# EPUT

NHS
Essex Partnership University
NHS Foundation Trust

# WORKING IN PARTNERSHIP WITH PEOPLE AND COMMUNITIES

## PARTNERING WITH OUR PATIENTS AND THEIR SUPPORTERS

‘PEOPLE FIRST, PEER LED’

# Contents

# Foreword from the Executive Director of Strategy, Transformation and Digital

Essex Partnership University NHS Foundation Trust (EPUT) has been on a journey of improvement and we remain committed to driving forward change, to learning, listening, and innovating, so that we deliver the highest quality and safest care possible. In January, we published our Strategic Plan 2023 – 2028, after extensive engagement with our service users, and their carers and families, as well as our staff and partners. As part of this we committed to ensuring service users and their families and carers are at the heart of everything we do.

To make this happen, it requires a key change in perspective, which is viewing our patients, their supporters and the communities we serve as partners in service design and delivery. We must consistently involve our patients and their supporters in shared decision-making, co-design, and co-delivery across all of our services. The benefits are multifaceted and the evidence tells us that we will have better decisions, better services, less waste, better relationships due to transparency, and improved health for those who are involved.

Our new Working in Partnership with People and Communities plan puts this commitment into practice by setting out some of our key achievements to date and our plans for the future. We already have some great work going on in our service user networks, a growing team of over 170 lived experience ambassadors, community and inpatient based peer support workers and wide ranging partnerships with public sector and third sector organisations. We want to go further. We have developed this plan in partnership and through engagement with people who use our services and their supporters, our staff and wider partners to make a real difference with measurable improvements to how we operate.

Furthermore, we recognise that partnering with our patients and their supporters is an integral part of the wider objective of helping our communities thrive. Therefore, it is extremely important for our new Working in Partnership with People and Communities plan to work in a supportive and enabling way for the many other community engagement initiatives evident in the realisation of that objective.

Such as the social impact strategy, initiatives like the Trauma Alliance and the Rough Sleepers Project, Enable East, and any locality community initiatives are important. As is the clinical service engagement with service users and their carers such as the active engagement sought from service users and carers in Eating Disorders Services, in the Perinatal service, and the Personality Disorders and Complex Needs Service User Network.

As a Trust, our values are that we learn, we care and we empower. These values could not be more relevant to working in partnership with people and communities. We all use NHS services and we all have something to contribute in making NHS services better. Our purpose at EPUT is: We care for people every day. What we do together, matters. This means: together with service users; together with their families and supporters; together across professions and services; and together with our partners.

We need your help to make this happen so please get involved!

**Zephan Trent - Executive Director of Strategy, Transformation and Digital**

# Keynote from the Trust Lived Experience Lead for Co-production and Participation

On July 20, 1969, astronaut Neil Armstrong made a statement as he stepped onto the surface of the moon, that it was 'One small step for man, one giant leap for mankind.' Now of course I'm not equating our working relationships with the people and communities you serve, with stepping onto the moon.

BUT! Sometimes it needs a small step to make the biggest difference. Slowly but surely the ethos of a cultural change will be the very air we breathe because those small steps of inclusivity, of an open mind, will create EPUT, to fully embrace the real benefits of this partnership approach. We just need to keep taking those steps.

**Mark Dale - Trust Lived Experience Lead for Co-production and Participation**

# Strategic Context

## Local context

**In January 2023 Essex Partnership University NHS Foundation Trust launched its new five year strategy, central to which is lived experience and partnership working with those on the receiving end of our services.**

## STRATEGIC OBJECTIVES

**We have four strategic objectives to achieve our vision:**

- **We will deliver safe, high quality integrated care services.**
- **We will work with our partners to make our services better.**
- **We will enable each other to be the best we can be.**
- **We will help our communities to thrive.**

## OUR VISION

**To be the leading health and wellbeing service in the provision of mental health and community care.**

## OUR VALUES

**WE CARE.**

**WE LEARN.**

**WE EMPOWER.**

## OUR PURPOSE

**We care for people every day. What we do together matters.**

**The people that use our services and their supporters are our number one stakeholder and central to everything we do.**

# National Context

**The Working in Partnership with People and Communities Statutory Guidance was published by NHS England and the Department for Health and Social Care in October 2022.**

**This guidance was co-produced with people and communities and sets out 10 principles for partnership working.**

**10** principles for working with **people** and **communities**

01 Centre decision-making and governance around the voices of people and communities.

02 Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions.

03 Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working.

