses a cohort of service users and therefore they survey service users annually).
- 2.19. At least one team undertakes “face-to-face” surveys.

- 2.20. Some surveys and questionnaires have been in use for some time (one team advised that they have used the same survey for 15 years) and may need reviewing to ensure they are still appropriate.
- 2.21. One team expressed their frustration that they have not been able to implement their new service specific questionnaire. They said it had been suggested to them that it is 'dead in the water' because their system is not able to send and receive questionnaires via email. The team sees 75,000 patients per year and collects feedback from only a very small percentage of those people. The team hoped that the electronic questionnaire would result in more of those people giving feedback about the service they received.
- 2.22. Very few surveys and questionnaires have been designed and developed with staff input. For example, a new survey being piloted by one team was designed by a specific Practitioner with no team involvement.
- 2.23. Very few surveys and questionnaires have been designed and developed with input from service users.
- 2.24. Where surveys (or any request for feedback) are sent to service users who may be living in residential care or specialised accommodation, for example, there is some uncertainty whether these service users would have help and support to complete the forms or whether carers, care home/other staff complete them "on behalf of" service users with the potential for data to be biased. Currently some of these surveys are not being formally gathered and the response rates are unknown.

## Summary

Contrary to the Trust's expectation that all teams undertake a service specific survey, we found many that did not. Most surveys and questionnaires go to randomly selected or targeted groups of service users. Surveys designed by teams may not be verified or checked for issues such as bias and variability or checked for accessibility. Survey administration is often done by administration and support staff and collection, collation, analysis and evaluation of data is piecemeal. We found little evidence of assurance that all surveys and questionnaires are designed using effective, comprehensive, consistent methodologies designed to elicit the desired outcomes. Again, we acknowledge that some of the Discussion Points below may be incorporated into ongoing reviews.

## Points for Discussion

### Points for Discussion - Surveys & Questionnaires

Some surveys have been verified by the Patient Experience & Complaints Team. What is the process for doing so?

Should teams be encouraged to add service specific questions to the Friends & Family Test rather than continue to use or design new surveys? (Note: some teams were unaware what freedom they have to produce service specific surveys.)

How can the Trust ensure surveys and questionnaires are accessible to harder-to-reach service users and those with additional communication needs? Data may not currently be reflective or representative of all service user groups or take into account protected characteristics.

Some integrated teams use surveys and questionnaires from social care (for example, a new Adult Social Care questionnaire is being developed for use by Learning Disability teams and some groups co-facilitated between Heath Visitors (Poole Bay) and the Borough of Poole use an evaluation form from the Borough

which the Health Visitors have had no input to). Is the Trust aware of these and do they work with colleagues in social care to ensure quality and shared learning?

Surveys may be analysed by staff who do not have the appropriate training and expertise, which can lead to potential problems in data accuracy. Staffing issues can lead to responses not even being used. If surveys and questionnaires are not used to elicit useful information the implications are; staff feel there is no point in them, time and effort is wasted, service improvements cannot be implemented and service users feel there is no point in giving feedback as “nothing ever happens”. Few teams talked about the guidance available as mentioned in point 5 under “Observations”. How will the Participation Strategy and the work mentioned in points 32, 33 and 34 (under In process of development..) reflect these issues?

Can teams work more effectively together to share methods, reducing duplication and ensure consistency where appropriate? (This applies to teams in similar roles or even those, such as Learning Disability, who may have more knowledge and experience of communicating with service users who have additional communications needs, especially service users unable to read or write).

There is limited co-production in design and development of patient feedback mechanisms. Surveys and questionnaires, in the main, were designed and developed from the Trust’s viewpoint rather than asking questions that may be important to the service user.

Can service users and volunteers help analyse and interpret information, generate insights and work on action planning with staff? How will this be addressed through the Participation Strategy?

We refer to the training issues and potential guidance we have documented under point 14 in the Executive Summary for further discussion.

### 3. Other feedback methods

- 3.1. Many teams undertaking group work or carers events, education courses and study days use evaluation forms and questionnaires that may include questions relating to aspects of the service user experience. Some of this information, for example feedback from invitation days and pain management programs undertaken by the Community Pain Service, is analysed by psychology assistants, actioned and shared with the Patient Experience & Complaints Team. However, much of this data in general is not analysed or used.
- 3.2. Community Mental Health (Adults) Poole North have run 2 events to talk to service users about their care and also regularly hold 1-2-1 discussions with service users with personality disorders about the care pathway (as part of care planning).
- 3.3. The Community Mental Health team (Older People) Dorchester team use a sticker system in Reception for feedback. The Locality Team have devised “postcards” to gather feedback asking “what went well” and “what could be improved” (this is a new initiative not yet being used at time of interview).
- 3.4. Poole Learning Disability give service users the opportunity to give feedback at annual reviews.
- 3.5. Many teams advised they have suggestion or comment boxes in reception or waiting rooms but these are often seldom used and/or seldom checked.
- 3.6. Some teams have undertaken focus groups, some successfully and some not. Some teams advised that focus groups had closed due to lack of service user interest but few teams had undertaken any further research

or discussions with service users to understand why these groups were not effective. Speech & Language (Poole) had some success working with service users from particular condition specific groups such as brain injury or Parkinson's. Health Visitors (Poole Bay) have a Parent Forum who have been involved in process reviews and had input to survey wording.

- 3.7. Most teams gathered informal feedback (mainly compliments) through cards, letters, emails, calls, drawings (Learning Disability) etc. Some is recorded and shared with teams such as the Patient Experience & Complaints Team but much is not (many teams said time was a factor). Some is discussed at team meetings. Some is recorded only for Continued Professional Development. Feedback is recorded on a variety of systems such as Excel, Word, Ulysses and Gather or in written folders.
- 3.8. Some service user feedback is only recorded on service user files or on systems such as RIO.
- 3.9. Some teams undertake a "self-audit" - process mapping the service user journey. However, there is little evidence that service users are involved in the process or whether some of these audits take into account service user views and experiences.
- 3.10. Some teams actively engaged with patients who had expressed concerns in order to prevent issues escalating. Much of this was not recorded.
- 3.11. All teams were aware of the complaints process. Some teams, for example District Nurses (Poole), have adapted the complaints process (investigate, feedback and share learning) to manage negative comments received that are not formal complaints.

- 3.12. Some teams encouraged service users to provide feedback through methods such as NHS Choices or Care Opinion websites.
- 3.13. Some areas use a variety of internal methods of gathering feedback such as weekly food satisfaction audits, Matron's rounds, checks/support calls to recently bereaved families, running Dementia Steering Groups, running and supporting dementia cafés. (Note: Yeatman Hospital has joined the Sherborne Town Council Dementia Alliance Team. Hospital Dementia Champions attend meetings and have access to resources and training).
- 3.14. Community Hospitals are currently implementing the Quality Mark for Elder-Friendly Hospital Wards which explicitly involves requesting feedback from service users.
- 3.15. As is already well known and well documented ,many of the Community Mental Health teams work closely with Dorset Mental Health Forum and their Peer Specialists to gather service user feedback (such as carers' events).
- 3.16. Some teams work with other areas who are responsible for service user feedback. For example, Health Visitors and Nursery Nurses (Weymouth & Portland) are working with Steps-2-Wellbeing on new group session evaluations (paperwork devised by Speech & Language).
- 3.17. Some areas are using social media to elicit feedback. For example, Health Visitors (Poole Bay) use a closed group Facebook page asking service users what worked, what didn't work, what they liked about the service and what they didn't like. Yeatman Hospital also uses a Facebook page.
- 3.18. School Nursing use a text service "ChatHealth" for young people to access school nurses. This has a feedback route built in - analysis of

which goes to the Trust Service Improvement Manager. This team work with children from age 5 so most feedback mechanisms are inappropriate. However, after 5-6 yr. olds are given their flu immunisation they are given a Gold Coin which they can put in a bucket - choice of 3 - (a smiley face, a sad face and an “in-between” face). There are potential problems, though, in that many young children are of the belief that the flu immunisation is in the form of an injection, so they can often arrive at clinic already upset or fearful. A Gold Coin in the sad bucket (for example) may reflect this fear, conversely a coin in the smiley bucket may be expressing relief not having an injection rather than how they felt about the actual clinic! (Note: Commissioners require 10% of the immunisation cohort (all ages) to be surveyed).

