Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

AWP Clinician Engagement Strategy 2012

'None of us is as smart as all of us…the problems we face are too complex to be solved by any one person or any one discipline. Our only chance is to bring people together from a variety of backgrounds and disciplines who can refract a problem through the prism of complementary minds allied in a common purpose'

Warren Bennis, Organisational consultant, scholar and author

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Executive Summary

There is compelling evidence that NHS organisations who engage staff, patients and others deliver better results with better patient experience, fewer errors, higher staff morale, less absenteeism and stress (The King's Fund, 2012).

It makes good sense to engage with a range of stakeholders and partnership is enshrined in the NHS Constitution. AWP has expressed its local commitment to the NHS Constitution with a staff charter. The AWP Fit for the Future Programme (July 2012) recognises engagement must be improved, engagement with service users, carers, staff and our partners. The Clinician Engagement Strategy represents delivery of a core commitment of Fit for the Future i.e. to develop and implement a clinical engagement strategy to underpin local, SBU and Trustwide decision making and improve staff morale.

This AWP Clinician Engagement Strategy is the result of consultation and collaboration with staff, providing views about what engages clinicians and how engagement can be improved.

The aim of the AWP Clinician Engagement Strategy is:

> *'To deliver the best outcomes and experience for all service users through the active consultation, partnership and involvement of health and social care professionals in Trust operational and strategic decision making'*

The Clinician Engagement Strategy has 3 objectives:

1. **To develop structures** that will enable the involvement of health and social care professionals in strategic and operational decision making
2. **To ensure a system-wide approach** to the engagement of health and social care professionals in strategic and operational development
3. **To develop and support health and social care professionals** to engage in strategic and operational decision making

Moving forward together will achieve the best outcomes and experience for service users and their families. This strategy represents more than a change in infrastructure, systems and job descriptions but signifies the intent to foster a culture where engagement is valued.

This vision for clinician engagement in operational and strategic decision making is best expressed as follows:

> *'None of us is as smart as all of us…the problems we face are too complex to be solved by any one person or any one discipline. Our only chance is to bring people together from a variety of backgrounds and disciplines who can refract a problem through the prism of complementary minds allied in a common purpose'*
> Warren Bennis, Organisational consultant, scholar and author

Whilst using this to guide clinician engagement, it holds true to the value of involving service users, carers and partner organisations. Our shared commitment to deliver the best outcomes and experience for all service users will harness energy and commitment to achieve positive change.

The present strategy must be implemented alongside the Community Engagement Strategy and 'New Ways of Working' programme and will ensure AWP is 'fit for the future'

What is Clinician Engagement?

It is important to define clinician engagement, what it is and why it is important.

Engagement is fundamentally about relationships and occurs best when '*the business values the employee and the employee values the business*' MacLeod and Clarke (2009). For both patients and staff, engagement transforms the experience of the NHS. They feel respected, listened to and empowered, and are able to influence and improve care.

This focus of the current strategy is 'clinicians' and includes both health and social care professionals. Through consultation the following working definition of clinician engagement was agreed:

> *"Clinician engagement is the active consultation, partnership and involvement of health and social care professionals in Trust operational and strategic decision making to ensure the best outcomes and experience for all service users"*

Professional Council is an important part of the Board endorsed Quality Assurance Framework. Professional Council recommends the standards of the Trust in accordance with the seven pillars of Clinical Governance as described in the Clinical Governance Framework.

The Case for Clinician Engagement

The 2012 King's Fund report shows there is strong evidence that leaders who engage staff, patients and others deliver better results on a range of measures. The business case for leadership and engagement is compelling: organisations with engaged staff deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation and less absenteeism and stress.

The importance of engaging and involving clinicians in NHS business is enshrined in the NHS Constitution and is central to NHS reforms resulting from the Health and Social Care Bill (2012).

The NHS Constitution pledges: *'to engage staff in decisions that affect them and the services they provide... All staff will be empowered to put forward ways to deliver better and safer services for patients and their families'*. It builds on principles set out in The NHS Plan (2000); High Quality Care for All: Next Stage Review (2008) and values developed by patients, the public and staff. It recognises the role of patients, the public and staff in providing high-quality care that is safe, effective and focused on patient experience, setting out the rights and responsibilities each group.

The Constitution enshrines the commitments, rights and responsibilities of all stakeholders. Staff should have:

- Rewarding and worthwhile jobs
- Freedom and confidence to act in the interest of patients.

To do this, they need to be:

- Engages in decisions that affect them and the services they provide
- Be empowered to put forward ways to deliver better and safer services for patients and their families
- Trusted and actively listened to
- Treated with respect at work
- To have the tools, training and support to deliver care
- Opportunities to develop and progress.

In return, NHS Staff have a duty to:

- Aim to maintain the highest standards of care and service
- Take responsibility for the care they personally provide
- Take responsibility for wider contribution of teams and the NHS as a whole
- Play their part in sustainably improving services by working in partnership with patients, the public and communities.

The AWP Staff Charter (appendix 1) affirms the NHS Constitution with our local commitment to deliver recovery focused services to a standard that we would be happy for our families and those we care about to receive. It includes commitment to partnership working – with one another, with service users and carers and our local communities – to constantly improve and be responsive to the needs of our communities. The AWP Staff Charter describes how staff will contribute to decision making and emphasises the importance of being open and honest.

The AWP Clinician Engagement Strategy builds on these foundations and in so doing, aims to achieve the best outcomes and experience for all service users.

Enabling Clinician Engagement

Clinicians have the major influence over patient care, from making the diagnosis to determining the pathway of care. They are central figures and need the support of the organisation necessary to implement their decisions. The decisions and actions they take have a direct bearing on the use of the organisation's resources. They also provide an invaluable perspective on how services can be changed and improved safely and effectively. Clinicians are the public face of the organisation and their considerable experience of the NHS gives them a wealth of knowledge about the strengths and weaknesses of the system. Although clinicians and managers sometimes take a different approach to decision making and improvement, they are both an integral part of achieving successful organisations and lasting change.

Leadership style has been identified as a key determinant of engagement. The King's Fund report emphasises the need for the NHS to break with the command and control, target-driven approach. Authors conclude the need for senior leaders to move towards a distributed leadership style that enables and empowers individuals to lead change and service improvement.

Effective clinician engagement is not achieved through a single action but through a range of coordinated and complementary actions that reinforce the value of engaging clinicians. Engagement strategies must be built upon an authentic commitment to partnership working. Successful strategies to enhance clinician engagement need to appeal to the intrinsic motivation of clinicians to provide high standards of care in a timely and courteous manner.

Organisations that engage both staff and patients have strong values of trust, fairness and respect which are consistently articulated and acted upon. The changes needed to implement NHS reforms require leaders who cultivate a strong culture of engagement for patients and staff.

The necessity for authentic involvement of clinicians in operational and strategic decision making is summarised in the following quote:

> *'None of us is as smart as all of us…the problems we face are too complex to be solved by any one person or any one discipline. Our only chance is to bring people together*

from a variety of backgrounds and disciplines who can refract a problem through the prism of complementary minds allied in a common purpose'
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Clinician engagement strategies might include the following:

- Education and training opportunities
- Identifying key opinion leaders
- Involvement of doctors, nurses and other clinicians in leadership roles
- Incentives (financial and other)
- Peer Review mechanisms
- Time and space (e.g. to review established practices or introduce new ways of working)
- NHS Leaders/Boards to foster organisational cultures that give greater priority to and value the contribution of staff (clinical and non-clinical) and service users
- Fostering medical engagement
- The contribution of staff at an early stage of their careers to leadership and service improvement needs to be valued and recognised
- Every NHS organisation needs to support leadership and engagement through effective appraisals, clear job design and a well-structured team environment
- Developing team leaders in hospital/community settings to create a climate that enhances staff well-being and delivers high-quality patient care

Co-production of Clinician Engagement Strategy

This Clinician Engagement Strategy was developed collaboratively, led by Trust Professional Council and supported by a core working group. Engagement with wider groups of health and social care professionals was achieved through, professional networks, Strategic Business Units and a survey via Ourspace. A working definition of clinical engagement offered a shared understanding of engagement to stimulate ideas as to how it can best be achieved. Staff were invited to comment. A report of the survey responses is provided in appendix 2.

In the light of feedback the following definition agreed:

"Clinician engagement is the active consultation, partnership and involvement of health and social care professionals in Trust operational and strategic decision making to ensure the best outcomes and experience for all service users".

The survey findings provided a foundation for Professional Council and the core working group to offer further ideas about decisions clinicians should be involved in and the relative weight of their voice in these decisions. An engagement model was used to consider what decisions health and social care professionals should lead, own, contribute to, endorse, follow and observe (Rosenblatt, 2012). This engagement model is expressed as a pyramid in which the vertical dimension represents the intensity of engagement and the horizontal dimension represents the number of people involved. The pyramid indicates widespread, low level engagement at the bottom and high intensity, deep engagement at the top.

Professional Council recommendations focused on decisions that clinicians should contribute to, own and lead, however, this framework offers a helpful prompt for wider consideration of how clinicians could be involved in decision making e.g. for corporate services to consider how clinicians might be engaged in non-clinical aspects of delivery.