04 Build relationships based on trust, especially with marginalised groups and those affected by health inequalities.

05 Work with Healthwatch and the voluntary, community and social enterprise sector.

06 Provide clear and accessible public information.

07 Use community-centred approaches that empower people and communities, making connections to what works already.

08 Have a range of ways for people and communities to take part in health and care services

09 Tackle system priorities and service reconfiguration in partnership with people and communities.

10 Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

**Start with People**

**Inform**
Sharing information about proposed changes so people understand what they mean.

**Consult**
Asking for people's opinions on one or more ideas or options.

**Engage**
Listening to people to understand issues and discuss ideas for change.

**Co-design**
Designing with people and incorporating their ideas into the final approach.

**Co-production**
An equal partnership where people with lived and learnt experience work together from start to finish.

## Our people and communities

## =

## Our workforce + our patients + their supporters

# In everything we do, our patients and their supporters are our partners.

## S01

**We will deliver safe, high quality, integrated care services.**

## S02

**We will enable each other to be the best we can be.**

## S03

**We will work together with our partners to make our services better.**

## S04

**We will support our communities to thrive.**

**Partnering with our patients and their supporters**

**S01:** ‘Empowering our service users, families and carers’

**S02:** ‘To build capabilities including volunteers and lived experience roles’

**S03:** ‘Continue to build our partnerships with our services users, carers, and their families’

**S04:** ‘Engage proactively with our communities to build on their existing strengths and priorities’

# Building blocks

**As an organisation EPUT has made steady progress in this space since April 2021, establishing many of the foundations that are required to propel us to the next level of participation, co-production, and partnership working. This is evidenced in the 2023 Patient Experience Annual Report.**

| | |
|---|---|
| **Lived Experience team** | The EPUT Lived Experience team was formed due to the work underpinned in the Involvement Strategy 2021 – 2023. This is now 190 strong, and growing at rapid rate. It is formed of people with lived or living experience of community and mental health services, be it as a patient, service user, or a supporter, parent or carer. Their input is invaluable to everything we do together. |
| **Co-production lead, Champion Network, & involvement leads** | Since March 2023 EPUT has had a lived experience lead for co-production and participation, and we now have a developing network of co-production champions. Furthermore, the very first EPUT Co-production Conference took place in October 2023. In addition to this the Trust has some great examples of co-production in action with our involvement leads, and having a real tangible impact on our services. |
| **Director and supporting corporate functions** | Since April 2021 EPUT has had a Director of Patient Experience, and professional lead for developing the Trust's capability for public participation and lived experience. Further to this the patient experience directorate is now well established, and continuously improving. |
| **Refreshed corporate strategy & concluded Involvement Strategy** | The two year Involvement Strategy agreed in 2021 is now concluding and delivered what it set out to do, as set out in our Patient Experience Annual Report for 2022/23.<br>The new Trust Strategic Plan launched in January 2023, with lived experience, service user involvement, co-production, patient partnership, and peer support highlighted throughout. |
| **Reward and Recognition Policy** | The Reward and Recognition Policy is now well established and being utilised to remunerate our Lived Experience team.<br>Along with this there are supporting systems and processes that have made getting involved less complicated. |
| **I Want Great Care and Peer Networks** | I Want Great Care launched at EPUT in January 2022 and whilst uptake started slowly, we have seen a progressive increase in response rates from those on the receiving end of our services. In addition to this, we are nurturing a network of peer networks to support and enhance our ability to listen to, and collaborate with, people using our services. |

# Strategic development

**The development of this strategy has happened in four stages and took place between April to November 2023.**

1

Analysis:
- Current state: The Patient Experience Annual Report April 2023
- Statutory guidance: The Working in Partnership with People and Communities Statutory Guidance (October)
- Best practice: Looking beyond the organisation to our peers for best practice.

2

Hypothesis of Core Issues:
- Led by the analysis stage, identifying the core issues that if addressed will drive the biggest change.

3

Testing the Hypothesis:
- Senior leadership interviews: Through a series of 1-2-1 private and confidential interviews with the senior leadership group, and from a mix of professions
- Thematic analysis: Having transcribed the interviews, themes were identified and gathered to pull together a prioritisation survey.

4

Prioritisation of Strategic Direction:
- A Trust-wide survey, led by the thematic analysis of the senior leadership group interviews identified the core themes and areas of focus for a wider group to prioritise and feedback on.

# Strategic Diagnosis

## Core Issues

**As part of the 1-2-1 semi-structured interviews with the senior leadership group the following core issues were identified as recurring themes.**

**1. Clear Boundaries:** not having clear boundaries of roles and relationships defined in order to work in partnership with patients and their supporters.

**2. Time and Capacity:** staff not having enough time to meaningfully engage and establish a working relationship with patients and their supporters.

**3. Organisational Culture:** As an organisation, it is not a cultural norm for our staff to partner with patients and their supporters.

**4. Staff Mindset:** In order to partner with patients and their supporters it requires a change in mindset which is not yet there for most.

**5. Power Imbalance:** The construct of the relationships with our patients and their supporters is based on most of the power being in the hands of the service providers and clinicians.

**6. Appropriate Representation:** Whilst we have lots of people who want to be involved they are not always the most appropriate to represent a specific group, service, or have the most recent experiences.

