

The OUH Trust Patient and Public Involvement Strategy, 2016-2019

Draft for Consultation

1. What this Strategy is about

This Strategy is about patient and public involvement in the work of the Oxford University Hospitals NHS Trust.

Definitions and models of 'involvement' vary across health and social care. Terms such as 'engagement', 'participation', 'partnership', and 'taking part' are often used interchangeably or synonymously.

The Trust's definition of involvement is based on:

- Organisational values
- Person and patient-centred planning approaches
- Involvement of patients at both a personal and public level.

A widely accepted model of public participation is that of moving along a continuum or ladder of being informed, to being consulted and eventually part of a shared decision making process – often referred to as 'co-production' when applied to public service design and provision.

The ladder of engagement

There are numerous 'models' which try to distinguish between different 'levels' of engaging with stakeholders. Below is an updated version of Arnstein's ladder of engagement.

This model from *Participation in Health and Care*, (NHS England, 2013) can be usefully applied to involvement, i.e. it is dynamic and progressive:

Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.

The drawback of Arnstein's ladder is an implied hierarchy. The Trust will need to consider what it is trying to achieve and which of the different levels of engagement

are appropriate at different times and in different situations. Ideally, patients and families should participate in agreeing what level is appropriate and when.

Personal involvement for a patient means self-managing care, shared decision making and personal care planning, processes whereby the patient and their social and healthcare professional discuss the options available and come to a view about which is the most appropriate so the patient has a voice.

The patient voice has developed beyond the personal to a point where involvement extends to having a voice in the development and delivery of services, which affect a patient's health care.

At its simplest and quickest, involvement can be giving feedback in a survey, e.g. the current *Friends and Family Test Survey* where patients rate how likely they are to recommend the service and provide a comment about the quality of the service they received. Involvement can also include: volunteering in a clinical research trial; fundraising for a specific piece of equipment; acting as Foundation Trust Governor; being an active member of a Public Participation Group or the Equality Delivery System Panel; sharing a personal experience as a Patient Story or being a volunteer guide for many years.

The Trust is alive with good practice in involvement. Eight best practice case studies from current Trust work at the end of this Strategy have been selected as a snapshot.

2. Developing the Strategy

This draft Strategy has six strategic objectives which were developed through stakeholder engagement with the Trust's Public Participation Groups (PPGs), voluntary, community and statutory partner organisations, Foundation Trust (FT) membership and staff.

This included a Seldom Heard Groups event in June 2015, attended by 20 groups and individuals. A further 40 community leaders, local experts and partner organisations were contacted in person and asked to share their views to identify and share good practice and to commit to contributing to the delivery of the Strategy.

Key staff across the Trust in clinical research, organisational development, volunteer management, fundraising, communication, safeguarding for children and adults, patient engagement, patient experience, PALS, gerontology, renal & transplant and trauma services were asked to share current practice, skills and knowledge. They evidenced best practice examples of involvement and helped to identify gaps and development opportunities and these are captured in the high-level priorities and action plan.

3. The aim of this Strategy

The overall aim of this Strategy is to promote and secure the involvement of the Trust's patients, families and public in its work delivering excellent health care. It includes, but is not limited to, involving patients and families in decisions affecting their care whilst in hospital. It includes offering a wider range of involvement opportunities across the Trust's services for the public as its stakeholders.

4. Who this Strategy is for

This Strategy is for patients, their families and carers who use the Trust's services. It includes the public as stakeholders who may not be receiving care but have an interest in how care is provided. It includes the 8500 members of the public who are currently signed up as Foundation Trust members. It also includes children and young people. It includes partner and stakeholder groups representing patients and public.

5. The Trust's Vision

All the Trust's patients and the public are offered the opportunity to be involved in the development, design and delivery of their own health care and the Trust's services and are supported to do so.