The core working group considered the following sources in developing strategic aims and objectives:

- Report of the Trustwide survey (appendix 2)
- Professional Council views on the extent of engagement in decision making
- Planned structural changes resulting from 'New Ways of Working'
- Evidence of effective engagement strategies from the literature.

The definition has been adapted and expressed as the aim of the Clinician Engagement Strategy.

Clinician Engagement Strategy Aims and Objectives

The aim of the AWP Clinician Engagement Strategy is:

> *'To deliver the best outcomes and experience for all service users through the active consultation, partnership and involvement of health and social care professionals in Trust operational and strategic decision making'*

The Clinician Engagement Strategy has 3 objectives:

1. **To develop structures** that will enable the involvement of health and social care professionals in strategic and operational decision making
2. **To ensure a system-wide approach** to the engagement of health and social care professionals in strategic and operational development
3. **To develop and support health and social care professionals** to engage in strategic and operational decision making

Each objective is underpinned by actions. These actions are briefly described below with suggested next steps.

Strategic Objective 1: Develop structures that will enable involvement in strategic and operational decision making

Action	Description	Detail	Next steps
1a	Develop **Trustwide Professional Group** as a strategic partner to Trustwide Management Group in decision making	**Proposed responsibilities**: Lead on the development of Clinical Policies Lead on the design of Care Pathways Define clinical standards Lead on the development of a Clinical Dashboard (clinical KPIs) Lead on Clinical Risk Management Define AWP quality improvement priorities Horizon scan for changes in the evidence base, innovation and improvement opportunities To contribute to strategic direction and operational decisions (e.g. organisational structures, CRES, business strategy	Terms of reference Methods of working Clarify support needs
1b	Develop **Locality Professional Groups/ Specialty Professional Groups**	**Proposed responsibilities**: Engaging with commissioners Local iteration of care pathway design Define local quality improvement priorities Lead on local clinical establishments Horizon scan for local innovation and improvement Contribute to local distribution of resources Joint working with other agencies and stakeholders Contribute to tenders and business decisions Contribute to local CRES plans Contribute to clinical environment design	Terms of reference Methods of working Clarify support needs
1c	Recognise, clarify and align the roles of **Professional Networks**	**Proposed responsibilities**: Horizon scan for profession-specific research, innovation and improvement opportunities Lead on the development of professional practice To maintain compliance with codes of conduct Clinical risk management Provide clinical leadership	Terms of reference Methods of working Clarify support needs
1d	Develop a **Register of Experts**	**Purpose**: Identify specific areas of expertise and ensure this information is widely available as a resource to support operational and strategic decision making	Develop implementation plan
1e	Utilise **Clinical Working Groups** (ad hoc)	**Purpose**: To support discrete, time limited pieces of work on behalf of Trust Board/ Trustwide Management Group/ Trustwide Professional Group	Pilot

Strategic Objective 2: Ensure a system-wide approach to clinician engagement

Action	Description	Detail	Next steps
2a	**Clarify decision making** responsibilities and processes between groups (system-wide)	To clarify the interconnections/interdependencies between: - Board - Trustwide Management Group - Trustwide Professional Group - Locality Professional Groups - Professional Networks	Incorporate into organisation restructure (New Ways of Working)
2b	**Corporate services** to review how clinicians can inform policy and systems development	Corporate review to include consideration of engagement opportunities for Corporate Directorates (using engagement pyramid as a framework). - How can health and social care professionals contribute to the development of non-clinical systems and policy development? - What methods can be employed by corporate services to ensure involvement? Examples cited: H&S Policy, HR policies, Charitable Funds spending, Governance Structures, Payroll, Statutory Requirements	Incorporate into Corporate Review and organisation restructure (New Ways of Working)
2c	Foster an **engagement culture** in which , 'the business values the employee and the employee values the business' MacLeod and Clarke (2009)	Actions proposed in objectives 1, 2 and 3 will affirm commitment to engagement Develop commitment –based contracts that describe rights and responsibilities. Commitment-based contracts will draw on the NHS Constitution and AWP Staff Charter. **Two contracts proposed** - Trust Board to health and social care professionals - Health and Social Care professionals to the Board	Implement actions Draft commitment based contracts for consultation

Strategic Objective 3: To develop and support health and social care professionals

Action	Description	Detail	Next steps
3a	**Clarify roles and job descriptions**	Clinical Director Posts Clinical Lead Posts Chairs of Groups and Networks Heads of Profession	Convene clinical working group to draft job descriptions
3b	To provide **leadership training** to health and social care professionals	Core Leadership Skills Training (Team Leaders) Professional Clinical Leads Training Training in consultation methods and skills Innovation and Improvement Skills training (currently focused on nursing colleagues as part of AWP Nursing Strategy)	Consider pace and scale of training delivery Consider additional training needs
3c	**Recognise and value the expertise** of health and social care professionals	Develop a Register of Experts and clarify its purpose and value - Resource to Board/ Trustwide Management Group/ Trustwide Professional Groups - Utility in business development - Support PALS - Support Communications team - Facilitate innovation and improvement	Implement 1d Make register (or part of register) publicly available
3d	**Create development opportunities**	Suggested: Back to the floor opportunities for senior managers and clinicians Operational Team Managers seconded to management level project work Mentoring/ partnering relationships between managers and clinicians Join Clinical Working Groups	Organisational Development proposal
3e	**Review engagement methods** to maximise involvement of health and social care professionals at all levels and locations	Suggested: Online chat room for staff to express and share ideas Brainstorming using Ourspace Increasing 360° appraisals Anonymous surveys Focus Groups Protected time for service development opportunities Clear invitations for involvement opportunities Good communication and feedback (You said, we did) Feedback mechanisms via team meetings/ Group/ Trustwide Professional Group	Develop advice on creative engagement methods

The implementation plan for the above objectives will be developed pending approval of Professional Council, Trustwide Management Group and Board. The implementation plan will include outcome measures to assess the effectiveness of the strategy in achieving its aim.

Summary

The actions described within this strategy will build the infrastructure, capability and commitment to actively engage health and social care professionals in operational and strategic decision making. The output of the strategy will be improved outcomes and experience for those providing and using the service.

The present strategy must be implemented alongside the Community Engagement Strategy and 'New Ways of Working' programme will ensure AWP is 'fit for the future'

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Appendix 1: AWP Staff Charter

STAFF CHARTER

AWP puts recovery and reablement at the heart of all that we do. We facilitate recovery through the guiding principles of hope, trust, partnership and mutual respect.

We enact this by:

- Working together to deliver services that we would be happy to use for ourselves, our families and for those we also care about
- Listening to one another and to users of our services, their carers and local communities, hearing what they tell us
- Welcoming new ideas. We embrace change and get better by doing things differently. We try to meet the needs and aspirations of those we support and the communities in which they live
- Working closely together, contributing to decision making, responding to the needs of one another and having equal and fair access to opportunities for development and progression
- Making sure that our actions reflect our words. We do what we say and are honest about what we cannot do. When things do not go as we hoped, we admit any mistakes, are open and reflective and try to improve by learning from the experience.

This makes us a good organisation to work with and we try to extend the options available to those who use our services through partnership working. We are proud of the collective contribution we make to improving people's lives.

Clinical Engagement Survey

August 2012

Report to Professional Council

Contents

Clinical engagement Survey Results

A survey designed by Professional Council asked AWP staff what their views of clinical engagement are. A definition of clinical engagement was given as a starting point. Respondents were asked the following questions:

1. Firstly, do you agree with the following definition of clinical engagement? **Yes or No**

"Clinical engagement is the active involvement of health and social care professionals in operational and strategic decision making to provide the highest quality care possible"

Comments – free text

2. How could AWP improve clinical engagement in decision making (who to involve and how)?
3. Please tell us which SBU or Corporate Directorate you belong to
4. Please indicate your professional group

Respondents

This survey was placed on 'Ourspace' during August 2012 for the period of 30 days. August is a month when many staff take their annual leave, even so the response rate of 176 members of staff was low. This represents 3.4% of our workforce (N5134 on 31st August 2012). The following figures illustrate the role and directorates respondents were derived from.

Figure 1. Respondent role description

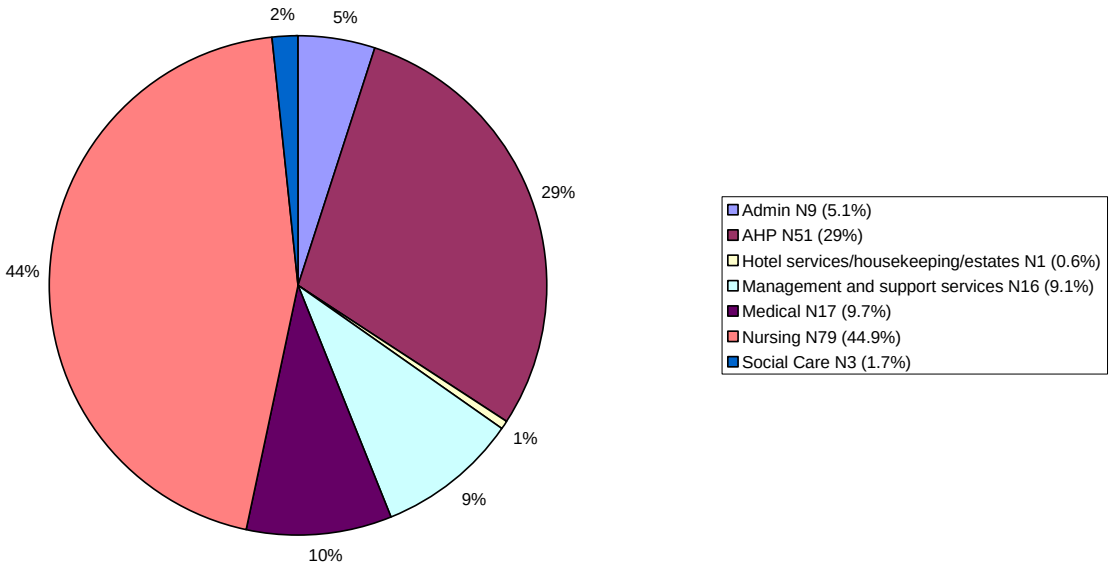

Figure 1 illustrates the wide engagement of nursing (N79; 44.9%) and allied health professional (N51; 29%) staff in the survey population. Table 1 below shows the level of engagement in this survey

compared to the total workforce headcount by role on the 31st August 2012. Allied health professionals are the largest percentage contributors overall (18.8%), followed by the medical staff (9.3%) and nursing staff (4.8%).