# Vision

**The vision for the strategy has four key aims which have been co-produced with our people based on the core issues identified above.**

1. We have equitable partnerships with patients and their supporters.

2. We are innovative with how we partner with patients and their supporters.

3. Partnering with patients and their supporters is an organisational norm.

4. We have an extensive training programme for all involved (staff, patients, and their supporters).

# Priorities

**The following priorities for the strategy have been co-produced and ranked with our people.**

1. A clear vision, mandate, and statement of intent.
2. A Trust-wide framework for partnership working with patients and their supporters.
3. A focus on addressing the organisation’s culture, including behaviours towards partnering with patients and their supporters.
4. A formalised strategy for partnership working with patients and their supporters.
5. A Trust-wide policy for partnership working with patients and their supporters.

# Strategic Delivery Plan

## Guiding principles

**As part of this strategic delivery plan we have identified three guiding principles which should continuously challenge us.**

1. **Equitable partnerships at every level of the organisation:** with people using our services, relinquishing power and control whilst maintaining our responsibility to care for people.
2. **Lived Experience Practice (LXP) is what we do, it’s in our DNA:** Our lived experience is invaluable, which we celebrate, and harness to drive meaningful change. In order to excel at LXP, our workforce and Lived Experience team have their training and support needs met.
3. **Co-production first:** Everything we do, we do in partnership with people using our services. Actively seeking and encouraging feedback, good or bad.

# The first next steps

1. **Clear vision, mandate and statement of intent**

2. **A formalised strategy**

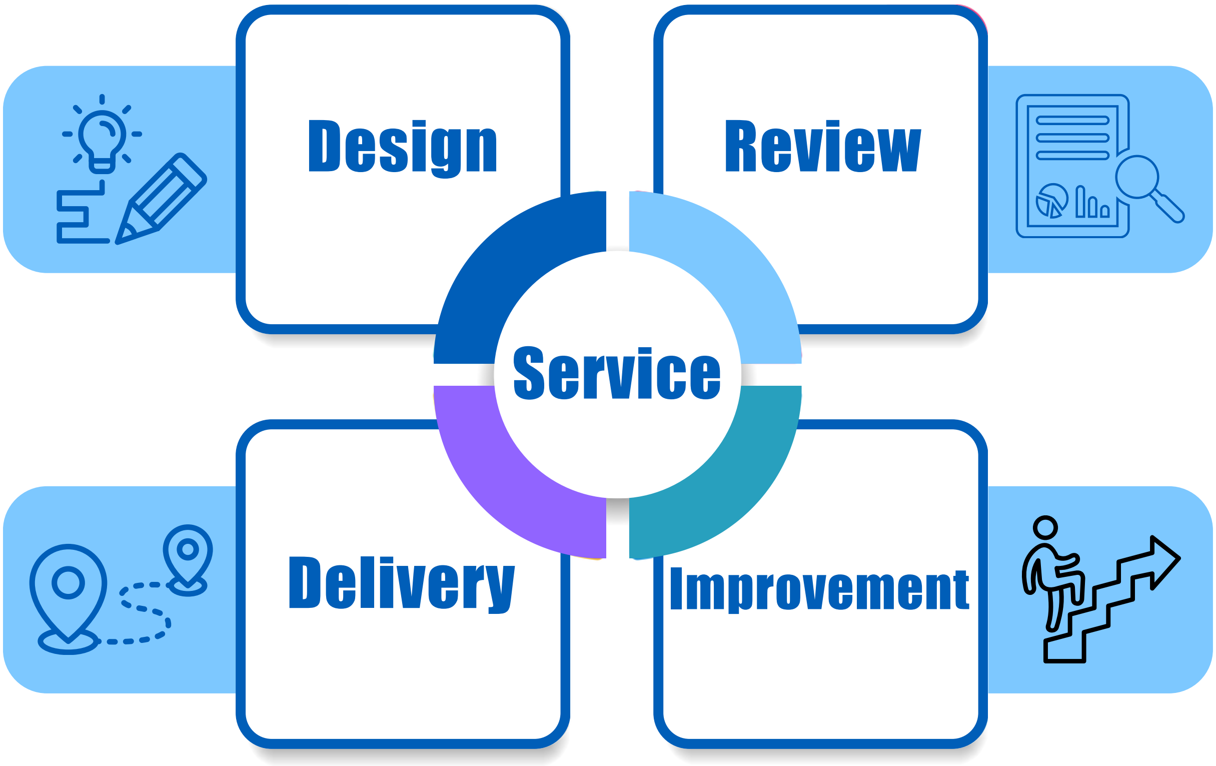
4. **A Trust-wide Framework**
A clear framework for partnering with patients and their supporters innovatively, clarifying boundaries.

5. **A Trust-wide Policy**
Clarifying the expectation for all staff and all services, with a supporting procedure document.

3. **Addressing Organisational Culture**
Addressing the organisational culture including behaviours towards partnering with patients and their supporters.