6. Six Objectives

The six objectives are aligned to the Trust's Quality Priorities, Patient Safety, Patient Experience, Clinical Effectiveness and Outcomes as set out in the current *Refreshed Quality Strategy*, January 2015 and based on the Trust's six core values: *excellence, compassion, respect, learning, delivery and improvement*. They are benchmarked against national best practice. They fulfil statutory requirements with regard to carers, seldom-heard people and vulnerable groups

The six objectives are:

- i. A good involvement offer is made to patients and the public leading to increased involvement from a wider range of communities and individuals.
- ii. The involvement offer is visible and fully accessible.
- iii. Patients, the public and staff are actively supported to be involved.
- iv. To increase the involvement of seldom heard people and groups, and provide additional support to facilitate involvement, where there are barriers.
- v. The Trust seeks out and works with stakeholders, to fund, plan and deliver increased representation and involvement.
- vi. The Trust's embeds involvement in its daily governance, policy and practice.

The Six Objectives Explained

Objective 1: A good involvement offer is made to patients and the public leading to increased involvement from a wider range of communities and individuals.

"Patients should be acknowledged for their contribution, supported to get involved and informed about the difference they make." (Hazel Murray, Interim Head of Staff Engagement)

A good involvement offer is made to patients and the public by the Trust based on partnership; it is one which clearly articulates what Trust needs and what it can offer in return, and matches this to what the patients, family members public wants and can offer in return. It is equally responsive to opportunities initiated by the public, and works with the public to develop new ones. Patients need to be part of the process of developing this offer, right from the start. This offer needs to be based on good

practice in patient involvement and participation, supported by evidence and research.

The involvement offer needs to acknowledge and encompass the following principles:

- Patients and the public are giving their time and commitment.
- Patients and the public are entitled to set and agree clear expectations and boundaries in terms of their involvement.
- Patients and the public are entitled to support so that there is equal opportunity for involvement.
- Patients and the public are ultimately accountable to the Trust’s Board of Governors.
- Patients and the public need to be thanked for their involvement and their achievements need to be celebrated.
- There are the skills, knowledge and resources from Trust and its staff to ensure the public can make informed choices about their own involvement.

A clear involvement offer from the Trust will help partner organisations to know how best to be involved and support involvement - and this is particularly the case for smaller Voluntary and Community Social Enterprise (VCSE) groups.

A short mapping exercise during the development of this Strategy has identified current activity as outlined in Table 1. The figures do not capture the variety and numbers across the whole Trust but provide a snap shot.

Area	Numbers involved pa
FT staff membership	11,000
FT public membership	8,500
Direct applications volunteers	640
Clinical research	500
Authorised volunteers	350
Public Participation Groups (PPG’s)	80 approx.
Work experience- Introduction to the NHS programme	48
Charity fundraisers	10-12
Chaplaincy	Not known
Host organisations: League of friends, Sobell House, SNNAP, Radio Horton and Radio Cherwell, Red Cross volunteers	Not known

Table 1 Numbers and activity of OUHT patient and public involvement 2015

The full extent of activity across clinical divisions is not known, is often in the hands of a few staff and the public because it is scattered and embedded within services, associated partnerships and networks. The networks may be local, national and even international, and therefore hidden to the vast majority of staff and the public.

A key aim of the Strategy is to more accurately capture the numbers of people and the levels of activity both in terms of the roles offered and the skills and knowledge being used, within each clinical division, so it can be shared with all stakeholders.

Objective 2: The involvement offer is visible and fully accessible

The public and patients are involved in the Trust every day. The public face of volunteers with blue sashes and a warm welcome at the reception desk is the tip of the iceberg. One of the key objectives of the Strategy is to publicise current and potential opportunities for involvement more widely.

Currently, people can get involved through a range of avenues. For example, staff and patients report that by far the most successful recruiting for Foundation Trust members, joining PPG's and getting involved in the values based interviews and peer reviews is personal face to face contact from peers or staff which persuades people to take the first steps to get involved. By contrast, the volunteer team placed nearly 1000 volunteers in 2014 with no active recruiting, primarily because 85% of applications come from those aged 16- 25 years who wish to gain experience for career development.

The Trust's complete involvement offer needs to be made clearly accessible to the public and staff and partner organisations and to capture all involvement opportunities across the Trust. A key opportunity is through the Home Page of the Trust website which has 350,000 visits per month and where there is already an invitation to 'Get Involved'. As well as showing clearly all involvement opportunities (e.g. research, volunteering, FT membership, PPGs) the website should showcase examples of successful involvement which demonstrate the positive impact on the quality of patient experience.

