Front Sheet: Public Board of Directors
Item number: 12
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Private/ public paper:	Public
Report Title:	**Lived experience report**
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Presented by:	Dr Caroline Johnson, Executive director of nursing, quality and professions
Vision and values:	This item supports the trust vision through **working with** and advocating for the local population and work towards **continuous improvement of services**. All the trust values are reflected in the work in this report but in particular **everyone counts** as often the work is focusing on the most marginalised in communities. This item supports **working together for service users** in ensuring we hear, understand and improve experiences
Purpose and key actions:	This report provides a summary of the last six months of **engagement, experience and peer support work** undertaken within the Trust. The report highlights **progress against the service user and experience strategy** objectives for this year with a focus on feedback and communications. The report also provides an **update on the work delivered on the carers strategy, the Patient and Carer Race Equality Framework (PCREF) and our volunteers and lived experience workforce.** The work in the report is overseen by the Lived Experience and Co-production Assurance Group (LECAG).
Executive summary:	Three highest areas of importance from the paper are: **Feedback including friends and family test (FFT)**. The report details the return rate of FFT which continues to be well below the average for a mental health trust of a size. There is also an absence of collation of feedback collected across services, which has led to service users not knowing the impact or value of this feedback. **Recruitment of experts by experience and volunteers**. The report highlights the concerns related to onboarding of experts by experience and volunteers and the recovery plan to address this. **Patient and Carer Race Equality Framework (PCREF).** The PCREF evaluation is due to be completed in March 2025, there has been progress made however a number of milestones are required to be reached to complete the evaluation in the timeframe. Appendices: Appendix one: patient feedback improvement plan Appendix two: engagement and communication strategy objectives actions from communications team for communication and engagement strategy

Which strategic objective does the item primarily contribute to:					
Effective Use of Resources	*Yes*		*No*	X	
Deliver Outstanding Care	*Yes*		*No*	X	
Great Place to Work	*Yes*	X	*No*		
Ensuring our services are inclusive	*Yes*	X	*No*		

What is the contribution to the delivery of standards, legal obligations and/or wider system and partnership working.

- Standards relates to CQC regulations under Health and Social Care Act, Equalities Act, Use of Force Act, Human Rights Act.
- Delivering on Patient Care Race Equity Framework, working in partnership to address health inequalities

BAF and corporate risk/s:	Directorate risk register: 5407 Risk that volunteers and experts by experience are working across the Trust without required DBS and employment checks and mandatory training BAF 0025b - There is a risk of failure to deliver the therapeutic environments programme at the required pace caused by difficulty in accessing capital funds required, the revenue requirements of the programme, supply chain issues (people and materials), and capacity of skills staff to deliver works to timeframe required resulting in impact on service user safety, more restrictive care and a poor staff and service user experience. BAF 0029 - There is a risk of a delay in people accessing core mental health services caused by issues with models of care, access to beds, flow, crisis care management, and contractual issues resulting in poor experience of care and potential harm to service users.
Any background papers/ items previously considered:	The Lived experience report is received bi-annually at the public Board of Directors and the Quality Assurance committee
Recommendation:	The Trust Board is asked to: - Note for **assurance** the report and update of engagement team activity and key areas required for improvement - Note the implications of the removal of care opinion (section 2.12) - Note the change in out of area contact (section 3.3)

Lived Experience Report: July 2024- December 2024

1. Introduction

This report provides a summary of the last six months of engagement, experience and peer support work undertaken within the Trust. The report highlights progress against the service user and experience strategy objectives for this year with a focus on feedback and communications. The report also provides an update on the work delivered on the carers strategy, the Patient and Carer Race Equality Framework (PCREF) and our volunteers and lived experience workforce. The work in the report is overseen by the Lived Experience and Co-production Assurance Group (LECAG).