# Co-Production first

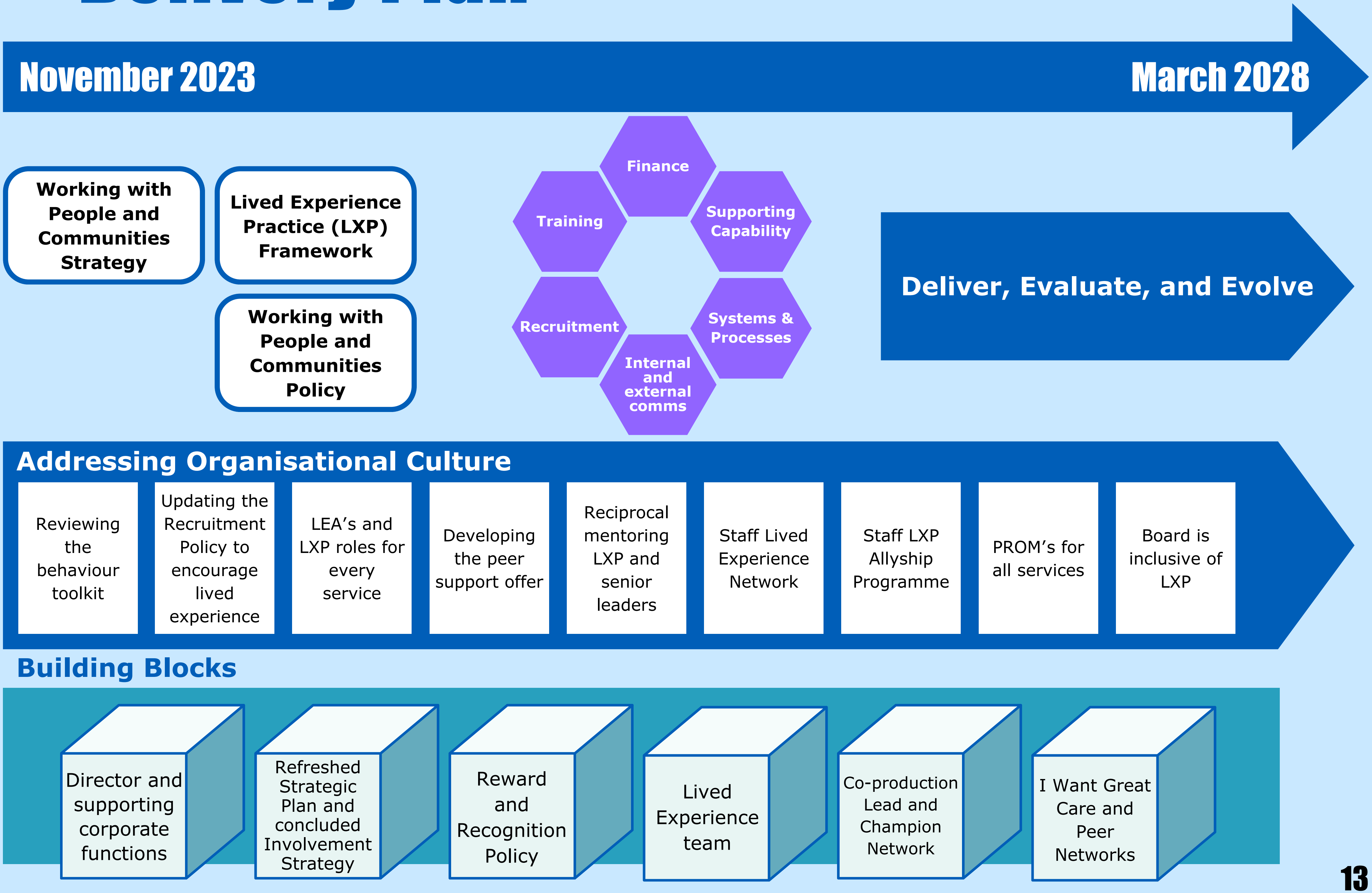
**We know that working in partnership with those who have lived and living experience of services improves care and we already have some fantastic evidence to support this (the Buddy Scheme, The Personality Disorder and Complex Needs Service User Network (PD&CN SUN), the Lighthouse Service and complaints redesign). Now we need to go further to embed co-production across all areas of service design, delivery, and improvement.**



# Operational challenges

| | |
|---|---|
| **Training** | Training generally for our Lived Experience team is challenging. Access, and a clear programme of training development is key. For our workforce, many feel ill equipped to working co-productively with our Lived Experience team. |
| **Finance** | All involvement activity that qualifies for reward and recognition is funded centrally. Perhaps now is the time to consider distributing this cost across the services, care units, and budgets so that all teams feel empowered to involve lived experience ambassadors in their work. |
| **Reward and Recognition Policy** | Although our Lived Experience team is growing rapidly, along with our Volunteers team, many of our services feel underrepresented or misrepresented due to a lack of targeted recruitment from within their patient cohort. Involving people who understand our services from a diverse range of communities is vital for us to partner in a meaningful way. Equality, diversion and inclusion must underpin our development. |
| **Supporting capability** | Although each care unit and service manager has a desire to partner with our patients and their supporters, sometimes they lack the confidence to do it in a meaningful way, and fear doing the wrong thing. Because of this, they need specialist capability to bridge the gap. The People Participation team is working hard to support all our services, but has limited capacity to do everything we would want to. |
| **Systems and processes** | Giving our Lived Experience team access to our training environment is difficult, and requires them being set up on ESR and having an NHS mail account. This takes time and creates pressure in the ESR team. Our method for remunerating our Lived Experience team is largely paper-based and time consuming for all parties. |
| **Internal and external comms** | Despite the development the Trust has experienced in this area since 2021, there is limited awareness both internally and externally of the opportunities for our workforce to partner with our patients and their supporters, furthermore many of our patients and their supporters are unaware of the opportunities to influence change across the organisation. |