3.19. The following teams were working with volunteers:

- Yeatman volunteers work with service users to complete “This is Me”.
- Community Mental Health (Adult) Christchurch & Southbourne linked with Hearing Voices.
- The Community Pain Service has a volunteer co-ordinator. Service user feedback is sought through volunteers and input to a steering group.
- Audiology’s 11 volunteers visit service users in their own homes to support them with hearing aids etc. (Note: at time of interview this group was under threat due to lone worker protocols). Volunteers often hear useful information on an informal basis e.g. service users feel overloaded with information or are not aware of/have not understood the information they have been given.

3.20. Some teams felt that working with volunteers took up too much staff time in terms of training, support and monitoring and there were issues around confidentiality, data protection and safeguarding.

## Summary

There are many and diverse methods being used to gather feedback from service users, many of which have not been evaluated for effectiveness.

There are also many areas of good practice which are not necessarily shared with other areas. Again, we acknowledge the reviews and ongoing work already documented.

## Points for Discussion

### Points for Discussion - Other feedback methods

How can the Trust help local teams to evaluate their patient engagement methods? Doing so may lead to “stripping out” those initiatives that are not working, freeing up staff time to discuss, design, and implement new ways of working or to pilot different approaches.

Many teams are working in isolation in terms of their Patient and Public Engagement activities with no easy route or method of sharing within directorates and/or across the Trust. How can the Trust provide a more effective platform which incentivises teams to share?

The Trust has recently published its new Volunteering Strategy (IN-542) 2017-2020. Although this document does not specifically state volunteers could be encouraged/trained to undertake engagement work, is this something that will be included as a potential new role?

Additional - few teams had heard of Experts by Experience, although we did note the following:

- The Tissue Viability service have an Expert by Experience who presents at conferences and offer stories for Quality Matters.
- Child & Adolescent Mental Health (Delphwood) have service users involved in participation groups.
- Speech & Language (Poole) have an Expert by Experience involved in producing videos about the service.

- Bournemouth Community Matrons had service users involved in Action Learning Groups.
- Learning Disability and Community Mental Health teams had peer specialist and Experts by Experience through Dorset Mental Health Forum.

## 4. Training

4.1. No team advised that they had received any specific training in patient engagement/involvement work, although we noted the following:

- The Community Pain service advised that they thought the Patient Experience & Complaints Team had run a customer service/service improvement workshop.
- A team member in the Continence team had received some training on research methods through a MacMillan project.
- Some staff (for example, in mental health teams) had received some training as part of professional Improving Access to Psychological Therapies (IAPT) degrees and other professional training.
- Child & Adolescent Mental Health Delphwood also advised they had a “Champion” for outcome measures.
- Some Speech & Language staff had received Quality Improvement training when working at another Trust.
- Staff at Wimborne Minor Injuries Unit had some training from previous roles in designing surveys and questionnaires.
- Intermediate Care Dementia (West) advised that the acting Manager had some training in engagement work and the new administration staff member had won awards in patient engagement work.

4.2. Some teams were unaware of the support and help available from the Patient Experience & Complaints and other teams.

4.3. One team had found it hard to get support from central Communications.

- 4.4. Many teams expressed concerns that they do not have the time to send staff on training courses or the resources to be able to allocate staff additional work load in terms of patient engagement work. However, nearly all teams expressed interest in having a centrally available patient engagement “expert” or “experts” that they could call on if, for example, if they needed help designing a survey or to discuss the appropriate method for a focus group.

## Summary

Across all teams we found a general lack of training in/awareness of and understanding of the methods and practicalities of implementing patient engagement and involvement work.

## Points for Discussion

### Points for Discussion - Training

Staff who are unaware of what patient engagement is, why it is important and how it can improve not just the service user experience but potentially their own work settings, are not going to be the powerful and empowered resource the Trust can call on to really make the most of the huge amount of feedback service users provide. If training is not a viable option, can the Trust use Champions (maybe from those identified already as having had training or previous involvement in engagement work), volunteers or incentives? Will this show to staff that the Trust is really committed to making engagement work a priority? This may form part of reviews mentioned in point 27 and 32 (under “In process of development...)

Turning feedback into action requires “interpretative skills” and effort. Staff analysing local services with no appropriate training may be making judgements based on assumptions about what the information is telling them and also what they can or can not do with it. Some teams said “we know what patients will say, it’s always about xxx, and we can’t do anything about that”. Will the

“toolkit” provide appropriate training or alternatively will the Trust provide expertise?

If staff undertaking engagement and involvement work (including survey design) are unaware of potential ethical, confidentiality, consent and Data Protection issues could the Trust be at risk? Where the Patient Experience & Complaints Team have been involved with designing surveys or other engagement methods have these issues been taken into account and what is the evidence for this? E.g. (Equality Impact Assessment)

## 5. Harder to Reach Groups

- 5.1. Few teams that were using service specific surveys/questionnaires or other methods of gathering feedback had considered harder-to-reach groups, service users with additional needs and/or those with protected characteristics, whether in the design of the methods used, questions asked or in implementation (e.g. not using easy-read versions or other formats even when available). One team advised that language barriers have not been considered for their service-specific survey as it is not an issue due to “the ethnic makeup of the area”.
- 5.2. Some teams involved families, carers, interpreters and/or advocates when gathering feedback from service users. Issues of consent were sometimes grey areas, though.
- 5.3. Learning Disability teams advised that they used easy-read formats and would like to make more use of tablets/iPads. They also worked with the Accessible Information group. Many of their service users have limited capacity so there is a need to be more creative with methods for gathering feedback.

- 5.4. Learning Disability teams also advised that for many service users the important issue is the relationship between them and staff. The actual service could be “rubbish” but if the service user likes the person they work with they will very often give positive feedback about everything and, conversely, negative feedback may be about the relationship rather than the service. Poole Learning Disability advised they try to gather feedback from everyone in some way which suits the individual. At the end of a session they may ask the service user to tell them 2 things they liked and 1 they didn’t. They also work alongside Poole Forum, Dorset Advocacy and the Health Action Group and use condition-related websites for support.
- 5.5. Some teams said that they would just ask for verbal feedback if service users were unable to complete forms or may even help them to complete forms. Not many teams could provide evidence about how this would be documented.
- 5.6. Teams working with children and young people advised that gathering feedback is often harder. Child & Adolescent Mental Health advised they struggled to find appropriate tools to help engage young people. School Nursing however, as already documented elsewhere, had developed more creative ways of gathering feedback.
- 5.7. Some teams had made assumptions that they would not get responses to surveys etc. from service users unable to read/write, with dementia or unable to post surveys back. Some said they made “on the spot” decisions on whether they felt it appropriate to ask for feedback or they know their service users so well they know if they need extra help.
- 5.8. Some teams were selective on who they asked for feedback. If carers or families seem under pressure they may not get asked or service users in residential care homes are sometimes excluded.

