Oxford University Hospitals NHS Foundation Trust’s
Patient and Public Involvement Strategy, 2016-2019

1. **What this Strategy is about**
   This Strategy is about patient and public involvement in the work of the Oxford University Hospitals NHS Foundation Trust.

2. **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, especially those who are seldom heard. 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.

3. **Who this Strategy is for**
   The Strategy covers the involvement of patients, their families and carers who use the Trust's services. This includes those involved in clinical services, research and education. The strategy includes the public as stakeholders who may not be receiving care, but have an interest in how care is provided. The strategy also includes the 8500 members of the public who are currently signed up as Foundation Trust members.

4. **What involvement means in this Strategy**
   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 and the involvement of patients at both a personal and public level. For the Trust, involvement means:

   - Patients and the public can have a say on their own care, on the organisation’s values, on research, and on service design, delivery and development.
   - The Trust will listen to feedback and take it into account.
   - There will be transparency about how the feedback is used and reasons given if it is not used.

5. **The ladder of engagement**
   A widely accepted model of public participation, and one used by the Trust for public involvement, is that of moving along a continuum or going up and down a ladder.
Involvement starts with being informed, moves to being consulted, and eventually progresses to power being devolved and being part of a shared decision making process. This is often referred to as ‘co-production’ when applied to public service design and provision. The drawback of using a ‘ladder’ model is that implies going up the ladder is best, but the Trust recognises that different levels of engagement and involvement are appropriate at different times and in different situations. Ideally, patients and families should participate in agreeing what level is appropriate and when.

<table>
<thead>
<tr>
<th>Devolving</th>
<th>Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborating</td>
<td>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.</td>
</tr>
<tr>
<td>Involving</td>
<td>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.</td>
</tr>
<tr>
<td>Consulting</td>
<td>Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens’ panels and focus groups.</td>
</tr>
<tr>
<td>Informing</td>
<td>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.</td>
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</tbody>
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This model is from *Participation in Health and Care*, (NHS England, 2013), and updated version of Arnstein’s *Ladder of Engagement*

6. **The voice of the patient**

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 voice of the patient has developed beyond the personal to a point where involvement extends to having a voice in the development and delivery of services, which affect the health care of an individual patient or a group of patient.

7. **What involvement looks like**

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 Partnership Group or the Equality Delivery System Panel; sharing a personal experience as a Patient Story; or being a volunteer guide.
The Trust is alive with good practice in involvement. Eight best practice case studies from current Trust work are in **Appendix 1**.

8. Developing the Strategy

The Strategy's six strategic objectives were developed with the Trust's stakeholders, and are benchmarked against national best practice. They fulfil statutory requirements with regard to carers, seldom-heard people and vulnerable groups.

This included Trust's Public Participation Groups voluntary, community and statutory partner organisations, Foundation Trust membership and staff, 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 (Patient Advice and Liaison Service), 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 six high-level priorities and action plan (not part of this consultation document).

9. 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.

10. 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. They are based on the Trust's six core values: **excellence, compassion, respect, learning, delivery and improvement** and 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 and the public are actively supported to be involved.
iv. To increase the involvement of seldom heard people and groups in particular, and to provide additional support to facilitate involvement of these groups, 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.

10.1. 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 based on partnership between the public and the Trust. It clearly articulates what Trust needs and what it can offer in return, matching this to what the patients, family members and public want to offer in return. It is responsive to opportunities initiated by patients and the public, and works with them 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 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 available 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, community and social enterprise groups.