Role	Overall workforce N	Survey respondents N	Overall %
Admin	712	9	1.3%
AHP	271	51	18.8%
Hotel services/housekeeping/estates	278	1	0.4%
Management and support services	1519	16	1.1%
Medical	183	17	9.3%
Nursing	1635	79	4.8%
Social Care	111	3	2.7%

Table 1. Percentage survey respondents compared to overall workforce headcount by role.

Figure 2. SBU/ Directorate

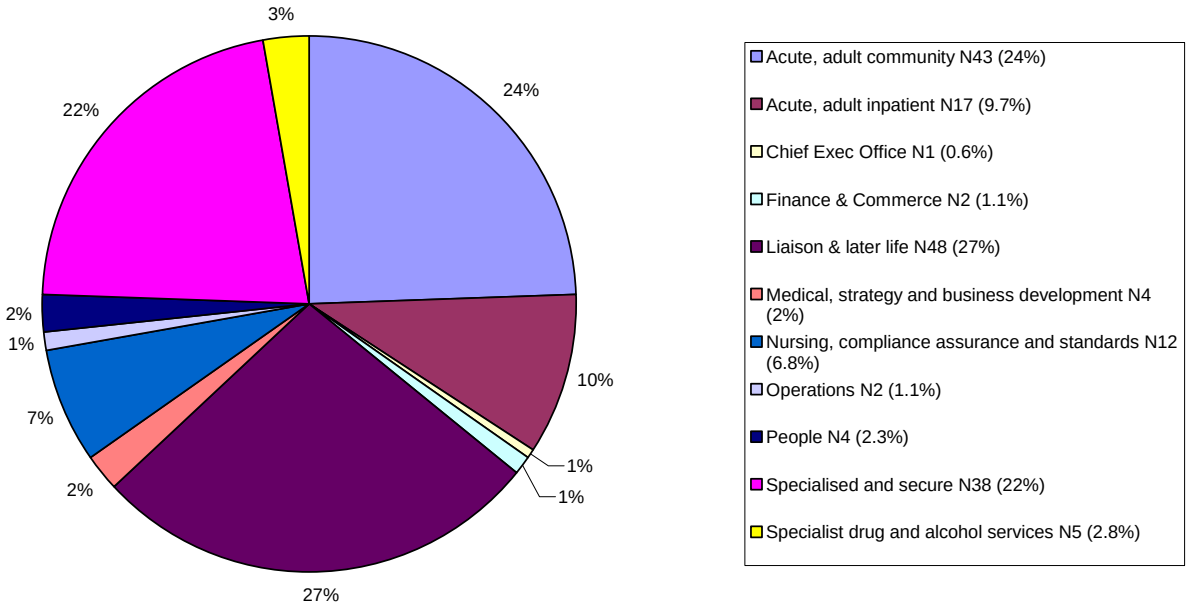

Figure 2 illustrates the directorate respondents are situated in. Acute, adult community (N43; 24%), Liaison and later life (N48; 27%) and Specialised and secure services (N38; 22%) were the most widely represented. Table 2 below shows the level of engagement in this survey compared to the total workforce headcount on the 31st August 2012 by directorate/ SBU. The greatest representation of responses came from Operations (18.2%) and Nursing, Compliance and Standards (14.8%).

Directorate/ SBU	Overall Workforce N	Survey respondent N	Overall %
Acute, adult community	724	43	5.9%
Acute, adult inpatient	336	17	5.1%
Chief Exec Office N1	18	1	5.6%
Finance & Commerce	109	2	1.8%
Liaison & later life	909	48	5.3%
Medical, strategy and business development	53	4	7.5%
Nursing, compliance assurance and standards	81	12	14.8%
Operations	11	2	18.2%
People	98	4	4.1%
Specialised and secure	792	38	4.8%
Specialist drug and alcohol services	251	5	2.0%

Table 2. Percentage survey respondents compared to overall workforce headcount by directorate/ SBU.

Level of agreement with the 'Clinical Engagement' definition

In response to the definition, 90% of respondents agreed with it and some gave further clarification (N69, 39% gave comments; N134, 76% answered Q2). Overall, the survey provided a forum for staff to give their opinions about the trusts past ability to consult, involve and collaborate with clinical staff in the trusts organisational business, strategy and decision making. It illustrated the wide scale disenchantment with leadership, senior management and the connection it has with the operational work carried out by the clinical staff. There was considerable scepticism that clinician engagement has been desired, suggesting past lip-service being paid to the concept with tokenism rather than comprehensive engagement. Some of the comments below provide some examples of the consistent messages found throughout the free text commentary:

> *"I agree that is the DEFINITION... not seen much evidence of it actually happening though!" (Nursing)*

> *"As a clinician I do not feel that the trust has operated from this perspective. No feedback has been requested from clinicians regarding operational & strategic decision making. When changes to the structure or operational procedures of the trust have occurred, staff are said to be consulted with, however this consultation is basically clinicians being told what the changes are, not seeking what clinicians opinions are with regards to the changes" (Nursing).*

> *"This has typically been lost within AWP historically. With top down decision making and crazy targets taking precedence over patient care and safety. We often have not known who is managing us overall and where accountability lies within the trust for decisions that are made that directly effect our service users and carers. There has been a total disconnect between*

upper management and staff. It's been really damaging and impacted on morale of staff." (Social Care)

"AWP has a tendency to make a decision and then roll it out through 'staff engagement meetings'. These meetings tend to be the first opportunity for clinical staff to discuss the decision and problem solve what may go wrong in practice. Unfortunately, the Trust response is almost always, 'sorry, the decision has been made and can't be changed'. This is very disheartening as we then watch all the things we thought would go wrong, going wrong. The recent mantra, 'don't tell us what's wrong with this idea, concentrate on how to achieve it', was particularly irritating." (Nursing)

"'Involvement' is a vague term. I have been 'involved' in a number of meetings, expressed my views and believe this has had NO EFFECT on decisions re strategy or quality. I know service users who feel the same. Feedback 'up the chain of management' about the effect of management restructure, decisions made by finance, disregarding information on it's clinical effect, major management hiring … has been given of the effect that management style has been having on Team morale...." (Allied Health Professional)

These responses reflect inconsistent rather than common purpose between decision makers, managers and clinicians, where objectives and outcomes are not shared but prescribed. One respondent, who did not agree with the existing definition of 'clinical engagement', challenged the nature of engagement and it's top-down philosophy. He suggests that rather than clinicians being deliberately excluded or considered difficult to engage in strategy and decision making, they should define the debate and decisions from the ground up instead.

"I don't agree - far too narrow a concept - the premise is that it is the job of managers to get clinicians (and then on again to clients) to engage, whereas in fact, the onus should be the other way round - managers being engaged in the debates that clinicians and others create - management strategy directed in a bottom-up approach." (Allied Health Professional)

It was also clear that the concept of 'clinical engagement' can be confusing and lack specificity. Some respondents suggested it can be used to describe the ways service users engage with services, rather than how clinicians engage with the trusts organisational business, strategy and decision making.

"Clinical engagement is a term used by nursing staff (all levels) to determine service user involvement. It is a working term for service user activity not professional decision making."(Nursing)

"My understanding of the term is 'when a service user engages with a clinician in a therapeutic way'"(Allied Health Professional)

Therefore it may be more accurate to use the term 'Clinician Engagement'. This is reflected in the amended definition shown later in this document.

Extending, clarifying and implementing the 'Clinical Engagement' definition

A respondent from a nursing background suggested the definition should be amended, removing *"'to provide the highest quality care possible' and replacing it with 'ensuring the best outcomes and experience of services for service users'"*. This change of emphasis reflects a focus on service user definitions rather than simply performance measures.

Some respondents felt the component parts of the definition needed further clarification, to include bench-making and evidence of engagement outcomes.

> *"Definition needs expanding on, how one knows it is happening! i.e. evidenced by....."* (Medical)

> *"I think it is quite broad statement, which inevitably will lead to challenge in particular 'the highest quality care possible'. There are many considerations as to whom decides what this is, and given the resources in terms of available skills and the trusts ability to ensure staff are enabled to practice in a high quality environment"(Allied Health Professional).*

The following respondent suggested some specific weighting for engagement, suggestive of a transparently proportional nature.