2. Summary of Progress against the service user and experience strategy

2.1 Progress towards milestones for 2024/2025

There are two milestones for 2024, of which there has been limited progression. Each of the objectives are updated below:

<u>2.1.1 Publish a clear and multifaceted communications plan that engages people in a variety of ways to give robust feedback</u>

There is a need for continuing development and visibility of the engagement team to support people to feel able to give feedback in different way. Work has commenced to increase the visibility of the Engagement team which is detailed below (section 2.2 and 3.2).

It has been recognised that many services and individuals within the organisation are unaware of the Engagement and Experience team and what function and support it can provide. Across the organisation there is a need for increased visibility of the engagement team and to raise the awareness of the roles and responsibilities of the team and how they can add value. This will support engaging both teams and service users in giving feedback.

There are two plans in place to address patient feedback which are referred to later in the report (section 2.2, 2.3, appendices 1 and 2). Delivering these plans will lead to an improvement in engagement team visibility and impact.

In addition, the Peer Support lead who has recently taken over responsibility of leading the team is developing a communications plan which will be outlined in subsequent reports to the Quality Assurance Committee once approved by LECAG.

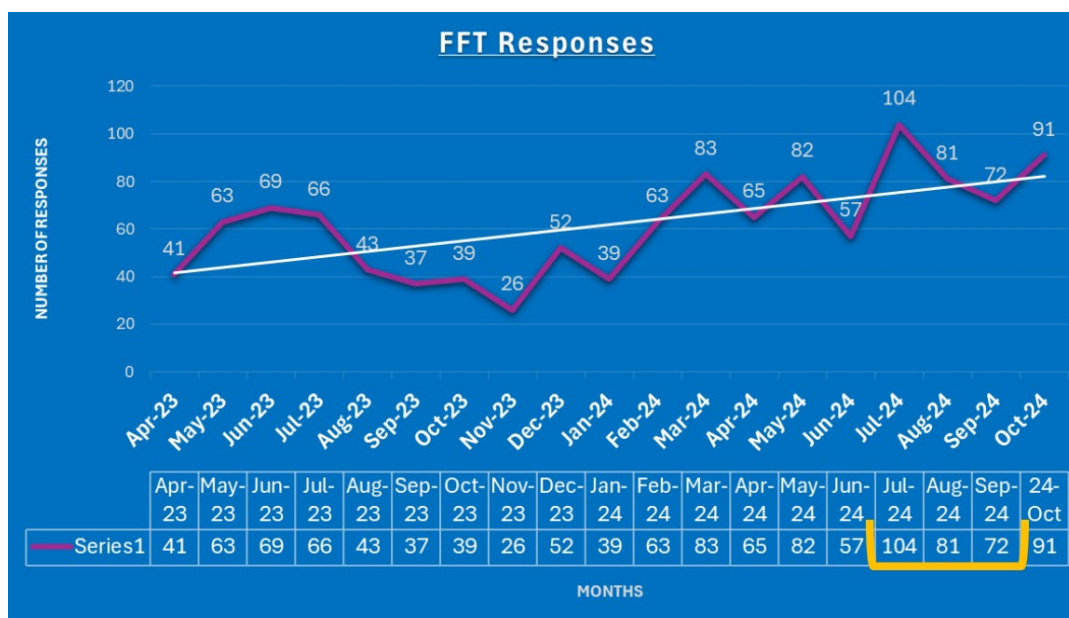<u>2.12 Grow Friends and Family Test (FFT) responses, incorporate Safe2Share into trust experience reporting</u>

Friends and Family Test

Service user, carer and friends and family feedback are integral to improving and delivering outstanding care. We need to have the service user voice and experience at the centre of all we do at SHSC.

Collection, collation and dissemination of feedback ensures we live our trust values of working together for our service users, everyone counts, commitment to quality and improving lives. The risk currently is that our feedback response and data is low, therefore as a result we are not capturing experience.

An example of this is the Friends and Family test, on reviewing data collected over selected points the FFT response for SHSC has been continually lower than mental health trusts of a similar size.