10.2. Objective 2: The involvement offer is visible and fully accessible

A short mapping exercise during the development of this Strategy identified current activity as outlined in Table 1.
Table 1: Numbers and activity of Trust patient and public involvement 2015

<table>
<thead>
<tr>
<th>Area</th>
<th>Numbers involved pa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Trust staff membership</td>
<td>11,000</td>
</tr>
<tr>
<td>Foundation Trust public membership</td>
<td>8,500</td>
</tr>
<tr>
<td>Volunteers - Direct applications</td>
<td>640</td>
</tr>
<tr>
<td>Volunteers - Clinical research</td>
<td>500</td>
</tr>
<tr>
<td>Volunteers - Authorised</td>
<td>350</td>
</tr>
<tr>
<td>Public Participation &amp; Partnership Groups (PPG’s)</td>
<td>80 approx.</td>
</tr>
<tr>
<td>Work experience programme - <em>Introduction to the NHS</em></td>
<td>48</td>
</tr>
<tr>
<td>Hospital Charity fundraisers</td>
<td>10-12</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>Not known</td>
</tr>
<tr>
<td>Host organisations:</td>
<td>Not known</td>
</tr>
<tr>
<td>League of friends, Sobell House, SNNAP, Radio Horton and Radio Cherwell, Red Cross volunteers</td>
<td></td>
</tr>
</tbody>
</table>

This is an underestimation, the full extent of involvement activity across the Trust’s five clinical divisions and one non-clinical division is currently not known, because it is scattered and embedded within clinical divisions, directorates, and wards and include many associated partnerships and networks - local, national and even international. The level of involvement and is hidden to the vast majority of staff and the public. A key action is for the Trust to capture more accurately the numbers of people and the levels of activity in terms of the roles offered and the skills and knowledge being used, within each clinical division, so opportunities can be publicised and shared with all stakeholders.

What is clear is that 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. Currently people can get involved through a range of avenues. Staff and patients report that by far the most successful recruiting strategy for getting new Foundation Trust members, joining PPG’s, taking part in the Values Based Interviews programme and Peer Reviews, is personal contact and invitations from peers or staff which persuades them 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.

Examples of existing involvement are also in Appendix 1.

- 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 volunteering in administration support, directing family and friends, running a help desk, working in the chaplaincy, and gardening.
- Clinical research, is very active, 500 people signed up last year involvement included assisting with the design and development of research.
- Fundraisers for charitable funds (as part of the work of Charitable Trust) also act as advocates, ambassadors and public role models for the Trust.

- Across the Trust's five clinical divisions, there are at least ten active condition-based Public Partnership Groups. They 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.

- A Patients Active in Research Group (PAIR) based in Oxford Biomedical Research Centre and Unit.

- Within Organisational Development, patients are involved in Peer Reviews, and delivering Values Based Interviewing training.

- Within the Renal Unit patients act as peer mentors, they have assisted with staff recruitment videos, website development, event organisers, and as experts by experience through personal blogs.

All the opportunities to be involved with the Trust, both clinical and non-clinical need to be made more clearly accessible. A starting point is the Trust's public website which has 350,000 visits per month. As well as showing clearly all involvement opportunities (e.g. research, volunteering, Foundation Trust Membership, Patient Partnership Groups) the website should showcase examples of successful involvement which demonstrate the positive impact on the quality of patient experience.

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 who are seldom heard, for example, people with sensory or cognitive impairment, a learning disability, and also older people aged 65 years and over.

Involvement opportunities need to be signposted in key communications to patients, such as OUIH News, Foundation Trust Membership invitations, volunteer services booklet, and patient information leaflets, to provide follow-through and reinforcement.

10.3. Objective 3: Patients and the public are actively supported to be 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 health care and 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 health condition, experience of trauma or bereavement, cognitive or sensory impairment and or having end of life care needs. Less easily recognised are a lack of confidence, anxiety, poor literacy levels, and being a young or older which will prevent a patient or carer from becoming involved.

The desire for involvement may also depend on where patients are in their care pathway, and their ability to accept and management their health issues. For example, a patient who has recently received a diagnosis of a life-limiting condition may be less able to get involved compared to a patient who is recovering and well enough to go home.
The Trust needs to provide a range of opportunities in different settings (e.g. at home or in peer support groups) to enable involvement. It also needs to use a range of ways to communicate and engage (e.g., dance, film, storytelling, touch, music, reminiscence, easy-read and signing, social media). A good example within the Trust is 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.

10.4. Objective 4: Increase the involvement of seldom-heard people and groups, and provide 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. 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.