# Delivery Plan



**November 2023** → **March 2028**

**Working with People and Communities Strategy**

**Lived Experience Practice (LXP) Framework**

**Working with People and Communities Policy**

- Finance
- Supporting Capability
- Systems & Processes
- Internal and external comms
- Recruitment
- Training

**Deliver, Evaluate, and Evolve**

## Addressing Organisational Culture

- Reviewing the behaviour toolkit
- Updating the Recruitment Policy to encourage lived experience
- LEA's and LXP roles for every service
- Developing the peer support offer
- Reciprocal mentoring LXP and senior leaders
- Staff Lived Experience Network
- Staff LXP Allyship Programme
- PROM's for all services
- Board is inclusive of LXP

## Building Blocks

- Director and supporting corporate functions
- Refreshed Strategic Plan and concluded Involvement Strategy
- Reward and Recognition Policy
- Lived Experience team
- Co-production Lead and Champion Network
- I Want Great Care and Peer Networks

# Success measures

1. **10 Principles of Working with People and Communities:** We have demonstrable evidence of improvements against all 10 principles with a significant improvement in principles 1, 2, 3, 4, 7, and 8.

2. **The Lived Experience team:** Significant growth in our Lived Experience team, and evidence of them being utilised at all levels.

3. **Lived Experience Practice (LXP):** at all levels, lived experience practice is adopted with a significant increase in lived experience roles and activity Trust-wide. Where feasible, every governing body has at least one lived experience practitioner, and there is significant evidence of LXP being central to decision making, particularly within services.

4. **I Want Great Care:** every service is using IWGC, with demonstrable evidence of experience data driving improvement activity, which is feedback to the public.

5. **Co-production:** As an organisation we have a co-production first approach, and there is significant evidence to support this at all levels. We celebrate and reward good practice seeking national award when we can.

6. **Peer review:** Our peers, (staff, patients and their supporters, and system partners) publicly recognise our improvements in working with people and communities, utilisation of experience data, and our competency for co-production.

# GOVERNANCE AND OVERSIGHT

**To ensure the successful delivery of this strategy we require leadership, oversight, and delivery capability underpinned by the corporate functions.**

| | |
|---|---|
| **Executive Sponsor** | As part of having a clear mandate and statement of intent, this enabling strategy will be sponsored by the Executive team, with a nominated Executive Sponsor. Furthermore, the Executive Sponsor will lead by example, demonstrating the guiding principles, and inclusive and collaborative leadership. They will hold the organisation and the strategy owner to account, ensuring the delivery of the strategy and its change priorities to deliver successfully what we set out to achieve. |
| **Senior responsible owner** | To drive forward the delivery of the strategy, the Director of Patient Experience will be the Senior Responsible Owner of the strategy, accountable to the Executive Sponsor, the Executive Director of Strategy, Transformation and Digital. The Senior Responsible Owner will be the driving force, and accountable for the successful delivery of the strategic ambitions at every organisation level. The professional lead for LXP, co-production, and patient and carer partnerships. |
| **Governing committees** | The governing committee will be key to ensuring the strategic direction of the strategy is right, and providing overall governance and making key decision for the direction of travel, evaluation and evolution of the organisational changes.<br>Key governing committees will be:<br>• The Patient and Carer Experience Steering Group<br>• The Quality Committee<br>• The Executive Management Committee<br>• The Trust Board. |
| **Informal Leadership Group** | We recognise a key point of feedback from the diagnostic phase was that making these changes at a senior and corporate level alone is not enough, and to make the changes lasting, effective and impactful at all levels we need to harness the power of our informal leaders across all services, professional roles, and places.<br>This Informal Leadership Group will help embed the guiding principles of the strategy within the operational day-to-day. It will be the working group that makes change happen. Empowering our informal leaders. |

# Governance structure

**Whenever possible we will use the existing resource, and governance structure to ensure the delivery of the enabling strategy. However we will introduce a new group as part of the delivery capability of the strategy, which is the Informal Leadership Group.**

**This group will be made up of our Lived Experience team, and the authentic informal leaders from across the organisation, essentially those that have no formal leadership role but are influential in making change happen within their respective areas of practice because they are widely recognised by their peers as informal leaders.**

| Leadership | Oversight | Delivery |
|---|---|---|
| Executive Sponsor | Quality Committee | Informal Leadership Group<br>New |
| Senior Responsible Owner | Executive Management Committee | Patient Experience Portfolio |
| | | Patient and Carer Experience Steering Group |

# Case studies

## Examples of good practice

**By Your Side**

By Your Side
Essex Maternal Mental Health Service

EPUT's By Your Side is a maternal mental health service focusing on perinatal loss (loss that occurs during pregnancy, birth or postnatally) and has recently launched in October 2023.