- 5.9. One team asked, “if a survey goes out to a random selection of service users, how can we know which ones have additional needs and won’t be able to complete the form?”
- 5.10. Speech & Language (Poole) had designed their own survey using “smiley faces”. They also sometimes used “Talking Mats” but this tends to be very time consuming. Some of the Community Mental Health teams also used “smiley face” evaluation forms for events.
- 5.11. The Community Mental Health teams advised that it is hard to get consistently good British Sign Language (BSL) practitioners. Some other teams advised it is also difficult to get forms in other languages and accessible for people with visual impairments.

## Summary

Many areas had not taken into account the needs and requirements of “harder to reach” service users in their engagement and involvement work (whether through lack of training and support or general awareness of inclusivity). Again, we are aware some of the points below should be included in reviews and ongoing work already mentioned.

## Points for Discussion

### Points for Discussion - Harder to reach groups

Can the Trust be assured that service users who have additional communication needs or have protected characteristics are given the same opportunities to be involved in engagement and involvement activities?

If service users with additional needs do not have the same opportunities to be involved, are results of surveys/questionnaires and other feedback methods potentially biased or unrepresentative?

How can teams that are working in similar areas or with similar groups of service users (e.g. with children and young people) share ideas and good practices for gathering feedback? How can all areas learn from those teams that work with service users with additional needs, such as Learning Disability, and have more experience, ideas and understanding? (See Healthwatch Dorset's "Be Yourself" project).

When designing engagement and involvement methods, surveys etc., has every effort been made to take into account the needs of harder-to-reach service users during verification? (Equality Impact Assessment? Liaison with third sector support groups?)<sup>1</sup>

## 6. Ethics/Confidentiality and Data Protection

- 6.1. In relation to engagement activities very few teams were aware of, or had considered any, additional ethical, confidentiality, consent or Data Protection concerns over and above what they already have to be aware of in "the day job".
- 6.2. Many teams were unaware if these issues had been considered ,even when working with/receiving support from central teams.
- 6.3. Most teams said feedback "tends to be" anonymous, is not shared elsewhere and is kept securely (however, feedback forms often collected but not collated are not necessarily kept securely (and may potentially contain personal data).

*Note: we have included Points for Discussion for the above with those for section "Training".*

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<sup>1</sup> Useful documents "Improving Understanding of Service User Involvement & Identity" Nov 17, Shaping Our Lives National User Network of Service User & Disabled People.

## 7. Action planning, sharing and learning

- 7.1. Few teams were undertaking any evidenced analysis of feedback whereby traceability was in place.
- 7.2. Analysis of the annual Musculoskeletal Annual Patient Satisfaction Survey is shared between the 8 teams Dorset-wide using Excel. Results are shared centrally.
- 7.3. Some feedback is logged in the service user care plan on the RIO system, discussed in team meetings and actioned as needed. A number of teams advised that their services are about reacting to service user needs so staff are always adjusting the way they work and responding to individual feedback.
- 7.4. Very few teams produce any specific action plans relating to service user feedback received. Often, the only record that feedback has even been discussed is in team meeting minutes. Most action plans that were produced were as a result of formal complaints. However, some teams, such as Speech & Language (Poole), could evidence a “Going Forward” plan with actions resulting from their service user survey.
- 7.5. No planning seemed to be done with any positive feedback. One team advised they used the feedback from their service user survey to set future goals and actions but as most of the feedback is positive they have nothing to learn from it.
- 7.6. Some teams have to implement service specific standards which incorporate aspects of service user feedback, for example, Audiology Improving Quality in Physiological Services, but it’s often unclear how the results of the feedback are used.

- 7.7. Some teams advised they just assumed any issues from feedback were taken up by higher management.
- 7.8. Few teams, other than some Community Mental Health Teams who have the already well-documented relationship with Dorset Mental Health Forum, involved service users in designing action plans developed from feedback. Some examples, though:
- 6 Users of the Leg Ulcer service helped design a survey.
  - 6 The Shaftesbury Intermediate Care Better Balance Group were involved in planning follow-up support and service users are invited to meetings where action from feedback is discussed.
  - 6 Tissue Viability service users helped design new service leaflets.
  - 6 Child & Adolescent Mental Health Delphwood service users choose a new name for a service due to feedback received.
  - 6 The Community Pain service involved service users through their volunteers steering group.
  - 6 Community Mental Health (Adult) Christchurch & Southbourne advised that service users can be involved in shared learning sessions at Bournemouth University and some co-facilitate certain groups.
- 7.9. Many teams were not sharing results of local surveys and/or any action plans resulting from them with the Patient Experience & Complaints Team.
- 7.10. Some teams advised service user feedback can inform staff training but how this was evidenced is unclear.
- 7.11. Feedback from service users is not consistently shared with all team members.
- 7.12. Some teams were sharing feedback with other organisations such as the Care Quality Commission (CQC).

- 7.13. Community Mental Health (Adult) Wimborne advised their carers workers worked with Rethink on events and shared feedback.
- 7.14. It was often unclear how service users and members of the public are informed of how feedback is being used and what changes have been made as a result. Some areas used “You Said, We Did” boards but often only displaying Friends & Family Test results.
- 7.15. Some teams advised that they did share service user feedback and results of actions taken internally across the Trust (often informally).
- 7.16. A staff member from Bournemouth Learning Disability attends the clinical leads meeting where feedback themes are discussed.
- 7.17. Team leaders from the 10 Intermediate Care Teams meet to standardise service specific questionnaires. Team leaders from Physiotherapy also meet monthly and share good practice.
- 7.18. Child & Adolescent Mental Health teams share across teams.
- 7.19. Community Hospital Matrons meet monthly and quarterly where they may share feedback but more informally than formally.
- 7.20. Poole Learning Disability use various forums to share and escalate issues and also input to framework provider reviews and evaluations.
- 7.21. The Matron at Yeatman shares relevant service user feedback with service leads where appropriate.
- 7.22. Some teams did not share more widely as they feel very service specific actions would not be relevant to other areas.

7.23. Many teams expressed interest in being given more opportunity to share and learn from service user feedback, not just about clinical issues, across the Trust. One team said, “we don’t often get to hear what’s happening outside our own directorate”. Other teams said it’s hard to know who’s done what and where and many teams felt they tended to work in isolation and sharing was not a priority. A very few teams mentioned Quality Matters and weekly communication emails.

7.24. Health Visitors (Poole) advised that they are currently reviewing ways to present feedback results back to service users.

## Summary

Overall, we found a lack of consistency in action planning from engagement work. Linking feedback to actions is piecemeal (that is not to say that there are no pockets of good practice) and the ability to audit and evaluate how service user feedback is ultimately influencing service change is therefore difficult, if not impossible, in some areas. Sharing results and actions from engagement and involvement (both internally and externally) also appears piecemeal and therefore difficult to trace and audit.