> *"The definition needs to include what weight would be given to the 'clinical engagement'" (Allied Health Professional)*

This could include a pledge for a specified number of clinicians involved in decision making from a selection of roles and grades; as well as understanding the routes and processes of decision making. The following respondent has clearly given this considerable thought and outlined an approach:

> *"Each SBU could provide a representative from each professional role to sit within a decision making council whilst truly representing the views of clinical staff. (7 per SBU) Representatives would be voted in by their peers and new representatives would be elected annually. Representatives would be provided with 1-2 days a month to visit teams within the SBU to gain live feedback around policy and decision making. Representatives would meet monthly for 'Clinical Engagement team meeting'. It is important that staff feel the representatives believes in clinical involvement and the representatives actively engage in the process. A Clinical Engagement chair would be elected from within and by the representatives." (Nursing)*

This method would provide a democratic and transparent level of engagement. It might provide a model of a 'government' style group, which could also adopt a senior 'cabinet'. This builds on existing structures, such as Professional council and could become a very formal opportunity for clinicians to *"put forward their preferred views"(Allied Health Professional)* and remove *"self interest"(Nursing)*. A respondent from management and support services suggested the definition should include *"partnership"* as well as active involvement. Again this suggests a desire for increased collaboration rather than merely prescriptive management. Respondents with a medicine background suggested "*Clinical engagement is not enough. We need clinical leadership of the service. 'Clinician led,*

manager supported'" and "Where are the medics?". This reflects a passionately held view that clinicians should be integral to Trust business.

Service user and carer involvement

Some respondents suggested engagement models should also include service users and carers.

> *"There is no mention of patients or 'service users'. To be truly collaborative their views are just as important as the staffs view, who can be completely out of touch with patients views/needs." (Allied Health Professional)*

Although this is an extremely valuable suggestion and must be given due consideration in an overall engagement strategy approach, it falls outside the concept of 'clinician engagement' referred to in this survey and report.

Pre-existing organisational philosophy

Despite much common ground, particularly seeking consultation and collaboration, viewpoints varied. The following comments reflect an prevailing dichotomy between operational management and clinical practice and expertise. It may be that until a common purpose is shared, frustration is likely to be perpetuated at the divide between the two.

> *"Clinical engagement needs to [be] thought of as different to operational management... Clinicians need to be allowed the freedom to consult, be consulted and be included in strategic direction but not necessarily be held to account in the delivery of this. Its their professional and clinical knowledge that needs to be harnessed."(Management & Support Services)*

> *"It also involves recognising specific clinical expertise - everybody's view may be of value but they are not all of equal value - in addition to a top down neglect of clinical opinion there has been a lack of recognition and channels for people with specific expertise to offer that to management - spend time to work out what is really preventing clinical engagement in decision making" (Allied Health Professional)*

Should engagement in strategy and decision-making increase in the future respondents felt it may be necessary to increase levels of clinician accountability for decision making according to the level of their involvement:

> *"Is there a way of including the idea that professionals need to take some responsibility/ownership of some of the more difficult decisions the Trust might have to make" (Allied Health Professional)*

Moreover, this would include developing a common purpose for the greater good.

> *"The aim of engagement should not just be to involve staff in decision making but also to ensure, as far as is possible, that staff take ownership of whatever decision is taken even if they disagree with it." (Allied Health Professional)*

Active consultation and involvement at all levels of the organisation

Overwhelming respondents want active listening and involvement in strategy, decision making throughout the service delivery cycle. They wanted this to extend beyond the most senior clinicians and consultants to the workers at the front line- "*Diagonal slice group" (Allied Health Professional)*. This means avoiding reliance on heads of profession alone. They also wanted all professional groups to be represented.

Ideas arising from the comments to develop the levels of clinician engagement included several domains. These include changes to the existing leadership and management culture and developing the organisations philosophy.

Evolving the organisational culture and philosophy:

- *Developing a shared purpose:*
  - *Rights and responsibilities approach*
  - *Have clear aims and objectives*
  - *Lead by example*
- *Developing a transparent organisational framework:*
  - *Evidenced based decision making*
  - *Making decision making processes clear*
  - *Clinical representation at board level*
  - *Regular back to the floor opportunities for managers, including 'ordinary meetings*
  - *Mentoring or partnering relationships between managers and clinicians*
  - *Involve clinicians in commissioning relationships and meetings*
  - *Independent policy review, proof-reading and ratification to ensure they are concise and accessible; supplemented by transparent accountability for them*
  - *Managerial training in consultation skills*
  - *Open doors at Jenner house*
  - *Face to face meetings rather than online communication*
- *Developing shared responsibility:*
  - *De-centralised decision making, allowing authority to act*
  - *Identify specific expertise and channels to harness this*
  - *Involvement in decision making, for example new security measures, how charitable funds are spent, staffing levels.*
  - *Clinical working groups to examine research and processes to inform policy*
- *Use existing expertise:*
  - *Nomination of individual practitioners by professional council when issues arise at board level*
  - *Operational team mangers seconded to management level project work regularly*

In addition specific practical ideas were generated as acceptable methods of facilitating communication through the hierarchy:

  - *Start a chat room for staff to express and share ideas*
  - *Brainstorming using Ourspace*

- *Increasing 360^{o} appraisals*
- *More anonymous surveys*
- *Focus groups*
- *Clinical leadership forum*
- *Monthly forums for discussion of operational and strategic issues, led by practicing clinicians*
- *Awards for clinical excellence*
- *Protected time for service development opportunities*
- *Clear invitations for involvement opportunities*
- *Good communication and feedback: 'You said…. We did….'*
- *Feedback mechanisms via team meetings*

Conclusions and new definition

In summary, although clinicians were unhappy with previous levels of engagement, it is widely desired and will be largely welcomed by these respondents. There was confidence that staff would become involved *"Listen to us! Ask and we will answer"(Nursing).* They suggested this needs a change in the culture and ethos of the Trust which values expertise and opinion and reduces the climate of fear. Moreover, this requires some re-assessment of the performance target drivers rather clinical perspectives. Furthermore the Trust need to be explicit about high regard for staff and their value in this process. This was suggested as a way to revitalise morale after a bruising period of re-organisation:

> *"I hope the strategy will feel empowering rather than just tokenism or more things …on top of the day job. Clinical engagement won't work if staff don't feel valued by the organisation e.g if simultaneously management is trying to push down bandings for the people in the Trust who have developed a degree of expertise through years of experience, additional training etc." (Allied Health Professional)*

As a result of this survey the definition of clinical engagement has been amended (see below) and should now be considered by professional council as part of the future 'Engagement' strategy. In addition to the definition this should include a description of the actions which underpin the strategy and the ways in which evidence of engagement will be collated. These might include repeated surveying, records of consultation and outcomes, new structures such as professional cabinet with the terms of reference and methods of identifying changes in leadership.

"Clinician engagement is the active consultation, partnership and involvement of health and social care professionals in the Trust operational and strategic decision making to ensure the best outcomes and experience for all service users."

Appendix I: Comments made in regard to the definition of clinical engagement

"Clinical engagement is the active involvement of health and social care professionals in operational and strategic decision making to provide the highest quality care possible".
Any comments?

The opinions of the care teams working with service users should be considered when implementing operational changes - they are most often the ones who have to make them work.

This does not happen well in AWP
Fairly obvious for a Health Trust I would have thought. However, as has been the case with the Redesign, the admin backup to clinicians has been sadly under-estimated. Good, solid, well organised admin needs to be in place prior to any new clinical teams being set up. It seems to be forgotten that health and social care professionals need to be organised by their admin support, you can't have good clinical engagement without good admin support. Overlook this and the Trust will continue to fail.

'Involvement' is a vague term. I have been 'involved' in a number of meetings, expressed my views and believe this has had NO EFFECT on decisions re strategy or quality. I know service users who feel the same. For example: The letter informing service users of changes as a result of the Adult Redesign – [we asked] almost two years ago, when we would be able to provide service users with information about these changes. We received the final letter for circulation to patients less than a month ago, well AFTER the changes were put into place, and affecting patients...Feedback 'up the chain of management' about the effect of management restructure, decisions made by finance, disregarding information on it's clinical effect, major management hiring without regard for feedback I know has been given of the effect that management style has been having on Team morale...The definition needs to include what weight would be given to the 'clinical engagement'.

I feel that this is organisational or structural engagement or even service delivery not clinical engagement. Clinical engagement would suggest more emphasis on the actual patient based activities, evidence based practice, treatment guidelines, research and development, best practice. The above definition barely makes reference to this except the last 4 words.

one of the 'developments' in the NHS over the last 5 years has been the gradual separation between management decision making and clinical involvement - there is a difference between an organisation being run in a business like manner and it being run as a business - it is time NHS managers and politicians understood this.

is there a way of including the idea that professionals need to take some responsibility/ownership of some of the more difficult decisions the Trust might have to make
The words make sense - but in practice what is considered to be active involvement, this could be very little. What is a health and social care professional, perhaps this should only refers to ones who have primarily clinical responsibilities.