Given the high levels of patients with particular needs, the information needs to be available in a range of formats for those who are unable to or prefer not to use an online resource. This particularly includes people with sensory or cognitive impairment or learning disability, and older people aged 65 and over.

Signposting needs to provide follow-through and reinforcement in key communications to patients, such as Trust News, Foundation Trust Membership invitation, volunteer services booklet, and patient information leaflets.

Examples of existing involvement:

- Ward-based volunteers' roles include: bed-making, assisting nurses, befriending patients, the library trolley, surveying patients for the Friends and Family Test, and assisting and directing patients within the Radiology department.
- Non-ward based volunteer options are administration support, directing family and friends, running a help desk, working in the chaplaincy, and gardening.
- There are numerous opportunities within clinical research - 500 people signed up last year involvement included assisting with the design and development of research.
- Fundraisers who raise charitable funds (as part of the work of Charitable Trust) for the Trust act as advocates, ambassadors and public role models for the Trust.

- Across the Trust's five clinical divisions there are nine active Public Partnership Groups which are condition based, and recruitment has primarily been through personal approaches to individuals. Their remit varies greatly across the Trust as does their representation and influence.
- PPGs lead on the development and implementation of patient surveys, comment on research proposals, and they are involved in business planning, and project championing and design.
- There is a Patients Active in Research Group (PAIR) based in Oxford Biomedical Research Centre & Unit.
- Within Organisational Development, patients are involved in peer reviews, helping staff develop values based interviewing, and advocating to staff for a values based approach.
- Roles within the Renal Unit include being a peer mentor (buddy), being filmed for staff recruitment videos, assisting with website development, event organisers, and being an independent blogger.

Objective 3: Patients and the public are fully supported to be actively involved

“Shared care has given me a sense of semi independence, a small piece of pride and an achievement and some of my life back.” Rob patient in Renal Unit

Some patients have complex support needs which must be met to enable them to be actively involved. This may be for reasons which are easily recognised, for example, being a child, being a frail older person, having a long-term condition, experience of trauma or bereavement, having a mental illness, cognitive or sensory impairment and or having end of life care needs. Less easily recognised needs are a lack of confidence, anxiety, poor literacy levels, and carer requirements.

Patients' and carers' desire for involvement may depend on where they are in their care pathway and their acceptance and management of their health issues. For example, those who have recently received a diagnosis of a life limiting conditions may be less inclined to get involved in the Trust compared to those who have been declared well enough to go home. This means the Trust should provide a range of opportunities in different settings (e.g. at home or in peer support groups), and using a range of ways to communicate and engage (e.g., dance, film, storytelling, touch, music, reminiscence, easy-read and signing). A good example within the Trust are the 'Digital Reminiscence Computers', which are now deployed in seven wards, designed by carers for carers of people with dementia and enabling staff and carers to design life story books.

A PPG workshop in November 2014 identified ways to improve the effectiveness of the groups. This included the need for a Toolkit to enable some common standards and good practice to be adopted across all groups e.g. a coherent remit with clear role descriptions, travel expenses, safeguarding policies, ways to link with each other, to identify gaps, share good practice, act as hubs to gather information and intelligence and to disseminate information across their area of influence. The role of a central coordinator is being scoped.

Some excellent work is being achieved in existing PPGs (please refer to case study 8, page 15), which are highly valued by both staff and patients. However, there are 183 services and departments are listed on the OUH Trust website and only 9

groups. An ambition to have a PPG for all 183 services would not be realistic or achievable, but having a group representing groups of key services is a goal.

There is also the need to establish clear links into formal decision-making processes and routes of influence. For example, the Trust's PPGs have asked for an overarching group with defined links to the Trust's Board and Governors.

Objective 4: To increase the involvement of seldom heard people and groups, and additional support to facilitate involvement, where there are barriers.

The Trust provides services to some of the most vulnerable children and adults locally and nationally, whose nine characteristics are protected under the Equality Act 2010: race, sex, sexual orientation, disability, religion or belief, being a transsexual person, having just had a baby or being pregnant, being married or in a civil partnership and age. These characteristics and other factors, such as homelessness, poverty, being a victim of crime, contribute to people who use services being at risk of exclusion from involvement.