An example of this is in September 2024, we received 72 responses out of a potential 3,792. In August 2024 81 out of a potential 4012 and in April 2024 43 out of a potential 5,157. For a mental health trust of this size the expectation would be to receive between 200 and 250 FFTs per month.

FFT Responses

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	24-Oct
Series1	41	63	69	66	43	37	39	26	52	39	63	83	65	82	57	104	81	72	91

MONTHS

The FFT has now gone live on Qualtrics which provides an online way to give feedback this is accessible via QR code and marketed on Jarvis, SHSC external website, and posters circulated to services. This has not yet increased the response rate so highlights the need to improve how the engagement team share and encourage services to embed this work and understand the barriers faced.

The target remains at 200 per month as would be expected of a mental health trust of this size.

The plan to address this is in a number of ways; improved communication and visibility with community services and increased promotion of the QR code as a method for giving feedback. Circulating posters and social media posts has not had an impact on rates which demonstrates the need for conversation and engagement with teams and service managers to work collaboratively to improve the response rate.

Quality of Experience Survey

The quality of experience survey was codesigned by service users and engagement leads to understand experience on inpatient wards. The number of these responses have declined and over this reporting period there have been 38 responses.

This survey is currently being reviewed as Safe 2 Share has recommenced which collects similar data in the same area. It would be of benefit to review how we are capturing quality of experience in the community and this forms part of the feedback plan.

The themes emerging from the last six months of the quality of experience survey are:

- Care planning: Approx 50% respondents responded that they were either somewhat or not involved in care planning

- Environment: Respondents spoke positively about the ward environments as a whole and felt that they were clean, tidy and they were able to sleep well. The only environment that received negative feedback was the dining areas.

- Staff support: This domain was overwhelmingly positive, services users being able to have 1:1 time with staff featured on over 80% of responses

- Activities: Respondents were able to benefit from what was on offer and engaged in activities, but felt there was not enough activities available.

Currently engagement officers have shared the feedback with the ward manager or nurse in charge and revisited it on subsequent visits. There is a need for a wider thematic review of feedback being collated, the business and performance manager is creating a dashboard to collate this data. Dissemination of the themes and data and subsequent actions will also form part of engagement officer role.

Safe2Share

Safe 2 Share is a web-based feedback tool that allows service users, carers and families to provide feedback on their care and experiences to either drive service improvement or ensure that high quality care continues to be delivered by establishing what is done well.

The project commenced in October 2023 with the core aim of delivering a digital tool that is accessible and easy to use, allowing people to give real time feedback.

The project lead left the organisation, and a new project lead has been appointed as of December 2024, but this has meant a gap in delivery of the project. There are 10 experts by experience working on the project alongside the project lead.

28 responses have been received in total. The positive themes from the feedback were the environment, cultural needs been met, people feeling they have a say in their care and treatment and having their legal rights explained. The areas which received lower scores were regarding staff understand how illness affects me and activity availability/range

There is a clear plan created by the project lead of introducing Safe2Share across wards between January and March 2025, this will be reported to the LECAG meeting in February 2025.

Care opinion

Care opinion is no longer in use or advertised by SHSC, however as this is a public forum there are still several postings that are being made on the website. As an organisation who does not subscribe, we only have two accesses (peer support lead and deputy director of nursing), this has meant that the peer support lead is responding solely to the most recent care opinion postings.

There is a concern that this was a way to collect meaningful qualitative data and experiences from people that do not normally have the opportunity to feedback, including people on wait lists or people that have been declined from certain services. Discussion is underway to determine whether removal of Care Opinion has resulted in unintended consequences and QAC will be updated once a decision is reached.

2.2 Communications Plan

The communications plan for engagement and experience has been aligned with the trust communications and engagement strategy. The communications and engagement team have had a joint meeting to discuss the objectives in both plans and how we work collaboratively to improve communications in the

domain of engagement. The peer support lead and head of communications are now meeting monthly to progress with updates on this work.