In the NHS Staff Survey 2016 95% of staff said patient/service user experience feedback was collected in their directorate, but in response to the question “I receive regular updates on patient/service user experience feedback” only 59% said “Yes”. In response to the question “Feedback from patients/service users is used to make informed decisions within my directorate/department” only 54% of staff said “Yes”.

## Points for Discussion

### Points for Discussion

We found very few examples of how service changes, or the impact of changes is monitored and evaluated. Will work already mentioned in 32, 33 and 34 review this?

People who give feedback need to know what happens with it and what difference it makes. The Trust is already aware it needs to do more on this issue but can more be made of working with third sector organisations to disseminate information?

Can more be done to share negative feedback publicly (for example #feedbackfriday) where the Trust can show, as a learning organisation, actions have been taken to change services and make improvements? (We have already mentioned this under Discussion Points for Friends & Family Test but it is also relevant to this theme).

Incremental service changes (those small things that happen as part “of the day job”) often go unrecorded. Over time a service can change quite substantially. How can the Trust monitor and evaluate this? (Possibly undertake a “benchmark” process mapping exercise which can then be repeated annually to identify changes.)

Many teams were unaware they could share action plans on Gather. When is further training scheduled?

Teams felt that there was nothing to learn from positive feedback, no action taken and often does not even get recorded. Positive feedback has huge potential to promote staff motivation as well as to analyse services and gain insights into team and organisational strengths. Those strengths (and the reasons behind them) can be shared with areas that may be finding it more difficult to make service improvements. How can the Trust encourage teams to make better use of positive feedback?

## 8. Barriers encountered in collecting feedback

- 8.1. Many teams said time and resources was an issue, with comments such as “we have no time to do anything but the day job”. Some teams had good ideas for engaging but felt they had no time to implement them. However, at least one team had found time to undertake phone interviews with service users.
- 8.2. Some teams said their services are often seen to be “embarrassing” and it is harder to get feedback from service users.
- 8.3. Some teams felt there were “lots of hoops to jump through” to get anything changed so what’s the point in asking for feedback that you cannot do anything with? Changes that may need to be escalated to higher management often take a long time to be agreed.
- 8.4. Many teams felt that the Friends & Family Test was not appropriate for their service user group (those with little or no IT skills, very vulnerable and elderly people and those with communication difficulties). Relying on families, carers etc to give feedback on behalf of a service user is potentially biased and not necessarily reflective of the service user view.
- 8.5. Not being able to send a stamped, addressed envelope with surveys/Friends & Family Test etc. potentially reduces response rates.
- 8.6. Frequent service users are more reluctant to give feedback as they may feel it will compromise future care, especially if anonymity cannot be assured. Teams said service users can feel “bullied”.

- 8.7. Some teams said collecting feedback can get “lost in the host of other things we have to do, it’s one more thing or piece of paper to remember to take with you”.
- 8.8. Teams said service users often give negative feedback about things the team feel they have no control over (e.g. car parking, availability of a certain medication).
- 8.9. Many teams said IT systems were often a barrier (mainly in general and not specifically to engagement work).
- 8.10. Some teams said service users are often using services because they have no choice, which can elicit negative feedback even though the service may be excellent. Many service users struggle with “endings” so are even less likely to want to reflect and feedback.
- 8.11. It’s often difficult to get feedback from service users in “the middle ground” - those that are neither happy nor unhappy.
- 8.12. Many teams found it difficult to decide when is the best time to ask for feedback. Service users can have lots of frustration about delays between assessment and treatment so if asked for feedback at this stage it may elicit more negative comments. This could be both an advantage and a disadvantage. An advantage in that it would potentially show where more resources are needed in the service, and a disadvantage in that the service user may be overall pleased with the service if they had been asked for feedback at the end of the pathway, so results could be biased.
- 8.13. Teams working with children, families, schools and other organisations such as social care may be unclear who to ask feedback from and about what.

- 8.14. Teams felt if feedback forms are given to service users in waiting and reception rooms their feedback could be biased by the surroundings and environment.
- 8.15. Some service users, for example those that may “pop in and out of Minor Injuries Unit in less than 15 mins”, are unlikely to be able to provide useful feedback. Maybe survey those who have a follow-up instead.
- 8.16. One team advised that if you send out a survey too close to Christmas, for example, you will likely get a low response.
- 8.17. Other teams commented that if a survey is only sent out on discharge you will never get feedback from people who are never likely to be discharged e.g. some service users with leg ulcers.
- 8.18. There’s an emphasis on getting higher response rates for the Friends & Family Test but patients have a right to refuse. Some staff feel “bullied by the Trust to bully patients into responding”.
- 8.19. Some of the Clinical Commissioning Group (CCG) targets are only about healing rates and there’s nothing about quality of life. It’s a missed opportunity - many teams make a big difference to service user quality of life (Leg Ulcer, Community Pain) which helps prevent further use of NHS resources but teams felt no one seems interested in this as a measure.
- 8.20. Teams advised that service users of integrated teams may not understand which part of the team (health or social care) they are commenting about - analysis that also doesn’t take this into account can bias results. Some service users, often those of Community Mental Health services, often have issues with housing and benefits and their negative (or positive) feelings about those services can be reflected in any survey they are

asked to complete (or any feedback they are asked to give) so feedback may not be about the service that has requested it.

- 8.21. Multiple service users get inundated with requests for feedback - they get “survey fatigue”.
- 8.22. Some teams felt that the Trust has “a big push for everything to be online” but it is not always right for certain service user groups.
- 8.23. 24/7 carers do not see completing feedback forms as a priority.
- 8.24. Teams do not want to be “bogged down” by process and procedure which may stifle creativity.
- 8.25. One team said that they want to undertake a service user event in the spring but will have to battle to get funding and will have to complete a time-consuming business case.
- 8.26. Some teams said they tend to hear from those that shout loudest. Poole Learning Disability advised that it is often the more able service users who are involved in committees and talks. Those with more profound difficulties are often isolated and unheard. This was also echoed by the Diabetes Nursing team who said service users who get involved are already engaged well with services and it is the disengaged service users who need to be heard and involved.  
*Note: NHS Dorset Clinical Commissioning Group is undertaking a review of this service and there will be a patient engagement stream.*
- 8.27. Feedback is often outcome-driven and not about the manner or professionalism of the service.
- 8.28. Some teams felt that they need to make service users more aware of what to expect from services, so that they don’t have unrealistic expectations and their subsequent feedback is therefore not “tainted”.

- 8.29. Small team size restricts innovation - “we struggle to do the day job”.
- 8.30. Some teams said lack of administration staff prevented them doing more engagement work. Teams still feel there is an east/west divide in what teams do and the amount of support they receive.
- 8.31. One team member said, “there’s always budget constraints and this has become the way we think - it stops us being innovative”.
- 8.32. Teams often felt frustrated when nothing is done with the feedback: “there’s no point in doing it. It can become “sterile, meaningless, and competitive”.
- 8.33. One team said “at a team leader meeting it was really highlighted how differently we work across teams, even those doing the same jobs. Some teams are integrated, and some aren’t. It doesn’t make life any easier in terms of sharing good practice!”