A *Seldom Heard Groups Strategy* is currently being developed with the involvement of approximately 40 Seldom Heard Groups and individuals in Oxfordshire and will set out how to increase the involvement of patients and the public from these communities in detail.

Children and young people (aged under 16) and older people (aged over 75) comprise a high proportion of Trusts users: 9000 babies were born in the care of the Trust's Maternity Services in 2014, and older people aged 75-85 are the highest users of Trust services. They need special provision and support within this Strategy to become and stay involved, as do their parents and carers, as set out in the Trust's Carers Policy.

Compared to other groups, there are relatively high levels of engagement from older people, through the PPGs, FT membership and voluntary organisations (e.g. Age UK and Carers Oxfordshire). The Trust has recently co-produced a carer feedback form with carers, which is currently being piloted. The iCare Card and Knowing Me Card have been introduced to facilitate the engagement of carers in the patient's care. 30% of patients using the Trusts services have dementia and the vast majority of these are older people aged 60+. The Dementia Leaders Group lead activity in this area and ensures there is wide ranging dementia education and training.

Currently there is a gap in children's and young people's involvement, feedback and representation across the Trust. This should be a priority because, we know that children and young people with long-term conditions are particularly vulnerable as they transition from children's to adult services, and that young men in particular can be harder to engage with managing their own health. We also know that peer influence can be greater than professionals and parents of some young people.

An 18 month funded project to address this gap launches in September 2015 with a remit to re-launch the Young People's Executive (YiPpEE!), nominate a young person to the Board of governors and to increase engagement through the development of social media and web platforms. There is a very strong network of both statutory and voluntary, community and social enterprise groups (VCSE) organisations supporting vulnerable children in the community, including schools. The Trust needs to identify these groups and develop opportunities together with them because working within community settings will reduce the burden on carers

travelling to the hospital and improve the offer available to children and young people.

Objective 5: The Trust's embeds involvement in daily practice and supports its staff to do this

“For me it's about how we see things through patients' eyes.”

Allie Thornley, Matron Renal Unit, Churchill Hospital

The Volunteer Team reports that it receives 20-30 emails a day from prospective volunteers. However, some staff reported that there is no obvious point of contact for staff with questions such as:

- When would be good time to involve patients?
- What is the process for doing this?
- What's the value of doing this?

Staff interviewed during the development of this Strategy were concerned about the risk of patients being over consulted.

Staff have requested

- A 'map' with information about seldom heard and VSCE groups.
- Specialist contacts of seldom heard groups who can support them to fully involve all groups and co-produce projects.
- A Trust-wide calendar of involvement events.
- A directory of key staff, PPGs, good practice and events across all clinical divisions.
- A central online resource which contains all this information.

Staff need formal training opportunities from the Patient Experience and Organisational Development Teams on how to nurture and manage a range of imaginative involvement projects with their patients and carers. Staff need to know:

- What good involvement is and looks like, what it feels like and what value it brings.
- When involvement is not appropriate and alternative options.
- What resources they can give to support the patients and public they are working alongside.

By far the best advocates for involvement are Trust staff themselves, who are passionate about their patients' involvement and are ambitious for increased and better involvement. There are some particularly helpful examples of clinical research studies which engaged over 500 people in 2015, whose experience of involving patients throughout the research cycle is clearly stated in their involvement Strategy. Research staff are willing to share the skills, experience, knowledge and their multiple examples of best and good practice. However, they need structured networking opportunities to do this to gain maximum audiences and impact. They reported the Dignity in Care day in January 2015 as being useful for this purpose.

The Patient Experience Team has a pivotal role in leading on the involvement work across the Trust, by providing a central point of contact or a 'front door' for staff and patients. This means working with teams across the Trust to align their work; this particularly includes the work of the volunteer, fundraising and organisational development, Foundation Trust membership teams. It also includes working with Governors and patients so that the involvement offer is clear and accessible.

Objective 6: The Trust seeks out and works with partners and stakeholders, to fund, plan and deliver increased representation and involvement

A key part of the successful development of this Strategy has been involving and working in partnership with the Trust's stakeholders across health and social care from the start. Health and social care providers have shared agendas, such as the need to fulfil statutory requirements, and to consult and engage with health and social care service users. Health providers and social care providers often have shared commissioners and funders and have an interest in working together.