Three key elements are to:

1. Promote opportunities for services users, those lived with experience, families and carers to co-design and co-produce services.

2. Identify and tell service user stories through internal and external channels.

3. Ensure people understand the impact of their contribution

There is also the Feedback February initiative which is being led by the engagement officers with the overall aim of 'increasing visibility and understanding of the engagement team'. There are a number of planned visits within SHSC and with VCSE services throughout the month of February with creative activities in how we improve feedback. Outcomes and evaluation of this activity will be reported through LECAG.

Another way in which communication will improve is through the feedback improvement plan (see below).

2.3 Feedback improvement plan

The feedback improvement plan (appendix one) is a 6-month plan to address immediate and medium-term concerns in relation to the lack of feedback being collected from service users, families, friends and carers.

The initial priorities are to review what feedback is being collated from services, the quality of this feedback and duplication. A lot of services have started collecting feedback, but this is not being collated clearly, fed back to service users and their families or used by services to inform quality improvement.

There is also a focus on improving process in the collection of this feedback with clear roles and responsibilities within the engagement team ensuring accountability for this. Following this a governance structure will be put in place from collection, reporting to closing feedback (Organisation & Service Level). This is identified as a key objective in both the communications and engagement and service user and engagement strategy.

There will also be an Engagement Roadshow - including supporting teams to embed experience reporting governance.

From a data perspective the strategy and quality performance manager will be working with the engagement team and services to develop process for recording data to a central location. They will also be developing an experience dashboard (integrated with Patient Safety Dashboard) alongside developing IPQR reporting on Experience.

3. Further LECAG updates

The Lived Experience and Co-production Assurance Group (LECAG) received updates in the key areas identified below.

3.1 Inpatient ward engagement

The engagement leads have continued to work into inpatient wards to support service users to share their experience of services and quality of care. 64 visits have taken place over the last six months to all inpatient services including

rehabilitation services. Relatives' meetings at Woodland View and Birch Avenue were also attended by engagement leads.

From attendance of the engagement team at relatives' meetings and based on feedback around visiting hours, it was agreed due to the confusion of visiting hours, it would be useful to create a card to give out to new residents about what happens at Woodland View and Birch Avenue. Engagement officers also informed both groups around support that is available from local charities and third sector services.

Regarding inpatient services/acute ward engagement, the engagement officers have been key in signposting service users to community services and support including practical advice and support and supporting in access activities on and off the ward.

Direct actions from the engagement work in these areas have included helping to resolve practical issues surrounding dignity, cultural needs and accessibility. The engagement leads ensured that service user feedback was taken seriously and was reported to nurse in charge and ward staff. The leads also supported in signposting service users to voluntary services and advocacy services.

3.2 Community services engagement

It was reported in the previous 6-month report that the engagement team had implemented an exit plan for engagement officers to move out of the inpatient setting and focus more on a community setting to ensure that service users in community services were heard and given the opportunity to provide feedback.

Inpatient feedback would continue to be through the cultural advocacy workers, in reach from Sheffield Flourish and Maan to these areas. There is now a monthly meeting where feedback themes are shared and there are clear lines of communication between all parties. From an SHSC perspective there is also the Safe2Share project which recommenced in December 2024 (see section 2.12)

Engagement with community services has started to increase, however the exit plan for the engagement officers from the in-patient wards has not been fully realised due to absences in leadership in recent months due to sickness. The engagement leads have visited the Tabernacle group at Northlands, Early Intervention and Sheffield Eating Disorder Services. There have been several visits to eating disorder services from the engagement leads and this will continue into the next quarter.

There is still a clear need to focus on community services, for the month of January the engagement leads are focused solely on community services. There are several areas of initial focus: North and South CMHT, Early Intervention Team Older adult CMHT and Eating Disorder Service).