Provided we get enough feedback on strategic thinking going on at management level which never seems to happen till well after decisions have been made

The aim of engagement should not just be to involve staff in decision making but also to ensure, as far as is possible, that staff take ownership of whatever decision is taken even if they disagree with it.
it needs to be proactive not reactive

I think it is quite broad statement, which inevitably will lead to challenge in particular 'the highest quality care possible'. There are many considerations as to whom decides what this is, and given the resources in terms of available skills and the trusts ability to ensure staff are enabled to practice in a high quality environment. We have many skilled staff ,who are not currently enabled to deliver skilled interventions. In Bristol the dis-integration between health and social care staff has been a step backwards.

i don't agree - far too narrow a concept - the premise is that it is the job of managers to get clinicians (and then on again to clients) to engage, whereas in fact, the onus should be the other way round - managers being engaged in the debates that clinicians and others create - management strategy directed in a bottom-up approach. the fault is not a failure of clinicians to engage, but in the development of this awful management lead culture over the last ten years, in which nonsensical and patronising jargon has replaced real and clinically lead thoughtfulness about how to improve the services we provide in any other than a target driven way

Staff involved with any decision making also need a sense of empowerment and clarity of boundaries.

But it's also more that this. Clinical engagement also involves clinicians being held to account for the outcomes of operational and strategic decision-making alongside managers

It also involves recognising specific clinical expertise - everybody's view may be of value but they are not all of equal value - in addition to a top down neglect of clinical opinion there has been a lack of recognition and channels for people with specific expertise to offer that to management - spend time to work out what is really preventing clinical engagement in decision making - I hope the strategy will feel empowering rather than just tokenism or more things we have to do (e.g. go to engagement events that don't make any difference) on top of the day job. Clinical engagement won't work if staff don't feel valued by the organisation e.g. if simultaneously management is trying to push down bandings for the people in the Trust who have developed a degree of expertise through years of experience, additional training etc.

I feel this is vital in order to work together to provide the most effective service for service users and their carers. I realise that some difficult decisions have to be made in this financially insecure times. However if clinicians were given the opportunity to put forward their preferred options and be involved indecision making this would help them feel more valued and their experience helps with practical problem solving processes.

It sounds a good ideal to aim for but does not seem to represent the present reality.

I feel that strategic decision making is a very top down process. Clinical staff are forced to make compromises in order to complete data input tasks to demonstrate our clinical activities at the expense of meeting service demand. On the ground we have to be very creative and it doesn't feel like our suggestions and concerns are listened to and our immediate line managers seem quite

powerless. There is a constant pressure to meet a ridiculous demand at all costs. Commissioners need to stop making promises that we can't meet.

There is no mention of patients or 'service users'. To be truly collaborative their views are just as important as the staffs view, who can be completely out of touch with patients views/needs.
Clinical engagement means something very different to clinicians, and the use of this phrase with a completely different meaning is likely to cause confusion

My understanding of the term is "when a service user engages with a clinician in a therapeutic way".

In clinical application i note that reflective practice is vital in ensuring that information is gathered from all professionals (HCA's etc often have the most contact and understanding of day to day running) working with service users to ensure care teams working with service users are operating from a systemic view. This means that these meeting take place on the ward to increase accessibility and there is a clear model to reflect with to ensure all are able to contribute.

Clinical engagement needs to thought of as different to operational management though. Clinicians need to be allowed the freedom to consult, be consulted and be included in strategic direction but not necessarily be held to account in the delivery of this. Its their professional and clinical knowledge that needs to be harnessed.

an inclusive statement so you can still take ownership even if you never see service users or carers.

Currently only limited engagement with social care professionals linked to the trust. Close the gap between operations and strategic management.

Hasn't happened for years - rare to have anyone above a service manager come to team. This isn't about L3 - as L3 has been better than other areas of trust I have worked in.
Would like to see engagement in improvement activities (research, innovation, improvement)
it needs to happen early on in any proposed process for change

To some extent but might add after 'active involvement' the words and partnership. Is it the combination of management and also clinicians working together that is the key.

I would consider this to be 'consultation & inclusion' .Clinical engagement has an established definition in many SU fora, as 'the involvement of Families, Service Users & Carers, in the clinical aspect of a care pathway. I think this will serve to confuse.

Agreed- can you share this with the Trust finance team who in effect hold the power and have done for some years. This philosophical statement is good. What drives the organisation though has been money and performance- (as clearly outlined in the report last week)

The definition is very good.

Clinicians need to be given the support to do this

As long as that is what happens.

but it does not happen

Definition needs expanding on how one knows it is happening! ie evidenced by.....

Clinical engagement is not enough. We need clinical leadership of the service. "Clinician led, manager supported"

Where are the medics?

It's not rocket science is it?

Term will be very confusing to most clinicians who use the term to me engagement of service user with team/service!!

Care Co-ordinators are being swamped with dangerous numbers on their case loads, so that targets are met. It would be difficult to know where the time will come from for more involvement.
AWP has a tendency to make a decision and then roll it out through, 'staff engagement meetings'. These meetings tend to be the first opportunity for clinical staff to discuss the decision and problem solve what may go wrong in practice. Unfortunately, the Trust response is almost always, 'sorry, the decision has been made and can't be changed'. This is very disheartening as we then watch all the things we thought would go wrong, going wrong. The recent mantra, 'don't tell us what's wrong with this idea, concentrate on how to achieve it', was particularly irritating. See the FED target for example.

Clinical engagement is also very significant in to the relationship between service users and providers of care. The purpose is that both parties are working towards the same goal. As a clinician I do not feel that the trust has operated from this perspective. No feedback has been requested from clinicians regarding operational & strategic decision making. When changes to the structure or operational procedures of the trust have occurred, staff are said to be consulted with, however this consultation is basically clinicians being told what the changes are, not seeking what clinicians opinions are with regards to the changes.

Ask those on the front line first

There could be many definitions but in this context it fits.
This has been sadly lacking for many years in AWP

so long as it isn't only "lip service " to involvement

the restructuring was a top down exercise, its failings are legion but to be fair I don't know how to fix them.

I believe the trust has made some strategic decisions about how to "redesign services" that have gone against the best advice from community services. By involving senior clinicians in these processes in the future should ensure that we are able to offer a more flexible service.

Sometimes Health and social care professionals are not involved in these decision making.

Highest quality care possible, could come from the relatives of the patients, by helping them under standing mental health better,

As an ex-operational manager I feel that I spent an inordinate amount of time in Top-down ineffectual meetings that did not facilitate problem solving of clinical/operational issues and at no time was I asked my opinion on how the service could be improved instead it was dictact after dictact with veiled threats of disciplinary action if as a Team Manager I did not comply.

I agree that is the DEFINITION... not seen much evidence of it actually happening though!

Not to "provide the highest quality care possible" but to "ensure the best outcomes and experience of services for service users"

I think of clinical engagement as something I do with service users and carers

Please try not to use imagery, such as the stethoscope above, that gives the impression that it is medics opinion that take priority

You could say "The engaging of clinicians is the key to the active...."

Clinical engagement is a term used by nursing staff (all levels) to determine service user involvement. It is a working term for service user activity not professional decision making.
clinical engagement is the work we do with service users

A clear link to clinical guidance should be evident when developing services. We should not be developing services just by ensuring we tick all the boxes. Services should be complete and available to all when they are provided.

For awp this has been long overdue nursing staff have been saying this for years why dose it always take incidence and critical reports to make this trust listen.

I would agree with the statement however it seems to fall short with no mention of engaging the people we work with.

This is just a definition - what's to comment on?

AWP currently do not have enough staff working at Fromeside to facilitate this. We can not cover the basics.

Clinician are the frontline members of the organisation. They need the support of the organisation to aid in implementation of their decisions.

start a chat room for staff to express and share ideas.

This has typically been lost within AWP historically. With top down decision making and crazy targets taking precedence over patient care and safety. We often have not know who is managing us overall and where accountability lies within the trust for decisions that are made that directly effect our service users and carers. There has been a total disconnect between upper management and staff. It's been really damaging and impacted on morale of staff.

to be honest I am very unclear as to what the term means

Appendix II: Comments made in response to the question: How could AWP improve clinical engagement in decision making (who to involve and how)?

The opinions of the care teams working with service users should be considered when implementing operational changes - they are most often the ones who have to make them work.

To involve everyone instrumental in the recovery of the patient - to have dedicated time to talk to carers, family etc (where possible, face to face - not via e-mail/letter)

Involve more staff - in all areas with decisions that affects service users and staff , and staff relationships with service users and staff and families.

The fact you are asking this question suggests you are up the creek without a paddle. See above. Go beyond the top consultant in each area. Allow for this to be part of peoples job rather than expecting it on top of an already crazy case load. Admin are affected by clinical engagement too but often forgotten or the last to be informed but it's us that are the front line when taking calls or letting people in to buildings.