The Trust needs to engage more with local and national VCSEs to co-design and co-produce involvement initiatives for patients. Good working relationships with partner organisations may lead to better representation and involvement from the public. For example supporting the Oxfordshire Clinical Commissioning Group's Patient and Public Locality Forums will avoid over consultation and competing for time and commitment from the same people.

Oxfordshire and adjoining counties have a wealth of VCSEs, seldom heard groups, and groups for specific medical conditions, examples include diabetes, acquired brain injury, autistic spectrum disorder, Downs's syndrome, young carers, early onset dementia, and stroke. These groups are vital to success of patient and public involvement, are increasingly becoming peer-led membership organisations which represent the interests of their members locally and nationally. These groups are highly skilled at advocacy and encourage self-advocacy from their members in order to contribute lived experiences.

The Trust's Privacy and Dignity Policy developed in partnership with Age UK Oxfordshire and Oxfordshire Mind is a good example of partnership working and co-production.

The Trust hopes that more opportunities for partnership working for better patient involvement will result from this public consultation.

Case Studies highlighting best practice

1. Patient Experience Star of the Month Award (December 2014): Jilly Heath, for improving dementia care and environments

In December the Patient Experience Star of the Month was awarded to Jilly Heath from Trauma for her work on dementia care and environments.

This award rewards the excellent work done within the Trust, motivates teams to continue to deliver high standards of care, and to share good practice.

Jilly is the Dementia Leader for the Trauma Service. She was part of the first cohort of Dementia Leaders Programme with Worcester University. She devised a local strategy which includes the implementation of small but significant environmental changes, based on the Enhancing the Healing Environment Programme (Kings Fund, 2012). She was awarded Patient Experience Star of the Month for her work under two criteria (see below) – “Innovative solutions” and “Continued commitment to improving patient experience”.

- The day rooms were transformed into ‘Quiet Rooms’, which provide peaceful down time away from the noise and confusion of a busy ward. The rooms have been redecorated with art work and images selected to stimulate long term memories and conversation.
- iPods have been purchased and loaded with music from the 1940s and 50s, to complement this reminiscence therapy.
- Orientation kits have been introduced which contain primary coloured items such as bed throws, clocks and improved signage.
- Stimulation kits are available which include laminated reminiscence items, ration books and magazines and items for occupying restless hands.
- Red toilet seats, toilet raises and commode seats have been purchased to provide a significant contrast in colour and stand out against the paler ward colour scheme providing guidance for people when using the toilet.
- The League of Friends have funded a dementia friendly computer software package based on a reminiscence theme. This can be taken to patient bays.
- Jilly won the Anne Harrold Radcliffe Guild of Nurses Award in 2013 which provided funding for the team to professionally produce a DVD for healthcare professionals highlighting the challenges faced by a patient with dementia and the successful strategies implemented.
- All new staff watch the DVD when they start, and it is followed up by a one-to-one session to enhance dementia awareness and the local strategy. All permanent staff receive training regularly, rotating issues such as delirium and communication. Administration and reception staff also receive training.

2. Patient Experience Star of the Month Award (January 2015): Rebecca Gunzler, whose dedicated efforts have improved the response rates on the Friends and Family Test.

The Patient Experience Star of the Month Award rewards the excellent work done within the Trust, motivates teams to continue to deliver high standards of care, and helps to share good practice.

In January the Patient Experience Star of the Month was awarded to Rebecca Gunzler, housekeeper on Gynaecology ward, for her dedication, encouragement,

and enthusiasm with the friends and family test. The response rate improved from an average of 13% between June to August, to an average of 32%.

The increased response rates means the ward now has the benefit of more feedback, which, on the whole, is very positive and is an excellent way of rewarding staff for their hard work.

“Rebecca the housekeeper was an amazing person and provided absolutely fantastic service. It was lovely to me such a kind, genuine lady.”

“The staff are so amazing, they make you feel re-assured, they look after the patient and their relatives in a caring, thoughtful and respectful way!”

“All areas of the hospital I saw were clean, tidy and looked after. Every member of staff was welcoming, friendly, smiling and gave thorough explanations of each stage of my stay, which made my visit much less stressful.”