An ongoing and successful piece of community engagement facilitated by one of the engagement leads is 8 hours a week of support to ACT (Aspiring Communities Together). They run weekly drop ins for Arabic speaking service users, carers and their families on Monday & Friday mornings. In these sessions practical and emotional support are provided alongside signposting and support. The Director of ACT recently met with the Peer Support lead and Executive Director of Nursing and gave very positive feedback in relation to the impact of this work within the local community, for people who would often otherwise not seek mental health support.

3.3 Out of area contact

The contact with out of area has been reviewed by the Deputy Director of Nursing and Quality, Peer Support Lead and Head of Clinical Quality, for effectiveness and purpose.

The importance of contact with service users out of area is apparent. However, a clearer process needs to be put in place to support service users out of area and to be able to both hear their experience and ensure actions are taken.

There were several issues identified from making out of area calls.

- The previous reports highlighted 'connected calls' which were often not followed by a conversation with the service user or feedback was not obtained from the service user directly

- Most of the phone calls were not with the service user but from private providers expressing dissatisfaction with SHSC input and services

- The escalation route was unclear if feedback was received, and the process was disconnected from the flow co-ordinators and out of area bed manager processes of oversight.

- Often the service users spoken to would be acutely unwell and distressed over the phone. It was identified that escalation routes were not clear as concerns were not handed over to clinicians.

- There were several hours spent trying to get hold of wards or individuals to little effect, as a result this impacted ability to get feedback in other areas.

It is recognised that being out of city is incredibly difficult for service users, families and their carers. Therefore, oversight of their care and experience is essential A dedicated post is in place to oversee out of city admissions, and only units with CQC ratings of Good or above are used, however experience of care is an important indicator of quality.

The Executive Director of Nursing is working to strengthen the approach to receiving experience of care feedback from patients and families who have received care out of city.

3.4 Culture of Care

Culture of Care Quality Improvement (Q)I programme is underway, and a lived experience lead has been recruited to ensure there is diverse representation from people with relevant lived experience and these people will form the Inpatient Reference Panel for the duration of this work. Recruitment is underway for 8-10 Experts by Experience (EbEs) to support the coproduced implementation of this work.

Culture of care will be reported and detailed through a separate report to QAC in March.

3.5 SUNRISE and SUSEG (service user involvement groups)

Due to a recent change in the engagement team the responsibility and oversight as of January 2025 for the SUN:RISE will lie with the engagement and experience leads. Attendance at this group has continued to decline over the last year and there is not a good representation of service user voice and experience.

Reviewing of the purpose and how to improve attendance of these groups has already commenced and engagement leads are confident on leading on the relaunch and development of both of these groups.

4. Summary of work on carers

4.1 Summary of progress and carers and young carers strategy

As reported in the previous report, in May 2024, Care homes, crisis teams and inpatient wards have received the first star award for stage one of the triangle care accreditation.

During Q2, several priorities have been achieved under milestone 3 of the implementation of the carers and young carers strategy particularly around embedding the Triangle of Care in service level activity.

There has been:

Rollout of introductory Triangle of Care workshops to staff within:

CMHT's, Early Intervention Service, 18-25 Transitions, Building Successful Families, Older Adults CMHT's, Memory Service and Community Dementia Support Service

Carer involvement in projects such as:

Stakeholder recruitment panels comprising of service users and carers, Carer involvement on Safe2share project, Relatives/carers attend meetings at Woodland View Forest Close and Carers Open Door Group and Co-production of Carer feedback leaflet at Forest Close

Improving carer identification through:

SHSC referrals to Sheffield Carers Centre increasing each quarter, Launch of Carers Big Count was an opportunity for teams to update service user records with consented carer information, including all protected characteristics, Early discussions with RiO Implementation Group to develop carer record.