## Summary

Most teams saw engagement and involvement work as a very low priority, even though many understood and acknowledged its importance. Where issues were raised that were seen to be “out of our control” there was little forward thinking in terms of, for example, the more feedback received on that issue the more likely something could be done (even to the extent of influencing commissioners). Every team we interviewed said they had no budget for engagement work (as far as was known).

## Points for Discussion

### Points for Discussion

Is there any budget for engagement and involvement work available at team level?

As already mentioned in previous discussion points, can the Trust provide more support and training in engagement work to help teams understand what they want to get out of gathering feedback and thus the best time to ask for it?

Reduce feedback for feedback's sake. One team had been told to collect feedback at initial service user contact but they felt this is the wrong time for that service user group.

## 9. What teams feel makes for effective engagement

- 9.1. More staff and time to spend with service users.
- 9.2. More information about services so service users know what to expect.
- 9.3. Someone independent asking for feedback rather than staff, so that service users feel they can be honest.
- 9.4. Ask at the right time for the service user and for the specific issue.
- 9.5. Some teams can't use comment boxes or tablets as they don't work out of premises as such. The question was raised "can tablets be taken out into the community?".
- 9.6. For many service users it is best to capture feedback verbally.
- 9.7. Incentives can help get more feedback.

- 9.8. Be more creative to get feedback from children and young people.
- 9.9. Engagement methods need to be asphasia-friendly. Speech & Language teams said more could be done with Talking Mats given time and budget.
- 9.10. Many teams said face-to-face engagement worked best for their service user group (a scoping exercise undertaken by the Community Mental Health (Adult) Poole North team in 2016 had provided a wealth of feedback from face-to-face interviews outside of Trust premises but it was a big investment in time).
- 9.11. We have not added a Summary and Points for Discussion for this section as most of the issues have already been incorporated into other Summaries.

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## Ideas from staff for service user engagement and involvement projects

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The ideas listed below were generated during our interviews with teams. It may be possible to pilot some, if not all, of these to help implement and “test out” some of the Discussion Points and recommendations documented in this report, to help and support teams to scope out their ideas, develop actions and design methods to gain service user involvement and feedback using co-design and co-production and track, monitor and evaluate impacts.

- **Continance Service** - re-implement the Quality of Life questionnaire.
- **Continance Service** - develop a forum for parents of children with continence issues.
- **Bournemouth Learning Disability** - used to have a “lessons learned” booklet to share good practice from feedback - no longer used. Develop something on these lines again?
- **Bournemouth Intermediate Care** - service users need to understand what the team does, so that they can give feedback based on a realistic

understanding of the limitations of the service. We experience lots of misunderstandings and unrealistic expectations which means things often start off on the wrong foot - patients / families / carers can be disappointed that they aren't getting the service they had been promised by whoever has made the referral. Whoever makes the referrals needs to know what we do - how can we do this?

- 6 **Shaftesbury Intermediate Care** - maybe one of the team could spend a day a month out of uniform visiting service users to get feedback.
- 6 **Child & Adolescent Mental Health Bournemouth & Christchurch** - we need a more creative and accessible way of engaging with children and young people (note from author - this may be an ideal opportunity for teams such as School Nursing, Nursery Nurses etc to work on something across teams). We'd like to do more peer mentorship and use tablets and iPads for feedback. Maybe once a quarter we could phone a selection of other colleagues patients (for independence) and maybe 6 months after intervention to see what impact it's had.
- 6 **Child & Adolescent Mental Health Delphwood** - we feel like we have lots of ideas but no space or time to implement them. We are conscious our service often gets bad press. Maybe we can develop our Experts by Experience to act as ambassadors. We also need to look at service user expectations, how to celebrate our successes better and how the remit of our service is better communicated to schools, GPs etc
- 6 **Physiotherapy Blandford** - one of the team members worked with a Learning Disability team - they have great ways of communicating about falls which could be really useful in our area.
- 6 **Leg Ulcer Service** - targets from the Clinical Commissioning Group are only about healing rates. There's nothing about quality of life. We can make a huge difference to service user's lives (and prevent people being frequent service users). Is there some way we can work with the commissioner to reflect this in targets?
- 6 **Leg Ulcer Service** - We would like some kind of after clinic - like a maintenance clinic - where service users can come if they are worried

about something. Rather than them treating themselves they can come and ask for advice etc. outside of the actual clinic. There was a support group but it was poorly attended - service users weren't getting anything for their actual legs i.e. not having anything physical done - so they weren't that interested - a combo would be better. There is a LEG CLUB - copyrighted - runs in places like church halls but that raises issues as well about infection control. We think we could run a group with a Healthcare Assistant and with volunteers maybe. This would help reduce re-admissions - service users are discharged with a maintenance plan but many are back in the clinic because they go back to the GP with problems and get referred back to us.

- **Intermediate Care Dementia (West)** - we would really like a Champion for engagement work.
- **Community Mental Health Team (Adult) Poole North** - we would really like some support on knowing what to do with the feedback we get and translating that into service improvements. It's hard to know who does what and where at the moment. There was talk of developing some kind of central forum to share - is this going ahead?
- **Community Mental Health (Older People) Blandford & Shaftesbury** - we would like to make letters more "patient friendly". It's hard to convince other teams to "de-medicalise" letters. (Note from author - this is an idea generated by the consultant - on interviewing Chair of the Executive Quality & Risk Committee we noted that a piece of work has just been carried out asking 368 service users about the letters they receive).
- **Wimborne Hospital** - many people are here for rehabilitation and are often bored sat around. In St. Leonard's the "Friends" funded an activity based co-ordinator so we are asking our "Friends" if this is something we can do. Maybe it's something that all the community hospitals could benefit from and it would also be a good way of getting patient feedback.

- 6 **District Nursing (Poole)** - maybe we can put a Friends & Family form in the Welcome Pack and it could then be returned anonymously but it would be better if we can also offer some kind of incentive.
- 6 **School Nursing (Mid Dorset)** - we feel more publicity about what we do would be good. We are very much like a hidden service - even GPs aren't aware of what we can do! We'd also really like to be able to use iPads to get feedback after sessions, children and young people are so used to using this kind of technology.

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## Initial SWOT Analysis

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STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"><li>• Commitment to involvement from top of the organisation</li><li>• Wide range of engagement activities across Trust</li><li>• Dedicated staff to promote and co-ordinate engagement activities</li><li>• Awards and recognition of good practice</li><li>• Some well-established partnerships with voluntary sector/advocacy groups and other stakeholders</li><li>• Willingness for Patient Experience and Public Engagement personnel to work together</li></ul>	<ul style="list-style-type: none"><li>• Large number of dispersed teams, many undertaking the same role but not effectively sharing and learning.</li><li>• Lack of clarity at local level about what all the HQ teams are doing</li><li>• Different teams responsible for coordinating engagement activity - risk of duplication</li><li>• Lack of understanding of the effectiveness of different engagement activities not always clear and what are the key factors in success</li><li>• Little evidence of joint approaches to collecting feedback between teams</li><li>• No agreed processes for handling conflict in the engagement activities</li><li>• Staff who feel they have insufficient time to report patient experience data</li><li>• Lack of training for staff in engagement methods</li></ul>

## OPPORTUNITIES

- Development of “co-design” and “co-production” across all teams.

## THREATS

- Management reorganisation disrupting communication links
- Engagement “overload” for service users reducing quality feedback received.

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## Appendix 1 - Examples of changes to services due to feedback received

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Examples noted in Trust documents reviewed in Phase 1.