Rebecca used the following techniques to increase the response rates:

- Mid-morning, she liaises with the coordinator about which women are being discharged that day.
- She personally gives each woman a comment card and explains what the ward does with the feedback.
- Each woman is encouraged to complete the comment card and Rebecca personally collects the responses in.
- This all takes place with due sensitivity for the women on the ward, some of whom may have had a pregnancy loss.

3. **OUH Trust Staff Recognition Awards**

The Annual Staff Recognition Awards were introduced in 2012. The awards form part of a values-based approach to recognition, which supports the Trust’s objective of “Delivering Compassionate Excellence” and enhances staff and patient experience. The Trust is proud to recognise the contribution its’ staff make to the success of the organisation and the care of patients. A key priority within the Organisational Development and Workforce Strategy is to promote an engaged, empowered, committed and flexible workforce, and a working environment in which outstanding contribution is both recognised and appropriately rewarded. Awards at both a local and Trust-wide level have been introduced to recognise and celebrate the contribution of staff.

Patient representatives are invited to form part of the recognition panels held annually at Trust and divisional levels. Roles for patients include reviewing staff nominations across a number of award categories, and helping the panel reach a decision on shortlist and overall winners. Patient representatives receive the nomination citations and assess each nomination in advance of the full panel meeting, to enable them to participate in agreeing final decisions. Patient representatives are invited to attend the divisional award events and the Trust Awards evening to see the recipients receive their awards. Patient views provide an opportunity to share in the celebration and success of the Trust and see first-hand how the staff are living out the values of the Trust.

Contact: Hazel Murray, Interim Lead Staff Engagement and Organisational Development

4. Oxford Mail Hospital Heroes

The *Oxford Mail* has an annual Hospital Heroes award that is open for nominations throughout July, August and September, in which members of the public can nominate an individual or team from the Trust who have given them exceptional service and compassionate care when in hospital and has gone above and beyond the call of duty.

The most outstanding of these nominations, one individual and one team, will receive the Oxford Mail 2015 Hospital Heroes award at the year-end Staff Recognition ceremony. Many of these Hospital Hero stories will be featured in the Oxford Mail.

Contact: Rachel Taylor, Public Engagement Manager

5. Rob's story of Shared Care for dialysis in the Renal Unit, Churchill Hospital

"I first started shared care without high expectations. There had been previous attempts to train me before but this was haphazard and did not seem to work.

This time however, with designated staff and support from other staff, I feel it's going well.

I have learnt quite a lot and learnt enough to just come on to the unit and get on with things. I cannot really put in to words how good that feels. Shared care has given me a sense of semi independence, a small piece of pride and an achievement and some of my life back.

It has also given me a better understanding of my condition.

Before I started shared care I felt I wasn't able to do it, I didn't have the confidence all. Now I do have the confidence and feel much better within myself for doing it. There are a lot of pros to doing shared care. At present, I am learning to disconnect and take myself off at the end of dialysis and this bit is harder and I am not enjoying it as much, but I know I will get there. All the staff have been very supportive and I would recommend to others."

Contact: Allie Thornley, Matron, Renal Unit Churchill Hospital

6. Patient Stories

Each month, a patient story is presented to the Trust Board or Quality Committee. This is a written paper which is sometimes accompanied by a film. The Patient Experience Team co-produces the story with a patient or family carer and the staff who had responsibility for the care provided.

The story provides an opportunity for patients to tell their personal experience and for staff, executive and non-executive directors to learn from what went well and what could be improved (both clinical and non-clinical), and reflect on the human experience of being treated in the Trust.

Where appropriate, the behaviours described in the stories are analysed against the Trust Values and used as examples on the Compassionate Care Training Course.