5. Patient Carer Race Equality Framework

5.1 University of Sheffield and the mental health implementation network update

The PCREF evaluation is looking at how SHSC is implementing PCREF. This is being done through the following 4 PCREF related activities

Activity 1 - Enhanced monitoring of inpatient restrictive practice and post-incident review.

This is focussing on the work of the race equity officer from SACMHA in this domain and the work of the restrictive practice oversight groups, reducing restrictive practice, Safewards and post-incident support.

Activity 2 - Cultural advocacy on inpatient wards

This is focussed on the implementation, impact and evaluation of the cultural advocacy workers (see section 8 of report)

Activity 3 - Improving access and pathways into Care to mental health services in racialised communities.

This is focussed on the community development workers (see section 4.3)

Activity 4 - Improvement of protected characteristics data collection methods

This is reviewing the work lead by Senior Head of Service on recording of protected characteristics.

5.2 Progress against PCREF implementation Plan

The period the report relates to is July-December 2024, which is when the implementation plan should be finalised. The top 5 priorities identified with board on June 2024 for PCREF implementation where:

- Advance choice directives

- Governance Structure

- Community Development Worker

- Develop a 'how to' toolkit

- Communications plan

5.3 Community Development Workers

Three community development workers were due to be recruited through Firvale community hub from three identified community groups and was one of the top 5 priorities for the PCREF implementation. Currently these development workers have not been recruited into post, this has been due to absences in the team and lack of clarity around contracting process. This has been escalated to the accountable executive director and a meeting is in place to address this.

6. Volunteers and lived experience bank activity

6.1 Update on Recruitment Process

Following concerns raised to Freedom to Speak Up, it was found that there are a number of experts by experience and volunteers that have not gone through the correct recruitment check process and have not followed the correct onboarding procedure.

This was immediately escalated and added to the directorate risk register (risk 5407). There are several immediate steps that have taken place to ensure that volunteers and experts by experience are working safely on the wards to protect both vulnerable service users and staff: It is important to note that no incidents of concern have been reported in relation to EbE or volunteer conduct.

Current volunteers and experts by experience – The bank office are working through the current experts by experience and volunteers recruitment checks. 70% of this group have now had all documentation completed or have submitted all their documents to the bank office to be processed compared to 30% in October 2024. There are weekly meetings between bank, business and performance manager and peer lead to ensure this continues to be progressed and any outstanding documentation is chased.

Change to how recruitment checks are done moving forward- there is an improved process moving forward in which recruitment will be part of the process as with every other role. The posts will go through Trac like any other position, this will ensure all the recruitment checks are done prior to the person starting in role. Prior to November 2024 this rested with one individual with no clear oversight.

Supervision- lived experience supervision is being facilitated and offered monthly

Mandatory training – Most EbEs have not completed mandatory training. Training days are being set up for the beginning half of the year to ensure that

EbEs are able to access mandatory training and there will be an engagement team member of staff to support. In the future this will be part of the induction process.

Following of policy – The policy relating to reimbursement has not been followed, changes made to the updated policy reflect the feedback we have received about what could be improved, particularly around simpler clarity for line managers wanting to recruit EbEs. It contains a clearer check list of roles and responsibilities for managers and the engagement team is included in the policy to give clarity and ensure the EbE is paid and supported effectively.

Impact this has had on EbEs and volunteers has been significant and lead to them feeling undervalued. A number of 1:1 meetings have happened with EbEs and the peer support lead to understand the experience and learn lessons. A group session was also attended by the executive director of nursing, quality and professions with EbEs.

6.2 Feedback from volunteers and experts by experience

As highlighted at the last QAC, it is important to collect feedback from volunteers and EbEs about their experience. Since commencing in role in November 2024, the peer support lead has held a number of 1:1 meetings. There will be a feedback form created for experts by experience and volunteers which will be distributed on a 6 monthly basis and reported through LECAG. The co-production task and finish group led by two EbEs is also recommencing in the New Year.