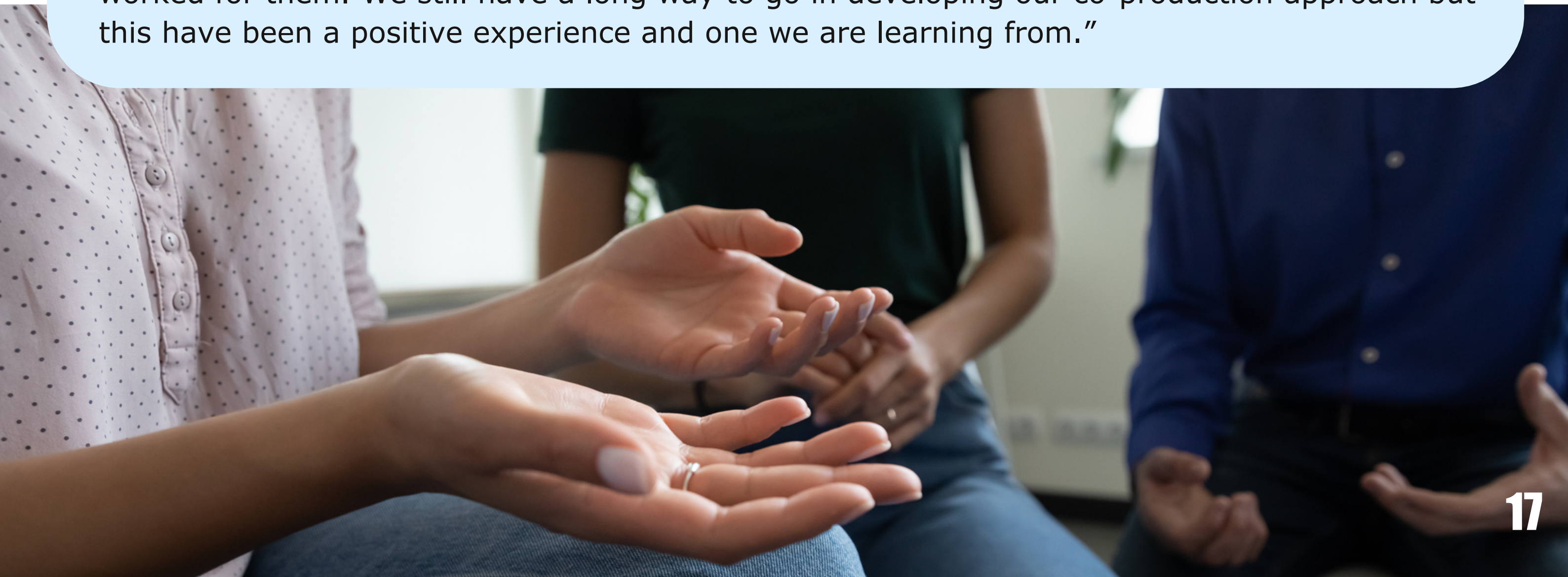
Throughout the process of procurement and implementation every effort has been made to keep the patient voice and experience at the centre of service design.

**Procurement:** The Pan Essex Perinatal Steering Group through the NHS Long Term Plan identified the requirement for a Maternal Mental Health Service (MMHS) to be available by March 2024. Enable East were commissioned to conduct an Essex-wide scoping exercise of stakeholders and services as well as service users and through this a core group of parents volunteered to support the development of the MMHS. A focus group was held to gather their experiences of services following their perinatal losses and this informed the business case and how the service should be formed.

**Mobilisation of service:** The parents with lived experience were involved in the design of the services, its name, logo, and branding for example. They also co-designed the leaflet and information sources for parents to access. During the launch a parents experience was read out to set the context of the service need and aspirations for the future.

**Forward looking:** There is a real desire for this service to listen to the lived experiences of parents moving forward and the services are committed to doing so through collaboration and partnership working.

**A quote from the team:** "I cannot speak for the parents regarding their experience but the feedback I have received suggests it to be a positive one. I think one of the challenges is how to engage with people when they have busy lives working and raising families. We held the focus group in the evening and tried to be as flexible as we could to speak with them when it worked for them. We still have a long way to go in developing our co-production approach but this have been a positive experience and one we are learning from."



## Psychological Services for Older People

Dr Maina Amin, Principal Clinical Psychologist and Clinical Lead, Psychological Services for Older People in South Essex, interviewed a person with lived experience to understand the opportunities and experiences of co-production in older people's mental health services. This interview has shaped thinking in co-design and co-production within those services.