Over the last 6 months, stories have come from a range of individuals and covering a range of circumstances and conditions, and staff from across the Trust were involved in the stories:

Story topic	Departments involved
A man with throat cancer.	Blenheim Inpatients Ward, Blenheim Outpatients, the Oncology Clinic and the Radiotherapy and Physiotherapy Departments
A man in advanced stages of motor neuron disease with a serious chest infection.	Motor Neuron Disease Centre
A young person who was admitted in an emergency with appendicitis.	Surgical Emergency Unit, and the Sleep and Ventilation Service
A woman with diabetes who had had a suspected stroke.	The Stroke Unit
The parents of premature twins who were cared for in hospital for 3 months.	Horton Maternity Services, the JR Women's Centre, Special Care Baby Unit and Neonatal Care Unit
The family of a man who received end of life care.	Surgical Emergency Unit

7. Privacy and Dignity Policy

Since the beginning of this year, the Patient Experience Team has been co-producing a Privacy and Dignity Policy with patients, staff and voluntary and community organisations.

This involved an initial workshop in January 2015, attended by around 20 staff including the Chief Nurse, a non-executive director, matrons, sisters, ward clerks, housekeepers and safeguarding leads. In addition, there were representatives from Age UK, Carers Oxfordshire, Unlimited Oxfordshire (Physical disability organisation), Healthwatch, Guideposts, Oxfordshire Mind, Alzheimer's Society and Oxfordshire County Council.

Subsequently, there was a half-day workshop with My Life My Choice (a learning disability self-advocacy organisation), where 8 members of My Life My Choice discussed in depth issues to do with privacy and dignity.

The policy will include:

- Attitude and behaviour
- Mixed sex accommodation
- Personal identity
- Needs and beliefs
- Personal space
- Communication
- Chaperones
- Carers
- Training.

Contributions also came from Patient Forum, which is a group of patients and carers who meet monthly to discuss their experiences and make suggestions to the Trust on improvements.

The policy will be reviewed for approval by the Trust's Policy Group in September 2015 and launched in November at the same time as Healthwatch Oxfordshire's Dignity in Care launch.

8. Nuffield Orthopaedic Centre – Patient Liaison Group

The Nuffield Orthopaedic Centre (NOC) Patient Liaison Group (PLG) is one of 9 patient involvement groups in the Trust. Through active communication and involvement within the NOC Divisional Team and staff of the hospital, the group strives to improve patient care and welfare, making a positive impact on patient experience. The group runs patient surveys and uses other methods (particularly interviews) to get patient feedback.

Collaboration with the Nursing Team, other NOC departments, G4S and Aramark, have made it possible to implement many of the changes made. Listed below are some of the changes that have been made over the last 5 years as a direct result of the group's work:

1. Introduction of weekend physiotherapy and occupational therapy to enable patients to be discharged sooner.
2. Menu improvements, improving nutrition and creating wider choice and options without increasing cost.
3. Breakfast trays on all wards and a menu of choices each day.
4. Mugs for all hot drinks rounds instead of cup and saucer, increasing fluid intake.
5. Introduction of soup and pudding bowls for keeping food warm.
6. Banning metal teapots on the hot drinks round as tea gets cold too quickly and is often very stewed. These have been replaced with hot thermos containers.
7. Holders on the wall of showers for washing items e.g. shower gel.
8. Fragmin information pack and small 'sharps box' free from the drug company.
9. Pharmacists spend more time talking to patients.
10. Pharmacists review patients' 'to take home' medications by ascertaining what supplies the patient has at home, before writing the discharge drug order, reducing the possibility of over-prescribing and drug wastage.
11. Reduced size of HiBiScrub to 125mls, for all preoperative patients to use for washing prior to surgery.
12. The doctor prescribing the regular medication taken by the patient should include the time at which the patient normally takes their regular medication when at home in the pre-admission information.
13. Name badges to be displayed at eye level for all staff members.

14. An information book to be placed on all inpatients' lockers. The PLG have reviewed and helped to plan the information to be included in the books, which will be distributed throughout the wards.
15. Pay phones on patient lockers were removed, along with the ticket dispensers from all the wards. Surveys showed that these were seldom being used¹. Each ward now has a cordless phone, to be used only for incoming calls to patients.
16. Provision of improved theatre gowns for increased dignity.
17. Provision of ladies' nightdresses and men's pyjama tops and trousers from the laundry suppliers.
18. Information checklist for pre-operation clinic.
19. Orthotics department: Provide an equipment board in every clinical assessment room with visual placeholders for all required equipment, to enable quick identification of any missing items, e.g. tape measure, shoehorn. This should reduce wasted time while the clinician looks for missing equipment.

¹ Most patients now use their own mobiles