6.3 Progress on targets

Within the previous 24 months of QAC reports there are previously reported figures of volunteers that do not align with the current picture. In July 2024, it was previously reported a figure of 43 volunteers, 10 applications, 13 successful applicants.

It is unclear where this number has come from, it is likely that the figure of volunteers and experts by experience has been amalgamated. Currently located and working we have 14 active experts by experience (3 of whom also do work as a volunteer) and an additional 7 active volunteers. Contact is being made with each of these individuals currently.

There is no clear list of information regarding experts by experience or volunteers within the organisation. This is currently being collated by the peer support lead and can be fed to the responsible executive director as soon as it is collated.

Contracted Engagement Work

7. Summary of Flourish Work

Sheffield Flourish continues to focus on the following objectives which it has achieved against during this reporting period.

Provide opportunities and links into community support for SHSC service users:

This has been achieved over the last period through continuing 10 weekly groups focused on football, gardening, music, art and poetry. They have also delivered 5 art workshops on the theme 'better connected'. They have also responded to feedback that people wanted activities in evenings and weekends and put on several one-off events to support this. They have also

started monthly sessions focussed on the benefits of mindfulness and meditation.

Provide mental health friendly communication, information and signposting for SHSC service users

They have held 16 digital inclusion sessions across inpatient wards, run community events to provide information on services available in Sheffield and distributed 3,500 mental health guides.

Support SHSC to co-produce and co-design services, policy and practice in partnership with people with lived experience of mental ill-health

In this reporting period, they have supported with Safe2Share, SHINDIG, older adults' transformation board and wellbeing taster workshop.

8. **Summary of SACMHA Work (Sheffield African Caribbean Mental Health Association)**

SACMHAs race equity officer now works within the respect and reducing restrictive practice team, his work is focused on the use and avoidance of the use of restrictive practice. Reporting for this work now goes to the least restrictive oversight group as opposed to LECAG.

The work delivered by the race equity officer in this area is a key activity in the delivery of the University of Sheffield and mental health implementation network group update (section 2.1).

9. **Summary of PMC (Pakistan Muslim Centre) work**

The PMC 'Being there' project continues on SHSC inpatient wards, the aim of this project is to offer culturally sensitive and inclusive mental health support, addressing the unique needs related to language, culture, and religion for inpatients at SHSC.

This project is led by two cultural advocacy link workers who work during the day and out of hours to ensure access to this support as much as possible. Reporting takes place quarterly and is evidence to LECAG.

In summary, over the last 6 months, 174 service users were supported by the cultural advocacy link workers and over 40 family members were liaised with. Of particular note is the impact of working with family and supporting with feedback to the MDT, specific examples of this were received from the PMC report highlighting the need for cultural advocacy for family members.

Areas of support include language and communication support, supporting staff to understand cultural issues and responding to feedback they receive in their advocacy work. Examples that were received in reporting included support in signposting to additional support particularly on discharge and providing access to personalised prayer guides and facilitating prayer times to support service users feel more connected to their faith.

In addition, cultural advocacy workers have spent time encouraging service users to engage with activities on the ward including facilitating table tennis games and art therapy sessions.

A training session was co-delivered between a cultural advocacy link worker and lead Christian chaplain to perinatal mental health services. This was to support the team improve cultural competency in supporting women who access their services. This took place in August 2024 and was valued by the perinatal service.

10. Summary of peer support work

Peer Support Work (PSW) has now joined the engagement and experience team. The objectives and update of peer support work and the peer support plan is reported through the people committee alongside other professional plans.

The Peer Support Plan is a five-year strategic plan which is currently in year 2 (July 24-July 25).

AIM: For everybody using our services to have access to a peer support worker.