### Supporting our services from the perspective of a person with lived experience.

### What types of co-production was involved?

The person with lived experience has been involved in many different projects including teaching and training staff at university level, ward inspections (including ligature inspections), staff interviews, buddy scheme, EPUT staff induction, commissioners meetings including two-year plan for NHS 111 option for mental health… to name a few.

With Psychological Services for Older People, the person with lived experience first became involved through the Patient Experience team because they met the opportunity criteria for a service user over 65. Since the first contact a few years ago, the person with lived experience has been involved in interviewing all assistant psychologists and interviewing nearly all qualified clinical/counselling/art therapy staff. They have co-produced the selection and wording of interview questions and have taken an equal role in interviews and selection of candidates – their opinion is highly valued and responses go a long way towards who is selected for roles.

Together with the service, the person with lived experience has also co-produced a ½ day teaching session on the Clinical Psychology Doctorate course at Essex University, which is a service user session part of the Older Adult Teaching Block. This has been successfully delivered annually since 2022.

### Any hesitation you've had about getting involved with co-production?

The person with lived experience spoke about being careful who they engage with and what they give their time to due to some challenging experiences where at times they have felt less valued or if professionals are not willing to pay for their time and expertise. They do feel able to say no when there is piece of work that they do not wish to engage in.

### What is your experience of involvement – what have you gained and what challenges have you identified?

The person with lived experience has had some difficult experiences in meetings; in a recent meeting, a fellow service user made a comment in the chat which was offensive and it had a significant impact on their wellbeing.

"The positives of involvement for me are people making me feel valued and explaining to me – please don't feel that you're talking too much as we learn a lot from you. I talk for the people who can't talk for various reasons and usually this is very much appreciated by professionals. I'm also talking to help professionals understand the service user's perspective and needs (for example – encouraging professionals to talk to service users about what is happening to them and give them an explanation and a rationale for decisions that are made about them. It is important for service users to feel that they are not being pushed away to other people). It feels good to be valued, wanted and needed and to know that I'm making a difference".

## Inpatient Settings Review and Service Innovation

The Early Interventions in Psychosis team facilitated a Lived Experience Group with families and service users to review the experience of inpatient settings. This feedback gathered during the process has go towards service improvements and innovation, such as the family and carer ambassador role as part of the Time to Care programme.

Themes discussed tended to be around the traumatic nature of a hospital admission and what this was like to negotiate, particularly in the early stages. See below for some examples of the feedback captured as part of this project which has gone towards service improvements:

- **Better information to explain the various types of medication:** Feels very confusing, what everything is for, how it might impact them, being informed of side effects, changes being discussed and reason for this and how this can impact families.
- **Clearer process for family members to navigate admissions:** Managing the admission process as a family member is difficult. Seeing loved ones being sectioned, not understanding what this means or looks like if this is the first time. It can be a traumatic process for all and feels very isolating as often own friends and family aren’t able to offer advice.
- **Improved information sharing:** Brief and important information needs to be given, can feel overwhelming or can be very difficult to get information from the ward. Practical information would be very helpful for families and loved ones, perhaps a handbook of sorts.
- **Named point of contact for families:** As the ward office is often hard to contact with staff busy, we suggest a named person not based on ward who can be the main liaison point. They offer general information to families and direct queries to appropriate professionals and respond.
- **Improved opportunities for families to speak with their loved ones:** It can be difficult to make contact with loved ones in the wards. This raises anxieties for all those involved, families and lived ones.
- **A summary sheet for professionals:** Having to tell our stories over and over again can be frustrating and triggering.
- **Communicating new information:** Sometimes families first hear new information about things that have happened on the ward during the weekly ward review meeting which can make it hard to hear and understand. There should be a process of briefing families ahead of ward review.
- **Triggers:** Sometimes triggers are unknown on both sides, families and professionals, and being clear what they are for people, can keep them safe. Having an open discussion about this and recording them can help people stay safe and well.
- **Client’s interests:** Being more aware of people’s personal interests can help to have more ‘tailor made’ interventions, recognising what a persons interests are.
- **Signposting:** Having support from professionals to signpost to trust information. Sometimes web searches can be very unhelpful
- **Family supporting on wards:** When people are really unwell, catatonic or in deep psychosis, they can neglect personal care and hygiene. In this case family members and supporters could come in and support the services to help with their loved ones.
- **Reception area:** Can be quite clinical looking and uninviting. Having team photos, key info, put a face to the name prior to meeting professionals is helpful.
- **Glossary of language:** Sometimes in meetings lots of different medical terms can be used and it’s not explained to families and supporters. It would help to have an accessible glossary of terms used to for families and supporters.

## Complaints Redesign

The Complaints team launched a redesign project for the complaints process and systems end-to-end. This was based on the evidence that people who used the service were unhappy with the outcomes, expectations were not being met, and the time to respond was too long. Furthermore, the lived experience of people using the service married up to what the data was saying in terms of the annual reporting around delays, time to respond, complaints being reopened, and referrals to the Parliamentary and Health Service Ombudsman (PHSO).