‘Seldom heard’ is a term used to describe groups who may experience barriers to accessing services or are under-represented in healthcare decision-making. Under the Equality Act 2010\(^1\) nine characteristics are protected 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 a range of other factors, such as homelessness, living rurally, poverty, being a victim of crime, an asylum seeker contribute to people who use the Trust’s services being at risk of exclusion from involvement.

A Seldom Heard Project at the Trust during 2015, ensured that people from these groups are more involved – both with their own health care and the how the Trust delivers and develops services. Approximately 40 Seldom Heard Groups and individuals in Oxfordshire were involved in developing the recommendations included in the Action Plan in Appendix 2.

Compared to other seldom heard groups, there are relatively high levels of engagement from older people, through the Patient Partnership Groups, Foundation Trust membership and voluntary organisations (e.g. Age UK Oxfordshire 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 leads activity in this area and ensures there is wide ranging education and training in dementia.

Currently there is a gap in children’s and young people’s involvement 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 during 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 peers can exercise greater influence than professionals and parents on some young people.

An 18-month funded project to address this gap launched 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 organisations supporting vulnerable children in the community, including schools. The Trust needs to identify these groups and develop working opportunities within community settings to reduce the burden on carers travelling to the hospital and improve the range of opportunities on offer to children and young people.

10.5. Objective 5: The Trust seeks out and works with 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. It is vital that the Trust works with health and social care providers and commissioners who often have a duty or desire to consult and engage with health and social care service stakeholders to get better quality involvement. For example, by working with supporting the Oxfordshire Clinical Commissioning Group’s Patient and Public Locality Forums, common themes can be identified in the early stages of service development and the risk of over consultation can be reduced.

Oxfordshire and adjoining counties have a wealth of voluntary, community and social enterprise groups which support statutory and non-statutory services. These groups are increasingly becoming peer-led membership organisations which represent the interests of their members locally, nationally and internationally. They are often highly skilled at advocacy and encourage self-advocacy from their members in order to contribute lived experiences. Some are condition based (e.g. diabetes, acquired brain injury, autistic spectrum disorder, Downs’s syndrome, deafness, loss of sight, early onset dementia, and stroke) whilst others support seldom heard groups (e.g. older carers or refugees).

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 needs to seek out and increase engagement with these partner organisations and develop good working relationships to ensure better representation and involvement from the public.

10.6 Objective 6: The Trust embeds involvement in its daily governance, policy and practice.

“For me it’s about how we see things through patients’ eyes.”
Allie Thornley, Matron Renal Unit, Churchill Hospital

Patient and public involvement needs to be happening and visible throughout the everyday business of the Trust. There is a need to establish clear links and routes of influence from patient involvement into formal decision-making processes with the Trust Board and Trust Governors. There is also a need to ensure that the development of key strategies (e.g. the Clinical Strategy) has patient involvement and that the direction of the Strategy is informed by the Quality Account.

By far the best advocates for involvement are Trust staff themselves both clinical and non-clinical, who are passionate about their patients’ involvement and are ambitious for increased and better involvement. However, all staff need structured networking opportunities to do this to gain maximum audiences and impact.

A key area for development is joint working and information sharing between clinical research and clinical and non-clinical staff. Clinical studies in the Trust engaged over 500 people in 2015 which is a significant way for patients and the public to be involved in the Trust. Clinical research staff are willing to share the skills, experience, knowledge and their multiple examples of best and good practice with their clinical non-clinical colleagues.

The Oxford Biomedical Research Centre works to involve patients throughout the research cycle and has a Patients Active in Research Group (PAIR), which aims to bring the patient/public voice to the overarching patient involvement strategy. It also works with a web of other research organisations who wish to increase public and patient activity for example, the Oxford Academic Health Science Centre and Network, The Collaboration for Applied Health Research and Care Oxford, The National Institute for Health Research Clinical Research Network: Thames Valley and South Midlands.