More 360 appraisals for management, and some weight given to the results. More open consultation, rather than 'fait accompli' decisions coming down from on high. Training in genuine consultation skills for managers, including a change in Trust ethos toward valuing clinical staff AND THEIR OPINIONS. Firstly I feel that the trust could do more to boost staff morale. Since the redesign when people have been forced to apply for jobs they have been doing for years morale seems to be at a low and even though there are pathways in place to support staff having a voice there is a general feeling that ultimately their voice does not get heard. Also that in many cases the appropriate people are not consulted. Also there needs to be a longer term approach to managing staff resources for example DBT resources. Many DBT trained staff are not given time to do DBT and training for new staff is only every 2 years this leaves DBT teams depleted. Staff not being supported in things like this also contribute to feeling powerless so what's the point? Need to involve staff at ground level and show evidence of listening to their views and incorporating them into plans in order for them to feel valued and part of the organisation. The organisation can feel very big due to the size of the geographical catchment area and for those on the outskirts of the area it often seems that the main focus is on Bristol and Bath. Services are becoming more spread out and less accessible for clients and training is less localised. A move to more localised services would help staff feel more involved. Costs seem to take priority over patient needs a lot of the time e.g. restrictions on patient transport making therapy less available. The voice of the patient/client needs to be heard.

By listening to people and acting on feedback. For too long people have felt that there is no point in engaging as nothing happens, nothing changes so you just carry on and do the day job
involve clinicians and people on front line of patient care, and people using the service

By actually acting on instead of paying lip service to, suggestions made. By greater engagement between executive/board members and front line workers - through attendance at 'ordinary' operational and other meetings, perhaps by mentoring, removing the fear of getting it wrong so people are reluctant to speak out (I think this is now happening), and by continuing the already improved open communication.

Clinicians need to be far more engaged at all levels in working with management to provide essential input into the clinical issues we face, and what measures support practice, and those that don't. improve flow of information, organisation has a very "top down" feel. ensuring all professions are fully represented, smaller professions are not always consulted and if we are our feedback is seen as unimportant as demonstrated recently by delays in redesign process due to OT issues not being addressed at an earlier stage. Issues are not always taken (upwards) by OT but have to be filtered through another profession/line manager who may not have a full understanding so they are not presented or resolved satisfactorily.

Broad involvement, beyond medical colleagues

More clinical leadership roles

AWP management culture being more respectful of the view of clinicians in general /listening /consulting opinion of senior clinicians who work at clinical level. Recent initiatives appear to be addressing this issue and are welcome. and more anonymous surveys!

Focus groups on relevant topics

By reducing our admin work and constant inputting of information on a system that impedes rather than supports our work

Have good clinical representation at board level. Make it clear to staff what the lines of management are to board level.

Make sure that the decision making processes in the trust are clear and that all the approproate staff groups are represented on these bodies and that those representatives attend the meetings of these bodies and take feedback on issues in the meeting agendas and give feedback on the decisions.

We need to have clinical lead roles that really make sense and are not just token gestures i.e. Physical health care needs representation from all the disciplines to cover all aspects of physical health but to have one lead who has a clear line of accountability to the Organisation and feeds back through a very simple management structure to ensure the correct messages get to all the staff.

Recognise the skills of Allied Health Professionals and ensure that they are better integrated in the care of service users - improve care pathways.

Hold monthly forums where operational and strategic issues can be discussed, by representatives of each profession. These could be allocated through team meetings.

Perhaps some clinically practising staff from all bands to input into Strategic forums, lead by practising clinicians instead of always leads from operational management. Specialist forums and clinical champions, to pull out good practice. Expertise more widely shared across SBU's.

management, from chief executive down need to engage with clinicians and clients - not the other way around - e.g. senior management spending a week a year working on a ward, or community team. that would be a much more responsive service

All staff should have an identified opportunity to contribute to development and understanding of DOH requirements

More involvement of clinicians in decision making of operational policy.

Demonstrating how clinician input has shaped operational plans (it's easy to be turned off when you are asked your views and get lots of nods and then nothing changes). 'Diagonal slice groups' could field views from across the range of people providing clinical care within a single service/pathway. Effective clinical engagement will involve clinicians throughout the service delivery cycle in the development of bids for new services/redesign, development of operations, evaluation of outcomes and subsequent/responsive actions.

Heads of professions in each SBU could make more active attempts to seek the views of frontline clinical staff about changes, rather than relying on their own views and experience only.
Identify the people in the organisation who have specific expertise and whose peers and colleagues value and acknowledge that expertise and provide channels for that expertise to be harnessed - make time to listen to people who want to offer their clinical expertise and give the people who have ideas about how to improve things the time to develop and implement some of these ideas.

Need to ensure there are pathways for including clinicians in the strategic decision making process and routes for people to be involved in the discussions including the obstacles. Leads in the business unit should be included in strategy meetings and the opportunity to have their opinion heard. Professional heads are important in communicating to their staff the process and ensuring their staff group are engaged and feel they are being heard. No high level decision involving the practice of clinicians should be made without them being involved.

I do not feel that there has been clinical engagement with the staff at grass roots level. I feel that there has been a lack of honest communication and what there has been has been not about involving staff in decisions but to tell them what decisions have been taken. Any consultancy has felt dishonest as decisions have already been made. I feel that for a lot of staff it would be better to meet face to face than be engaged via the intranet. Staff I believe feel passionately about providing high quality care but feel that the system does not always allow this - and would like the opportunity to give their opinions about how this quality service is being eroded by performance indicators etc. Increase trust board and clinical meetings to discuss new ways of improving the service, and in putting forward new proposals. Increase representatives from each profession to look at improving services and feed this back to the strategic level meetings. Continuing with surveys for service users and carers.

By trying to include the voice of more clinical staff (in face to face contact with service users) and service users before decisions are made.

Care plans kept up to date and all involved people being communicated with on a regular basis.

adopt a reward based rather than punitive approach to clinical work. Ie awards for clinical excellence, meeting targets rather than fines. This would give clinical staff a sense of agency and interest in improving the service. Ensure protected time for clinicians to be involved in service development, including meetings. Reduce the number of emails sent to clinical staff to essentials, sometimes face to face meetings work better! I certainly feel swamped by info emails that I am supposed to read to keep up with developments, detracting from clinical time. Employ neutral others to conduct service user surveys rather than asking clinicians to use of their clinical time, potentially biasing SU response. Evidence base operational and strategic decision making.

Involve the people directly involved with clinical engagement and recognise the time spent in this engagement. how ? ask the people direct.

By inviting members of the MDT to become involved

Listen to front line clinicians. Employ more admin staff to do the data entry elements. Stop making so many changes so frequently - people can't keep up with them and people end up not feeling clear about what they are meant to be doing. Too many changes seem to be based on knee jerk reactions which then lead to more necessary changes. Perhaps if more appropriate staff were consulted and listened to, you wouldn't need so many changes.

By making sure frontline staff have input and are listened to. Frontline staff are underrepresented in decision making meetings because of the ongoing pressures from their clinical caseload.
In my four or so years with the trust, the thing that has struck me from my first contact is the unwieldy nature of the trust structure and associated governance procedures. When I started in my post (from another NHS organisation) I ask my manager to explain how AWP was organised. Beyond mentioning “the new SBUs” he couldn’t tell me. I thought it would become clearer as I became more familiar with the trust but I remain bewildered! This has important clinical consequences: for example when policies are written (I have experience of this myself) there is a complex series of committees and groups they must be approved by. But few, if any members of these committees have the time (and many lack the relevant expertise) to really read through the policy in detail. And the detail matters if the policy is going to work ‘on the ground’. I would suggest that policies (especially clinical ones) should be assigned an independent peer reviewer who will undertake to properly proof read, comment on and put their name to the document. The same could be said for other trust documents, for example information leaflets. In more general terms, there should be a trust structure which can be outlined on one webpage or sheet of paper. I understand that we have ward managers and modern matrons, but where the nursing hierarchy goes after that is a bit of a mystery to me. How do those linked in to the teams and units relate to senior staff at Jenner or Blackberry Hill? What are the routes of communication? I have similar problems understanding the management structures for medics. I realise for many people this is not relevant in their day-to-day work, but I see it creating problems all the time. Create a structure to engage clinicians (through professional council for example) and then make it clear how this relates to the rest of the trust. If someone needed to escalate something, what would be the process? I hope this feedback is helpful. I'd be happy to discuss it further!

Staff at all levels- focus groups. Service user forums.

Come onto the shop floor and actually talk to staff.

Chippenham is so far away! I do believe that at times this trust can feel too large and it's easy to become negative about the management staff it their "ivory tours". More support for Bristol? an identified local person to whom we can feel more of a relationship with?
Perhaps members of all disciplines and different grades - not sure of the logistics with this though.
to be inclusive of all grades of staff at meetings, to allow agreed time for staff who work shifts to attend meetings

The Trust needs to first organise and pay attention to it's structures of professional leadership. For at least two years now, many professional leads have been trying to clarify their roles and responsibilities and get the Trust to define through job role descriptions their role within the organisation. In order to involve clinicians from the frontline, the Trust should be giving attention to the views of the professional leads who represent these clinicians. These individuals have many skills and a vast experience and knowledge of the clinical services that has been overlooked in the past in favour of manager's views and corporate priorities. The Trust is under using this group of highly skilled individuals. These are the people who should be engaged or rather included in operational and strategic decison making. It isn't complicated but failure to listen and give any status to this group has contributed significantly to the Trust's abysmal assessment by outside agencies in terms of connectedness to the clinical services.

it needs to be accessible for staff to attend and feedback affectively. Firstly this involves ensuring there is effective communication on the systemic picture in which decisions are being made and on a practical level people need the time and accessibility to input. This means that there needs to be consultation within staff meetings, there also needs to be feedback about what was received in this consultation and information about how the decisions were made in relation to what was gathered. More opportunities for consultation with health and social care professionals through email surveys, information dissemination, face to face meeting.