FOUR THEMES:

Developing the peer support network

Enhancing Service User Care

Sustaining peer Support Work Strengthening Peer Support work across the ICS

The achievements and successes of year one implementation have been:

- Growth and visibility of workforce
- Training sessions with teams
- Collaboration between South Yorkshire (SY) ICS and nationally
- Service user focus groups
- Communication re peer support across services and to service users including training sessions and service user focus groups
- Job planning work started for individual peer workers
- Training for peers and peer supervisors

The objectives and achievements of year two so far include:

- Working with local communities: The peer lead was successful in being awarded a bid through Sheffield Charities to employ two peer workers through Maan to help us improve the care we deliver to the Somali community
- System working: SHSC led on an ICS wide peer event and awards ceremony bringing together peers from NHS and voluntary sector (this will be bi-annual)
- Collaboration for training across Sheffield: The PCMHT and SHSC peer workforce have started delivering training together to ensure a collaborative system led approach to peer work.
- Continuing growth of workforce: Since June 2024, a further 5 peer workers have joined the peer workforce in SPS, CMHT and rehab services with further recruitment of peer workers in Jan/Feb 2025.

11. Conclusion and next steps

The report highlights several areas within the engagement team which need immediate attention identifying a number of which are currently being addressed as a matter of priority.

The PCREF implementation plan is an organisational priority overseen by Executive director of nursing, quality and professions. There are regular meetings planned between key stakeholders in the PCREF implementation to ensure the deadline of March 2025 is met.

To be able to meet the strategic aims outlined by the service user and experience strategy the feedback improvement plan and communications plan will be a priority for the engagement team.

Over the last month there has been progress regarding the EbEs and volunteers experience, however work is planned over the next month to continue to improve on this as it remains a key priority. The engagement team has a key role within the successful delivery of this work through increased visibility across teams and services.

12. Recommendation

The Trust Board is asked to:
- Note the report and update of engagement team activity and key areas required for improvement
- Note the implications of the removal of care opinion (section 2.12)
- Note the change in out of area contact (section 3.3)

Appendices:

Patient Experience Improvement Plan.

TASK	ASSIGNED TO	PROGRESS	START	END
Feedback				
Contacting all clinical teams and establishing existing Feedback - methods, previous returns, frequency, content	Zoe Dodd	0%	1/1/25	31/1/25
Review content of surveys - duplication, relevance, gaps	Zoe Dodd / Teresa Clayton	0%	15/1/25	15/2/25
Establishing the "what" and the "why" of feedback content	Zoe Dodd / Teresa Clayton	0%	15/1/25	20/2/25
Process Functions				
Feedback from services for existing service from Engagement Team	Zoe Dodd / Teresa Clayton	0%	17/12/24	30/1/25
Establishing clear roles and responsibilities for Engagement team and clinical teams	Zoe Dodd / Teresa Clayton	0%	1/1/25	30/3/25
Governance structure from collection, reporting to closing feedback (Organisation & Service Level)	Zoe Dodd / Teresa Clayton	0%	18/12/24	30/4/25
Engagement Roadshow - including supporting teams to embed experience reporting governance	Teresa Clayton	0%	1/5/25	31/7/25
Data Input/Output				

Establish Database for holding experience data	Henry Harrison	0%	19/12/24	15/1/25	
Working with Services to develop process for recording data to central location	Henry Harrison	0%	15/1/25	30/1/25	
Establishing output reporting into Services	Henry Harrison	0%	15/1/25	15/1/25	
Develop Experience Dashboard - integrated with Patient Safety Dashboard	Henry Harrison	0%	30/1/25	31/3/25	
Develop IPQR Reporting on Experience	Henry Harrison	0%	30/1/25	28/2/25	

Appendix two: Engagement and communication strategy objectives

Effectively engage and inform service users, families and carers.	Embed co-design and co-production as a core element of the trust approach through supporting the objectives set out within the Service User Engagement and Experience Strategy. Provide timely, accessible information about service change and transformation, focusing on the why. Support development of two-way mechanisms to close the feedback loop. Promote opportunities for services users, those lived with experience, families and carers to co-design and co-produce services. Identify and tell service user stories through internal and external channels.