Experience of Care Strategy

Delivery Plan 2024 - 2027

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

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Strategy Goal 1a

Asking What Matters To You?

Aim: We will ask what matters most to patients during their care pathway so that we can provide care that meets their needs and wishes.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will ask 'What matters to you?' to all the people we support.	• Roll-out the 'What matters to you?' conversation tool and approach to all inpatient areas. • Discuss and collate the successes and challenges of rolling out 'What matters to you?' across Divisions and agree the dissemination of key learning to staff. • Agree monitoring plan and indicators to provide assurance that 'What matters to you?' is embedded. Utilise patient surveys and embed as standard in the Clinical Accreditation Programme. • Ensure all patients are asked their preferred names and that these are visible in their Electronic Patient Record and in key relevant patient information (for example on bed boards).	• Roll-out the 'What matters to you?' conversation tool and approach to all pre-operative and outpatient areas. • Extend training on 'What matters to you?' to therapy teams, medical teams and volunteers to enable the approach to be used by all multidisciplinary teams. • Evaluate findings of year one delivery and produce recommendations for embedding and improving approach. • Embed phonetic spelling of patient's names to ensure staff pronounce names accurately and respectfully.	• Continue to embed 'What matters to you?' in the culture of the organisation and work towards the 'What matters to you?' approach becoming the norm. • Offer 'What matters to you?' as part of non-mandatory training for key clinical groups to equip staff with the skills required to embed the approach. • Evaluate findings of year two delivery and produce recommendations for embedding and improving approach. • Audit a sample of patient notes to ensure preferred names are being recorded and phonetic spelling of patient's names is in place.

Strategy Goal 1a

Asking What Matters To You?

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will make best use of the 'What matters to you?' conversations to involve patients and carers in decisions about their care and treatment.	• Embed the 'What matters to you?' approach in best interest decision meetings and groups involving patients. • Display what is important to patients clearly to all professionals involved in their care, for example through shared communication and 'patient at a glance' boards • Explore becoming early adopters of the NHS England National Care Partner work, by adopting the 'What matters to you?' approach with carers.	• Embed the 'What matters to you?' approach as part of the pre-operative assessment of patients waiting for planned care and treatment and form part of therapy assessments and goal planning for discharge from hospital. • Share learning from the 'What matters to you?' approach more broadly in the Trust to proactively link with other relevant strategic projects and working groups. • Year 2 milestones to be confirmed subject to agreement to become early adopters for the National Care Partner work.	• Undertake an audit to identify how successfully the 'What matters to you?' approach has been embedded in peri-operative assessment and goal planning conversations for discharge from hospital and agree improvements as required.

The strategy period covers a five year duration. This delivery plan sets out our ambitions and milestones for years one, two and three. The objectives and milestones for years four and five will be set at the end of year three, based on the current situation, progress made and remaining gaps.

Strategy Goal 1b

Shared Decision Making (SDM)

Aim: All patients and clinical teams will be involved in a collaborative partnership, learning together and developing pathways of care to support patients to make their own choices through SDM.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will work collaboratively with system partners to ensure processes are in place to support SDM both within UHBW and the wider community.	• Identify a lead and Executive sponsor for SDM across UHBW and North Bristol Trust (NBT) Hospital Group • Undertake self-assessment on National Institute for Clinical Excellent (NICE) Guidance on SDM and pro-duce recommendations report to reach compliance with guidance over a 3-year period. • Be a proactive and engaged partner in the new Integrated Care System Personalised Care Steering Group.	• Align approaches for SDM across the Hospital Group by learning from early roll-out by NBT. • Implement recommendations for year one.	• Integrate approaches for SDM and the tools and resources that support it across the Hospital Group. • Implement recommendations for year two and begin to evaluate impact.
2. We will enable and support all clinical teams to receive training in SDM and have the necessary tool kit to carry this out routinely in their everyday practice.	• Undertake staff engagement to better understand existing experience and application of SDM in practice to inform priorities.	• Work with NBT to bring together resources for staff to access information on SDM tools.	
3. We will enable and support patients with long-term health conditions to build the knowledge, skills and confidence to self-care and proactively manage their own conditions.	• Carry out focus groups with patients on their experience of SDM to inform priorities.	• Work with NBT to bring together resources for staff to access information on SDM tools.	