- More therapy staff recruited at St Leonard's hospital and procurement of new wheelchairs.
- The number of ECG slots increased at Shelley Road and waiting times reduced.
- Winterborne hospital - An increase in pre-op patient information about procedures and more discussion about procedures with patients on admission and pre-op.
- The Intensive Support Team West (Learning Disability) ensure patients have all appropriate phone numbers for support.
- The multidisciplinary falls project continuing in the long-term conditions service.
- Space for Growth at St Ann's - raised bed gardening introduced through the "Dragon's Den" initiative (included patient feedback and involvement).

Examples noted during Phase 2 interviews:

Note - Some of these examples have already been recorded in various Patient Experience & Complaints Team reports.

- Changes to Audiology clinic environment at Shelley Road. Also many patients wait a long time at the walk-in repair service. The team are changing 1 session which will be specifically for service users that work.
- The Continence service are setting up an electronic system to reduce the wait for pads.
- Service users of the Shaftesbury Intermediate Care team said they weren't sure who had visited them because many staff were tucking their ID lanyards into clothes. Staff now wear clip on ID badges

instead. A relative advised they were unhappy with the amount of therapy their relative received in a care home. The team discussed the concerns and visited the home, spoke to staff, Patient Advice & Liaison Service and Dorset Advocacy, made changes and feedback to the relative. Service users of the Better Balance Group advised they wanted to try exercises they can do after the groups end. The team arranged a Tai Chi instructor to do a session and now service users can continue with it independently should they wish.

- Young service users of Child & Adolescent Mental Health (Delphwood) did not like the name of a service so the team asked for their suggestions and it has been changed from “Preparation for Change” to “Thinking Differently”.
- Service users at Blandford Physiotherapy said they had been waiting over 15 mins for appointments but an audit suggested otherwise. The team put notices at reception asking patients to let staff know if they had waiting that long.
- Staff at the Leg Ulcer service worked with Ezeq patient transport service to change routines and timings so service users had less waiting around (patient with diabetes were sometimes picked up late effecting their condition and sometimes the clinic had closed at 5pm but service users were still waiting for pick-up).
- Dermatology service users had been involved in adapting and modifying patient leaflets.
- The Diabetes North (West) team undertook more study days to cover more disengaged service users in the north of the county.
- A service user of the Community Mental Health (Older People) Dorchester service co-presented with staff to the Clinical Commissioning Group about the benefits of a carers groups. They are now planning to commission groups on the same model. This team also support service users to input to dementia review meetings and workshops.

- The School Nursing team (Mid Dorset) now go to schools to give booster immunisations as it is easier for children using wheelchairs (rather than them attending clinic).

## Appendix 2 - List of teams interviewed in Phase 2

Swanage MIU	Wimborne MIU	District Nursing North Dorset 2 (Blandford)
District Nursing North Dorset 1 (Gillingham)	District Nursing (Canford Health & Birchwood)	Community Matrons (Mid Dorchester)
Community Matrons East Dorset	School Nursing Mid Dorset	Tissue Viability Service Pan Dorset
Community Matrons (Bournemouth Central)	Health Visitors Poole Bay	Health Visitors Weymouth & Portland
District Nursing Herbert Avenue (now merged with Heatherview)	Intermediate Care for Dementia (Weymouth Community Hospital)	Intermediate Care (Bridport)
Intermediate Care Shaftesbury ICRT (Westminster Memorial Hosp)	Intermediate Care Bournemouth	Audiology
CMHT (Older People) Dorchester	CMHT (Adult) Poole North, Central, West (Alderney)	CMHT (Adult) Wimborne
CMHT (Older People) Blandford & Shaftesbury	CMHT (Adult) Christchurch & Southbourne	Orthotics

Dorset Bladder & Bowel Continence Service	Dermatology	The Willows (inc. other areas of Yeatman)
CAMHS (Delphwood)	CAMHS (Bournemouth & Christchurch)	Podiatry
Poole Community LD	Bournemouth Community LD	Complex Leg Ulcer Boscombe
Speech & Language Adult Poole	Diabetes Nursing (West)	Community Persistent Pain Service
Physiotherapy Blandford Hospital	Physiotherapy Weymouth & Portland	

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## Appendix 3 - Comments from teams taken from the survey carried out by the Trust's Patient Experience & Complaints Team

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- 6 Comment from Addictions Clinical Psychology Service:

It would be helpful as teams to have some clarity about who wants what from where. It would appear there are definitely a number of teams/people asking for feedback on satisfaction/compliments/complaints etc. which can be confusing and time consuming. Therefore, if there are any changes (in terms of what is expected to be submitted and to who) then this needs a proper launch so that teams can start afresh, otherwise we could just end up doubling up sending in various information. I am not clear from the above box whether we are now to be submitting information to your team or whether you will be collecting data from the other places this is submitted to (e.g. Friends and Family/Complaints/customer Services team etc. I hope this makes sense and look forward to hearing from you.
- 6 Community Nursing Team

Within District Nursing a lot of verbal feedback will be missed as there has not been a reporting system for this also the teams are busy with a lot of patient documentation they will not have time to also have to do more documentation for this so it potentially will not be completed.
- 6 Community Mental Health Services

We often struggle with the time allowed to meet the need of recording clinical data let alone compliments, so quickly and with minimum fuss.
- 6 Community Mental Health Team (Adults) Southbourne and Christchurch

Can someone help us get this started properly please? I have been TL for 2 years now and have spent a large amount of time putting processes in to help deliver the service, it is now time to look at how to be better at recording feedback. Sorry it has taken so long.

- 6 Community Parkinson's disease Nurse (East)

Unfortunately I am a one-man band so I have not carried out any surveys as you requested. I am unable to supply you with any information. I do the Friends and Family test.
- 6 Learning Disability Team and others

They might get better feedback from Friends and Family Test if the reply forms were postage paid. It would be helpful to have space on the Friends and Family Test form for people to put contact details so they could meet with the service users to sort out some issues locally.
- 6 Weymouth Urgent Care Centre

When can we have a texting system for Friends and Family feedback like they have at DCH?
- 6 Assertive Outreach Weymouth

Most service users are chaotic, and needs driven and reluctant to offer feedback
- 6 Intermediate Care Poole

It would be good to know who sees the feedback - is this escalated to managers above us?
- 6 Intermediate Care St Leonard's

It would be good to record feedback once - seems to be recorded 3 times in various places
- 6 Yeatman Minor Injuries Unit