Talk to the staff on the shop floor, if there opinions were listened to, and actioned, the service to service users would improve so much.

to ensure that clinicians are actively involved in contractual decision making with commissioners
Use the professional council.
thru strengthening the cpa process. not cpa without the service user, even if it only involves the su, care coordinator and carer for the first meeting, then the carer, cc and medical etc staff for a second meeting or by telephone. just so we get everyone's views and they get a copy of the cpa care plan.
Better and more open communication with staff. More shop floor engagement from senior management. To move from a scape-goating to a learning culture. Greater decentralisation of decision making both within the trust and SBU's.

Employ a Head of Social Work and Social Care. Operational team managers to be included in project work on a regular basis. Fro example, recent development of Primary Care Liaison Service had only very limited operational staff input. Service development forums need to become more inclusive.

for senior people to come out to teams and for clinicians to be seconded into decision making arenas - from the front line. would be good learning experience too.

Increase engagement in operational (team/ service/ SBU) and strategic (Trustwide/ professional) decision making. Increase engagement in improvement activity and 'quick fixes' i.e. how do we respond rapidly to incidents or things that need changing immediately without putting in place massive machinery.

don't limit this to one method. staff have lots of good ideas and these need to be heard and responded to. let people know what they can be involved in and how. Let us know what's changed as a result of being involved. need a process that doesn't take forever.

Volunteers have been difficult to find in the past so aspects of planning meetings well in advance to allow clinical practice accommodate involvement is important. Those clinicians involved have to see that they are listened to and this is not a tokenistic exercise but bridges have to be built somewhere. Make sure that clinicians are involved in top level decisions. Employ Chief exec staff with experience of working in ground level health care

Clinical directors are processors really providing in my experience checks and balances (assurances to NCAS) and not providing clear clinical direction. There is no 'tension' in the organisation from clinicians against the CRESS plans and cuts that we are forced to make. SBU's (or whatever structure) need to have clinicians involved at local levels (which does happen in many areas) however it is above 8b where many decisions are made that do not involve clinical staff. NCAS is worth about £4 million. We are supposed to get specialist clinical advice from staff who do not practice?! NCAS should be very small (assurance work) and the rest out in SBU's leading practice.

Taking a longer term view on this subject, it would be very useful to bring together individuals who are both clinical and non clinical within AWP at all levels. Currently below service Director level, there is very little forum for this to occur. This approach would support the long term engagement from a number of angles, which in turn would support clinical engagement. This could be achieved by having clinicians included as part of induction for staff, clinicians should also be included as part of the business planning /development process. Also, one day per year could be spent with clinicians delivering front line care from non clinical band 8b and above (or even below). Finally, whilst the engagement of clinicians is key (along with other groups) it may be useful to set out the reasons and benefits of this as an organisational engagement charter for all stakeholder groups, this would also support engagement from other colleagues within the Trust who are not clinical and may feel excluded from this and disengaged as a result.

The single most important change is for clinicians to be truly listened to. The main reason for non-engagement previously is that many clinicians including myself felt it was a waste of time as we wouldn't really be listened to and our views would not be truly valued. This entails a proper understanding of the clinical perspective.

GPs, Psychiatrists, Police, Care Coordinators, Social services.
intelligent communication-paul miller's updates have gone down well-much better than the attempts at humour in the weekly round up by comms

Current LLAL SBU leads have sidelined those who can help, even after meetings at which decisions were made and still appear to be following an agenda that is not at all flexible or includes any input from below

AWP managers and directors could visit wards and teams and talk to staff, not just team managers. More local management. More awareness of local needs and not a one size fits all approach. What works in Bristol does not necessarily work in wiltshire.

Build on the LLL model

actually listen to us, have clinicians involved in meetings with PCT

Clearer authority and role of medical (clinical) leads with mandate explicit from clinical director. This role needs consideration in the new SBU management structures

centre prof Council in structure and ensure it is supported to carry responsibilities for it's agenda
Putting clinicians in charge of the service. Only they know what it is really like in the front line. Consultants could be more involved if they were given adequate allocated time to do this. I think Consultants do not put themselves forward because they have a full clinical caseload also. PAs have been cut recently, and so there is less time and less inclination to get involved with management decisions.

Where are the medics? Medical staff, particularly consultants, are highly trained and paid and, in general, are therefore expected to be the automatic clinical leads of their respective teams. The SHA document explicitly mentioned that medical input was, to paraphrase, rubbish. Why has this been diluted here. Really, why, what was the thinking?

I refer you to the above comment. You must involve everyone by trying to get different parties in the same room when dreaming up new ways of doing things. You must eliminate a culture of fear. You (senior management) must actually take advice on board instead of pretending to listen and then doing what you planned to do anyway. You must give the authority to act directly to the person with the idea. Novel, I grant you.

have more frontline clinicians on Professional Council and make PC more central to service decision making

There must be scope to get ideas from the clinical teams in the first instance. If the Team Leaders from CRHT had been asked, 'how can we demonstrate that we involve you in FED and how can we improve your involvement?' We could have given you some SMART targets that would have been clinically relevant. No one has still ever asked.

Clinicians need to be involved in the decision making process to a much greater extent. It is important that clinicians working within areas that are being 're-designed' or operational procedures reviewed, have involvement in the process of change without it being seen as just a paper exercise.
more defined roles and better staffing

relatives, friends, even neighbours where appropriate

Visit teams in their locality to discuss how to implement
Have a route that all clinicians can utilise when the usual structures of line management are not effective. Often staff have excellent ideas on how to provide quality care and improve our services through operational plans but don't get heard. Sadly some lines of communication through the management chain are very poor and at times block clinicians voices. There needs to be a route around this that supports clinicians to have a voice when immediate line managers don't want to listen. Everyone should have a chance to be heard, to be involved.

Include the people working on the ground with a caseload of clients and having to manage the difficult job of care coordination and keeping to targets. Also talk with the staff on the ward about what may get in the way of clinical engagement eg shift patterns, other things more important like observations or record keeping etc. Operational staff etc who have not done any clinical work recently could work on a ward for a day, in the community, in assessment teams, intensive teams etc to see what makes it easier or more difficult to engage clinically and perhaps to pick up on any blind spots the teams may have.

By talking with the people that implement the Trusts strategies, not those who manage them but the poor bloody infantry. I've worked for the Trust for 15 years and this would be a first.
by actually listening to staff comments and suggestions and negotiating how things can be taken forward.. it has felt that "consultations" have been more token gestures at times and I have heard staff say that they have not been heard which does not improve staff morale.
latitude for staff, clients(service users) and family to directly feedback from ground floor level - to the priorities and definition important activity that takes AWP staff time up

This is a complex question. There is no doubt that the executive part of the Trust has seemed distant and separate to many clinicians. The increasingly separate and in some cases almost competitive nature of the SBU's has not helped this engagement. The increasing influence of those who negotiate performance targets that do not make clinical sense also creates a sense of clinical separation. It is not easy to see why the attempts to involve clinicians in decision making haven't worked and understanding this might help. To some extent clinicians themselves are responsible as there has been poor levels of involvement in places eg IG where there can be involvement. There have also been many different forum eg Acute Care local and central IG, MAGS, Professional Council, local management meetings, central management meetings, redesign meetings, performance meetings etc which perhaps dilute clinical involvement and also dilute the 'flow' (like too many tributaries in a river) of involvement. Clinicians need to spend there time delivering clinical services and so careful thought needs to be given to the focus of clinical involvement. Having NCAS as a separate directorate means that there is another dilution as consultant nurses and others often seem not to be inputting directly into the service delivery streams. Medical Lead system seems confusing with local inpatient and community leads plus chairs of MAGS (who may be different again) and then SBU leads plus a deputy and director. It is not always clear how all this works cohesively and again may dilute involvement. Not all health and social care professionals seem able to be involved in a strategic way and self interest is often evident.

Allow more decision making at a local level. Asking for clinician reps of all grades to be involved in op and strategic decision making that has an impact in clinical care

Local professional forums, feeding into Trust and national ones. Staff encouraged to attend conferences and given opportunity to feed back best practice from elsewhere. Create a culture where staff know that initiatives and innovation are encouraged.

more multi disciplinary forums that are more than just disseminating information from the top down and have a genuine input to decision making and truly represent the workforce and to do this need a mechanism for feeding information

anonymous feedback useful, maybe signifier of job description included. When we are doing our job and things are difficult we are often left with no clear idea of how to give feedback
I would welcome a hierarchical structure where staff were routinely asked what would make a difference to the care that they give rather than told what was expected of them. It is very one sided at present.

Within my own field of Intensive services, I believe that the team managers and senior practitioners are best placed to inform the organisation how we can offer the best service. An executive committee including some of these practitioners would be able to give the best understanding of where we are now and what we need to do to improve service provision.

more involvement from staff on the work floor not just managers who at times can be removed from the clinical setting

By involving all the members of the MDT who works for them. Use of e-mails and regular meetings would help.

Involve the relatives in decision making.