Public Partnership Groups (PPGs) (Appendix 1 Case Study 8), are highly valued by both staff and patients and membership of the groups is usually a mixture of both staff and patients. There are 183 services and departments listed on the Trust website and only nine groups and an ambition to have a PPG for all 183 services would not be realistic or achievable. PPGs provide valuable a snapshot, important networking and information sharing opportunities, but they are not fully representative of patient’s views. PPGs recognise they need to develop and share common standards and good practice and to work harder to engage with seldom-heard communities, this is being developed and the role of a central coordinator is being scoped.

During the development of this Strategy, staff reported that they need training and development support and easily accessible information about opportunities to engage and involve patients, particularly those who are seldom heard, fairly and effectively. 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, alternative options, what resources they have to support the patients and public, and how to nurture and manage a range of imaginative involvement projects with their patients and carers. The Patient Experience and Organisational Development Teams are best placed to this alongside patients and carers themselves and need to share current resources more widely in a planned way across the Trust starting with staff induction.
The Patient Experience Team has a pivotal role in leading on the involvement work for staff across the Trust. Key areas are working more closely with the research, volunteers, fundraising, organisational development, and Foundation Trust membership teams. The team provide a central point of contact or ‘front door’ for staff across the Trust who need support with involvement activity and works with teams to align their involvement work and reduce the risk of over consultation and duplication. The Patient Experience Team needs to lead on developing a Patient Experience Strategy Group to include representation from all key staff and external stakeholders including research, the Patient Partnership Groups, Foundation Trust Members and Governors to lead on the Public and Patient Involvement Strategy and drive forward the implementation of the action plan.

11. Consultation and Action Plan
A high-level action plan is attached to this Strategy at Appendix 2 and will be supported by a detailed action plan with performance indicators and measures for formal implementation from 31 January 2016 for 3 years.

12. Governance and monitoring
A reporting schedule will align this Strategy with the annual Quality Account, Annual Patient Experience Report and the Trust’s Annual Report.

Trust Board responsibility and leadership for this Strategy is provided through the Chief Nurse. All Trust Board and Executive Board members will support delivery of the Strategy across all the activities of the Trust.

This Strategy will be delivered and monitored by the Head of Patient Experience at the Trust.

13. Conclusion
This Patient and Public Involvement Strategy, 2016-2019 will lead and shape involvement across the Trust over the next three years. It will take account of significant changes across the Trust and externally. Trust patients themselves have a right to be, and want to be, increasingly involved.

The primary outcome will be a good ‘involvement offer’ to the Trust’ patients and the wider public. There will be a wide range of clearly accessible, signposted opportunities for involvement with extra support for those who experience significantly more barriers to engagement including those who are seldom heard or have characteristics protected by the Equality Act 2010. Trust staff will have clearly routed resources and support to enable them to engage with and involve patients and the public, with confidence.

The development of the Strategy focussed in the Trust and ensuring this sustained when the Strategy is fully implemented is a key priority for the Trust.

Appendix 1

Case Studies highlighting best practice
1. Patient Experience Star of the Month Award (December 2014): Jilly Heath, for improving 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.

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

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 artwork 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 has 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.

Contact: Rachel Taylor, Public Engagement Manager

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 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 respective 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.

**Contact: Rachel Taylor, Public Engagement Manager**

### 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:

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

7. Privacy and Dignity Policy

In 2015 the Patient Experience Team co-produced 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 Oxfordshire, Carers Oxfordshire, Unlimited Oxfordshire (physical disability organisation), Healthwatch Oxfordshire, 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 eight members of My Life My Choice discussed in depth issues to do with privacy and dignity.

The policy includes:
• 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 was reviewed for approval by the Trust’s Policy Group in September 2015 and launched in November 2015 at the same time as Healthwatch Oxfordshire’s Dignity in Care launch.

**Contact: Rachel Taylor, Public Engagement Manager**

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.

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2 After many successful years, this NOC-specific group no longer operates. All PPGs are now associated with particular specialties, departments, directorates or divisions.
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 used. 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 women’s 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.

Contact: Monique Wilkinson, Chair of Patient Liaison Group

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3 Most patients now use their own mobiles