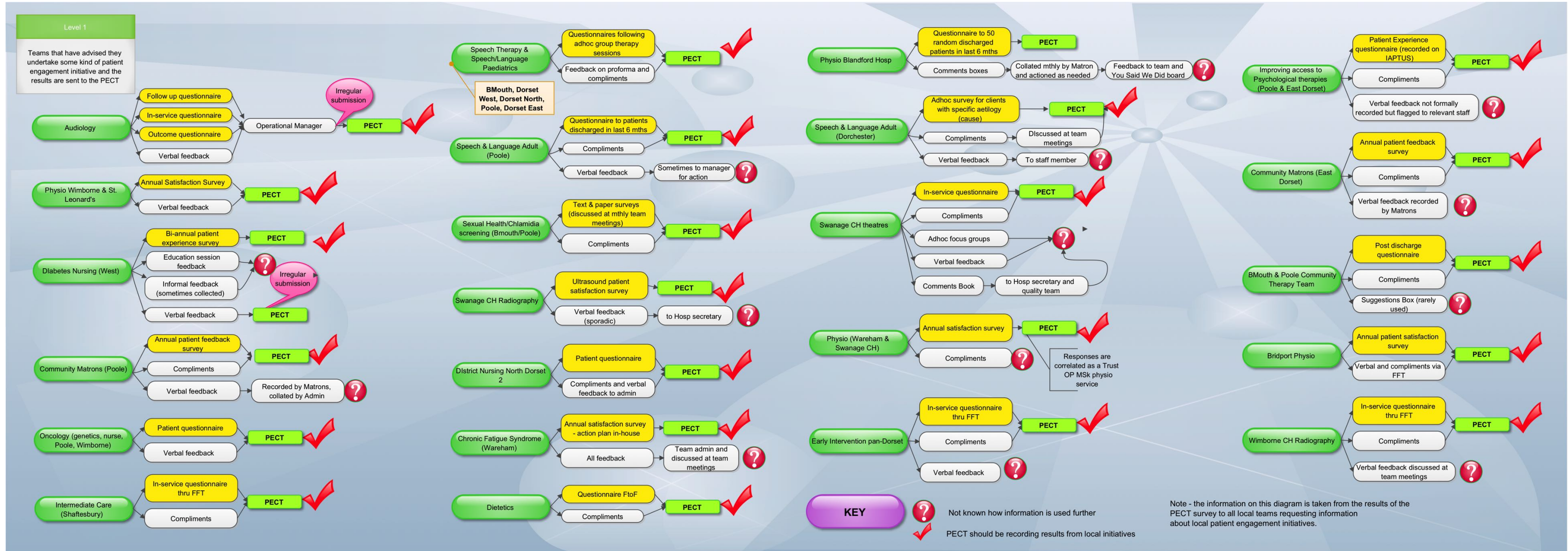
Feels like this has turned into an industry - staff on the shop floor don't have time to collect, collate and submit information over and above what they already do
- 6 Learning Disability Psychiatry Poole

People with a LD and MH difficulties can sometimes be bombarded with questionnaires from various support agencies as they often use multiple services
- 6 General comments
- 6 Patients are bombarded by requests for feedback
- 6 It's hard to get high FFT response rates

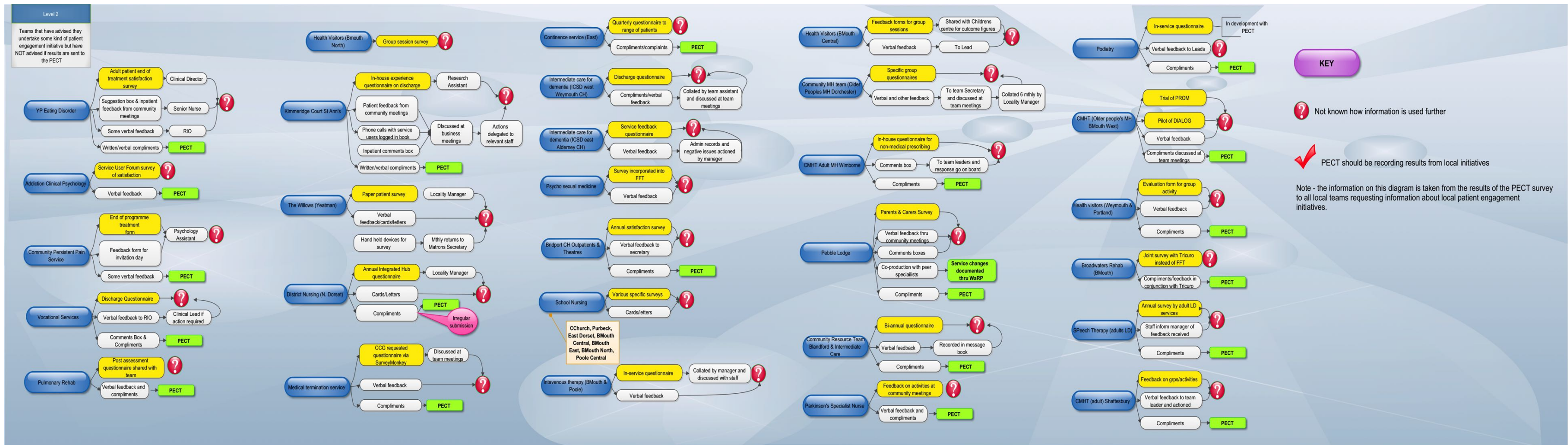
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- 6 Patients in very sensitive services are reluctant to provide feedback
  - 6 Needs to be less frequent but more meaningful
  - 6 We need guidance for collating data, consistent recording templates and methodologies
  - 6 Help for developing survey questions is needed
  - 6 Patient using multiple services are bombarded with FFT
  - 6 Patients in care homes find it hard to engage and staff rarely feedback
  - 6 Some of our service patient feedback goes through other organisations such as NHS111
  - 6 The FFT questions don't feel relevant to some services
  - 6 Could we have monthly prompts from the PECT
  - 6 Too many forms hidden in badly indexed places
  - 6 Patient can't give honest feedback on FFT if the practitioner is in the same room when they are given the survey
  - 6 Elderly patients get confused by FFT
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# Appendix 4 - Roadmaps of local team engagement activity