By involving clinicians " on the ground". Currently it feels as if concerns are not listened to or even acknowledged. Heavy influence on meeting targets Governance meetings are not accessible to clinicians but are represented by Management and little feedback given. There is no where to voice concerns or to make issues we may have known about or would like to engage

Particularly all staff working directly with service users. Obtain staff views when ideas are being banded about

Have frontline clinical staff attend operational / planning meetings

use different clinicians, use people who are actively involved in patient care use people who have different levels of experience, seek the opinion of teams by going to see them and explaining the decision, don't just use the select few who are believed to be experts.
Involve clinical staff more in decision making.

I there are service delivery issues to be resolved both strategically and at team level through my own experience setting up elements of service including a Crisis Team, a Family Therapy Team, and a service for Homeless people. The key issue is to identify the elements that make a service operate in a responsive, appropriate fashion. The way to do this is to look at other areas with very successful teams and pick from them the best ideas then adapt these to the local area. Which is what I did when setting up the Crisis Team and the Homeless project. Also, to be clear what skills you need in the team and not to have staff pushed into roles through re-deployment when they had not got the skills and do not want to do the job they are being told they have to do. This reduces moral and you do not get the best out of them. I would suggest the development of a Clinical Leadership Forum which meets to solve service delivery issues from a Clinical as well as operational perspective. It it vital that the medical staff are involved and own this as they have a lot to contribute if given the chance.

REMOVE ALOT OF THE TEDIUOIS PPAERWORK AND BLAME CULTURE IF THE APPROPRITAE PAPERWORK IS NOT COMPLETED I AM NOT A COMMUNITY PSCHIATRIC NURSE NOW BUT A COMPUTER PSYCHIATRIC NURSE. MORE AND MORE ADMIN IS ADDED TO THE CLINICIANS WORK LOAD NEVER TAKEN AWAY

we have quality accounts more use of those and meaning given to them and engaging with staff around what makes a difference. Who is difficult as you want people who are change agents and innovators who through their skills can lead change recognising what barriers there are . Its very important to recognise and listen to operational issues that are difficult and have a more listening attitude . professional leads must recognise there will be many views across professions and within professions and have a skill to interpret the quality into the highest operational care.

I feel that AWP management teams need to engage with and listen to experienced clinical staff in decision making. Our current performance agenda reflects decisions about targets that do not reflect clinical experience. I feel that we also need a clear clinical engagement in our governance structure to ensure that there is a clear management route. It is a common experience to receive requests or directives for pieces of work from lots of different people and departments with short deadlines .
In the last couple of months we have already seen significant changes to attitudes from awp with positive communication from paul Miller. This and other incentives to promote greater clinical involvement have been valuable as well as empowering. All team leaders as well as clinical leads in areas could continue to attend and participate in future events/discussions. Clinical engagement will inevitably be improved when staff can see positive outcomes from participation - eg. ideas and views carried through into final decisions about services.

Involvement of ALL staff at local levels in decisions that directly affect patient care or have an impact on how staff work on a day to day basis- for example in decisions about new security measures, how charitable funds are spent, staffing levels....

You're main problem is the entrenched cadre of middle managers who embody the centralised, authoritarian and institutionalised attitudes that have so nearly destroyed this Trust. Whatever creativity, skill and motivation we have at clinical level counts for absolutely nothing with these hacks who visibly glaze over when one talks about clinical priorities or the patient's experience and whose main strategy is to threaten and undermine clinical staff in order to maintain their own shaky authority. I now believe that my service would be better off if AWP is disbanded and we were taken

over by our local Acute Trust who would at least let me get on with my job. Your only hope of saving AWP is to clear out these managers and recruit people who actually have some motivation for clinical improvement rather than just their own power and position with an institution. If you are needing clinicians to rescue you from your managerial failures, surely you should look at why your existing managers have failed so badly to create a thriving clinical culture in the first place. I am very highly motivated in my clinical work, even after 31 years, but everything I have achieved clinically is DESPITE these AWP mangers rather than being helped in any way by them. You do have a talented and motivated clinical workforce but we are all hiding in our trenches from these managers and actively avoiding having anything to do with them so I fear there is zero chance that good clinicians will "engage" with AWP as we have all learned to stay as invisible as possible to avoid the world of pain that our managers dish out to anyone who comes near them. If you want effective clinical engagement you will have to provide worthwhile managers for clinicians to engage with. I have personally turned down several offers of promotion for these reasons, as have many good clinicians that I know but the result is that the specimens who have climbed the ladder are the worst sort. You need to consider why this organisation has all its talented and creative people at the bottom and the not very bright and narrow minded mediocrities in management!

Have a clear rights and responsibility framework for all professionals and an accountable professional leadership model

Slow down the rate and pace of change so that people are not constantly anxious about if they will have a job in the near future Don't ask people their views if they are not going to be taken into account

Open the doors at Jenner House

Ask Heads of Profession to nominate individual practitioners to input when issues arise at board level that would benefit from practitioner input. Use appraisal to identify people who wish to input. look at a means to manage caseload work load, to try to encourage more reflective practice.
Better communication in a timely manner. Letting people know what needs to happen but involving them in deciding some of the how.

More local protocols to fit into Trust policies. More uptake from clinical services into board level meetings (perhaps clinical representation from each SBU at a lower level than senior manager).

Clinical professionals to engage more with partnership agencies, for example, safeguarding meetings such as Marac and then feeding back experiences through boards. Clinical working groups to look at research and processes that would inform policy.

It could be made clearer that this is about managerial, corporate and strategy and business decision making - the definition as it stands is too global. If this was clearer it is then about encouraging and facilitating attendance at relevant forums both in SBUs and at the centre

by talking to the front line staff, getting representation from front line staff - having a discussion with staff at the Band 6 days and the unregistered staff forum days

The terminology should be defined and shared widely before involvement can occur. If staff are unclear as to its meaning they will avoid it.....it is far easier for staff to feel valued in operational decisions at a local level however often glaze over when strategic business is discussed. NCAS as a support for clinical staff need to be far greater involved in supporting teams and individuals to be valued and heard. Staff feel vulnerable in the current climate within health especially AWP (recent changes) and another project will be hard to promote as a positive agenda when resources are been reduced.

Facilitate consideration/review of all ideas submitted by Trust staff to improve Services
Why should it just be professional, why not involve service users and their families in the decision making process?

More involvement from staff in clinical roles in decision making. Most teams have staff who have lead roles within the teams so have a special interest or knowledge on a subject so this may be one way to identify them

More engagement of front line staff. and not just being listened to just so the trust can say "we consulted and..."

For greater involvement with staff on the shop floor. To understand their views and ideas they may have about ways of improving the service.

By listening to more of what Dr's and nursing staff have to say about in delivering good care to patient [remember it could be you one day that needs care] Therefore have more Dr's carers and nurses making decision as they no the patients best. To do this we need to have less management there are far to many and bring them back to working on the wards or community then pts could get the care they deserve and need then may be the trust would save more money and have less complaints made against them as a lot of complaints come from pts and carers that there are not enough Dr's and nurses around to deliver the care that is needed.

Clinicians of all levels need to be involved more and shown that they are valued by the organisation. Decision making currently appears so abstract and divorced from the clinical reality of situations clinicians feel devalued, de-motivated and depressed. How do we engage anyone when we feel so disengaged ourselves?

Why not try to involve staff that have most contact with the patients? Like Nurses and HCAs. Less input should be accepted from those with less contact - psychologists, therapists, managers, and uber managers.

Give frontline clinical staff more opportunity with better access to meetings/events/workshops to be able to voice our opinions and ideas. Listen to us! Ask and we will answer.

In Bristol the decision to split health and social care is a mistake. It does SU's a huge dis-jointed service Reversal of this decision would be a start.
Wards need to be properly and safely resourced with safe staff numbers, this is currently not the case.

Clinician should be involved from the onset. They have invaluable knowledge and skills, and knows what works and what wont. However, they can be resistive to change, therefore, this need active management skills. Get the facts and figures accurately, Have clear objectives, focus on quality rather than quantity. Address the non-believers-engage in 1-1 sessions. Communicate on a regular basis.

Lead by example to facilitate change and improvement. The leader has to be someone of exemplary character and an innovator. Listen to the clinicians.

Front line staff who have direct contact with service users.
By asking frontline staff to identify areas of improvement, engage them from the beginning through face to face meetings or through ourspace and brainstorm suggestions.

Clearer communication from immediate management band 7 upwards. Management actually listening and respecting staff's views and engaging with finding solutions to difficulties rather than quoting targets and making threats re job cuts.

Each SBU could provide a representative from each professional role to sit within a decision making council whilst truly representing the views of clinical staff. (7 per SBU) Representatives would be voted in by their peers and new representatives would be elected annually. representatives would be provided with 1-2 days a month to visit teams within the SBU to gain live feedback around policy and decision making. Representatives would meet monthly for 'Clinical Engagement team meeting'. It is important that staff feel the representatives believes in clinical involvement and the representatives actively engage in the process. A Clinical Engagement chair would be elected from within and by the representatives. I would be happy to discuss this idea further.

It would be helpful for managers to go around teams to find out their views. I was emailed a document on proposed changes to look at before completing this survey but frankly who has the time to look at all this stuff to form an opinion about the best way forward. What we can tell you is our experience of what works.

Have practitioners, not just managers, involved in all levels of discussion and decision making. Often it is only managers who attend such meetings and they do not necessarily feed back clearly