The Complaints team established a co-design collective made up of service users, service leads, and the Complaints team. Together the group discussed issues and perspectives from all sides. Identifying key issues around time and capacity, impartiality, misunderstanding due to the lack of broken and sporadic dialogue, and conflicting priorities for services to give care whilst needing to respond to complaints investigation. Over the period of six months the co-design collaborative collectively worked through the issues and agreed solutions for each, co-designing a new process end-to-end which has resulted in systemic change across the organisation including significant policy changes, and investment in the newly established Complaints Liaison function.

The anticipated outcomes of the complaints redesign work were threefold:

1. Better outcomes
2. Improved experience
3. Greater learning.

**After evaluation the outcomes achieved were much greater then what was intended:**

1. Complaints are being resolved more quickly and informally, with a reduction of nearly 20% in formal complaints and nearly 70% increase in informally resolved complaints.
2. So far throughout the year to date, we have seen a 100% reduction in referrals to the PHSO.
3. We have seen nearly a 15% reduction in reopened complaints with 92.5% of all formal complaints being resolved without being reopened.
4. As part of the non-executive director assurance process, we have seen an overall approval rating of the complaints reviewed move to 100% in 2023 from 70% in 2022.
5. Learning has also improved with 63% of formal complaints identifying learning and improvement actions in 2023.

**Quotes from service users:**

“I was so grateful that you called me. I was listened to and given the space and time to offload my frustrations. I really appreciated it.”

“Thank you for arranging a resolution meeting for me. I’m glad I had a chance to address my concerns directly with the doctor. I felt that his apology for the upset caused was heartfelt and that meant a lot to me.”

**Quotes from staff:**

“With regards to the process it was much easier thank you! A lot of the time consuming work was taken out and I could just review the notes and take actions as necessary.”

“I think this way of managing complaints works well in terms of freeing up clinical time to care.”

## Trauma-Informed Waiting Rooms

The Service Development Collaborative (SDC) is a stream within the Service User Network for Personality Disorders and Complex Needs, and is comprised of a group of volunteers who support the development of projects and use their lived/living experiences of personality disorder and complex needs and mental health systems to help transform services.

Following feedback from the members, improvements to community mental health waiting rooms were made to be more aligned with trauma-informed care principles, to create spaces that felt more safe, empowering and collaborative. The former waiting rooms were described as places which were “dark and depressing” with “no sense of safety,” with major contributing factors being the lack of privacy from other service users and staff, and feelings of entrapment.

Trauma-informed care aims to bring hope and empowerment to reduce the disparity between those who use services and those providing them (Filson & Mead, 2016), and addresses the large role of trauma in the lives of many who come into contact with mental health services. The general principles of trauma-informed care are Safety, Trust, Choice, Collaboration, and Empowerment and Cultural consideration.

Current literature supports natural light and access to windows, connection with nature and colour are all significant contributions to improvements in waiting rooms (Arneill and Devlin, 2002; Nelson Worldwide, 2020). Research has also shown that a design that reinforces segregation can exacerbate feelings of threat for service users. Sensory adjustments and inclusivity are further important considerations.

To address this, the group was awarded a £1000 bid from charitable funds and decided to focus on two waiting rooms to concentrate their efforts and create a template that could be applied to other sites across EPUT. After much deliberation, the waiting rooms based at Reunion House (Clacton-on Sea), and Coombewood Centre (Rayleigh) were selected.

The group worked towards making the following key areas present for each waiting room:

- Access to as much natural light as possible
- Increasing nature in decoration and displayed artwork
- Available sensory box with free-to-take items
- Up-to-date information and reading materials.

At the Coombewood Centre, the initial visit to the site showed that there could be improvements to the design and layout of the space as the waiting area was located in a busy corridor. This sparked conversations around the inclusion of Experts by Experience in the layout of Trust premises from their initial design so that the space could have been designed differently. Within the scope of this project, the design of the buildings could not be altered, and many of the additional changes that the group were proposing were reactive to the layout of the space, which could have been prevented. There were barriers within the Coombewood Centre which prevented many of the proposed changes from going forward. The sensory box and updated reading materials were the only suggestions which were able to be implemented in the Centre.

At Reunion House, the same problems arose due to the design and layout of the existing space being narrow and poorly lit. There was also a small sign-in hatch at reception which was perceived as segregating and made service users feel like they were “children in primary school,” and is supported by literature to contribute negatively to healthcare outcomes (Liddicoat, 2020). The group were able to understand from the estate managers that the property was rented out and therefore no major changes could take place to open up the hatch.

The additional changes that were able to be implemented at Reunion House were decorations of honeycomb and nature-themed wall decorates, cushions which were made by a volunteer, artificial plants and small reflective mirrored panels which could enhance the natural light available in the space. Moving forward the group showed the importance of Experts by Experience being consulted in the initial planning of waiting room spaces in community mental health buildings.

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