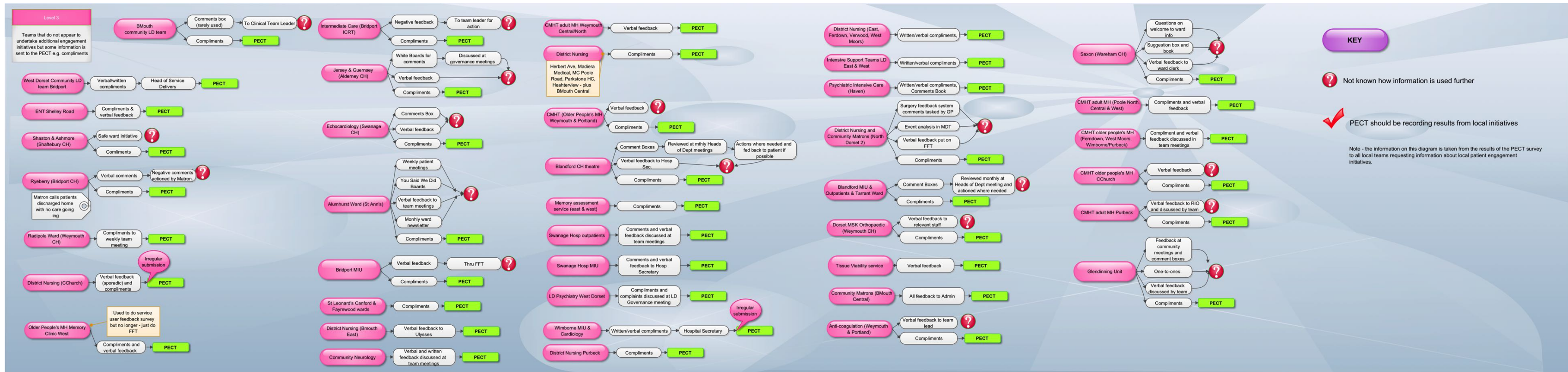
## Level 1

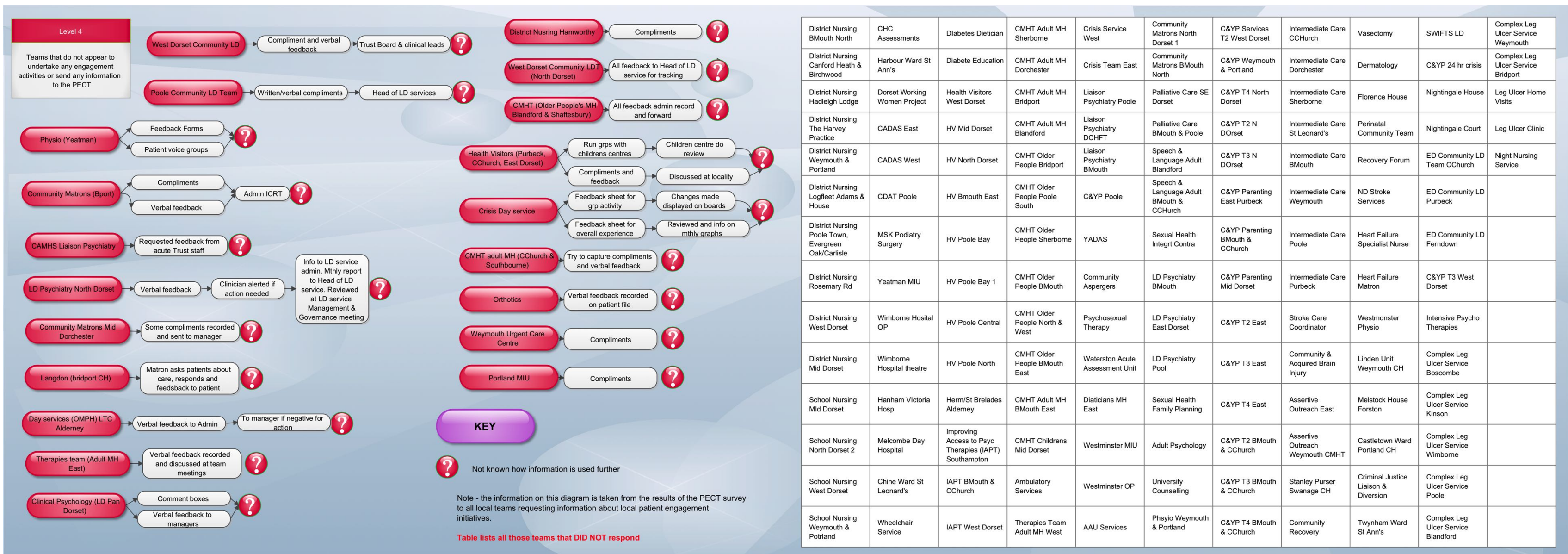


Level 2



Level 3





District Nursing Bmouth North	CHC Assessments	Diabetes Dietician	CMHT Adult MH Sherborne	Crisis Service West	Community Matrons North Dorset 1	C&YP Services T2 West Dorset	Intermediate Care CChurch	Vasectomy	SWIFTS LD	Complex Leg Ulcer Service Weymouth
District Nursing Canford Heath & Birchwood	Harbour Ward St Ann's	Diabete Education	CMHT Adult MH Dorchester	Crisis Team East	Community Matrons Bmouth North	C&YP Weymouth & Portland	Intermediate Care Dorchester	Dermatology	C&YP 24 hr crisis	Complex Leg Ulcer Service Bridport
District Nursing Hadleigh Lodge	Dorset Working Women Project	Health Visitors West Dorset	CMHT Adult MH Bridport	Liaison Psychiatry Poole	Palliative Care SE Dorset	C&YP T4 North Dorset	Intermediate Care Sherborne	Florence House	Nightingale House	Leg Ulcer Home Visits
District Nursing The Harvey Practice	CADAS East	HV Mid Dorset	CMHT Adult MH Blandford	Liaison Psychiatry DCHFT	Palliative Care Bmouth & Poole	C&YP T2 N Dorset	Intermediate Care St Leonard's	Perinatal Community Team	Nightingale Court	Leg Ulcer Clinic
District Nursing Weymouth & Portland	CADAS West	HV North Dorset	CMHT Older People Bridport	Liaison Psychiatry Bmouth	Speech & Language Adult Blandford	C&YP T3 N Dorset	Intermediate Care Bmouth	Recovery Forum	ED Community LD Team CChurch	Night Nursing Service
District Nursing Logfleet Adams & House	CDAT Poole	HV Bmouth East	CMHT Older People Poole South	C&YP Poole	Speech & Language Adult Bmouth & CChurch	C&YP Parenting East Purbeck	Intermediate Care Weymouth	ND Stroke Services	ED Community LD Purbeck	
District Nursing Poole Town, Evergreen Oak/Carlisle	MSK Podiatry Surgery	HV Poole Bay	CMHT Older People Sherborne	YADAS	Sexual Health Integrt Contra	C&YP Parenting Bmouth & CChurch	Intermediate Care Poole	Heart Failure Specialist Nurse	ED Community LD Ferndown	
District Nursing Rosemary Rd	Yeatman MIU	HV Poole Bay 1	CMHT Older People Bmouth	Community Aspergers	LD Psychiatry Bmouth	C&YP Parenting Mid Dorset	Intermediate Care Purbeck	Heart Failure Matron	C&YP T3 West Dorset	
District Nursing West Dorset	Wimbome Hosital OP	HV Poole Central	CMHT Older People North & West	Psychosexual Therapy	LD Psychiatry East Dorset	C&YP T2 East	Stroke Care Coordinator	Westmonster Physio	Intensive Psycho Therapies	
District Nursing Mid Dorset	Wimbome Hospital theatre	HV Poole North	CMHT Older People Bmouth East	Waterston Acute Assessment Unit	LD Psychiatry Pool	C&YP T3 East	Community & Acquired Brain Injury	Linden Unit Weymouth CH	Complex Leg Ulcer Service Boscombe	
School Nursing Mid Dorset	Hanham Victoria Hosp	Herm/St Brelades Alderney	CMHT Adult MH Bmouth East	Diaticians MH East	Sexual Health Family Planning	C&YP T4 East	Assertive Outreach East	Melstock House Forston	Complex Leg Ulcer Service Kinson	
School Nursing North Dorset 2	Melcombe Day Hospital	Improving Access to Psyc Therapies (IAPT) Southampton	CMHT Childrens Mid Dorset	Westminster MIU	Adult Psychology	C&YP T2 Bmouth & CChurch	Assertive Outreach Weymouth CMHT	Castletown Ward Portland CH	Complex Leg Ulcer Service Wimborne	
School Nursing West Dorset	Chine Ward St Leonard's	IAPT Bmouth & CChurch	Ambulatory Services	Westminster OP	University Counselling	C&YP T3 Bmouth & CChurch	Stanley Purser Swanage CH	Criminal Justice Liaison & Diversion	Complex Leg Ulcer Service Poole	
School Nursing Weymouth & Potriand	Wheelchair Service	IAPT West Dorset	Therapies Team Adult MH West	AAU Services	Physio Weymouth & Portland	C&YP T4 Bmouth & CChurch	Community Recovery	Twynham Ward St Ann's	Complex Leg Ulcer Service Blandford	