Strategy Goal 1c

Accessible Communication

Aim: To be able to effectively communicate with all patients and communities in a way that is accessible to them.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will improve our current translating and interpreting services to ensure that all patients receive accessible communication that supports their care, treatment and choices.	• Raise awareness of the Trust's spoken and non-spoken translating and interpreting services for our staff and communities. • Work with our external translating and interpreting suppliers to ensure that regular training is available to all staff to book and work with interpreters. • Embed the new translating and interpreting contract across the Trust, working closely with external suppliers to ensure our services work effectively for our communities. • Explore how we can ensure patient information leaflets are translated into a variety of formats to meet the needs of our diverse communities.	• Utilise available technology (for example video relay) to help remove the barriers people face in accessing our services. • Understand the experience of people who use our translating and interpreting services through feedback methods and continue to evaluate the service as part of quality assurance meetings with suppliers. • Ensure that information and updates about our Trust and services are available in a wide range of languages and formats to meet the needs of the people and communities we serve. To include improvements in communication methods for patient information and appointments for example, translating outpatient information such as SMS appointment reminders into different languages. • Prioritise the delivery of translated patient information leaflets and which formats and leaflets will be included as a starting point.	• Hold engagement events with the people and communities we support to ensure any concerns or suggestions about translating and interpreting services are heard and acted upon. • Work with our external translating and interpreting suppliers to share resources so the people and communities we support feel reassured that their communication needs can be met by our Trust. • Ensure there are effective mechanisms for patients who require interpreting services to be confident that an interpreter has been booked for their appointment. • Continue to progress with the roll out of translated patient information leaflets across the Trust.

Strategy Goal 1c

Accessible Communication

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will reach full compliance with the NHS Accessible Information Standard (AIS), ensuring we communicate effectively with patients, carers and communities with additional information and communication needs.	• Regularly update communities about improvements to the ways in which we are improving accessibility via the Trust website, the digital patient portal and community events. • Rollout of AIS e-learning training which has been developed with and includes experts by experience and introduce a guidance document to support staff to confidently and accurately add and use communication alerts on the Electronic Patient Record system. • Work with Digital systems staff to develop an AIS dashboard to identify a baseline measure of AIS to track progress.	• Ensure that patients, carers and visitors are aware of the AIS, how they can inform the Trust about their communication needs and to let us know how we can best meet their needs. • Ensure informal learning and training opportunities are widely available to support staff in understanding the importance of meeting communication needs and ensuring they have the resources to do so. • Monitor and improve compliance with AIS by introducing a new measurement system (a data dashboard) to track and support how well AIS is embedded across the services provided by UHBW.	• Continued use of the AIS dashboard to ensure we are fully compliant with the standard and can evidence our progress.

Strategy Goal 1c

Accessible Communication

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will improve our systems to ensure we have the capability to meet the information and communication needs of patients, carers and communities.	• Work with Digital Systems and Human Factors teams to review and refresh the AIS alerts options on the Electronic Patient Record system and how they are used to ensure communication needs are recorded and shared effectively. • Work with the Trust's Outpatients Team to ensure that the digital patient portal is accessible by implementing the actions arising from the Equality Impact Assessment. • Work with the Communications Team on a series of resources to promote and raise awareness of the AIS across our Trust and ensure that accessibility requirements are embedded in the design work for the new UHBW website.	• Evaluate the effectiveness of the new AIS alerts options and refine process based on staff feedback. • Explore how two-way communication can be used within the digital patient portal so that patients can ensure they can tell us about their communication needs and these can be recorded, shared and met. • The Communications Team will work collaboratively with the new website design team and community partners to ensure greater accessibility options are available on the new Trust website.	• To work with our main digital patient portal to ensure it is fully accessible and patients and communities are able to feed back about their experience using the system. • Share case studies and good news stories about the importance and progress of accessible information across our Trust with colleagues and community partners.

Strategy Goal 1d

Chaplaincy

Aim: We will provide a skilled chaplaincy service that is increasingly inclusive to all, enriching the experience of our patients and staff by providing a visible compassionate presence within our organisation

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will work in partnership with our local communities to develop inclusive spiritual and pastoral care for patients, carers, families and staff.	• Use data to identify what percentage of people within a faith group were offered access to appropriate chaplaincy support whilst they were an inpatient. • Work with our Divisions to modify the current nursing admission forms , specifically in the area of religious needs and requirements, to make it easier and more meaningful to use. • We will then train ward staff how to ask these questions so that people of faith are not excluded from accessing the spiritual, pastoral and religious help that they need. • Review census demographics and identify any gaps in our current provision to faith groups in the city. We will then reach out to establish new links with these faith groups. • Contact leaders of all faiths and ask if we can arrange meetings or focus groups with them to identify areas where we can work together.	• Run regular refresher sessions for our ward teams concerning the assessment of pastoral and spiritual needs of different religions. • We will obtain staff feedback to see how the assessment tool is working and can be improved upon. • We will analyse the data to evaluate if chaplaincy support is becoming more inclusive. • Offer training and support for faith groups to be able to support their community when they come into UHBW. • Work with faith leaders to address any gaps in our service through specific education and training programmes.	• Ask faith groups (identified through Bristol census 2023 and Weston census 2021) to provide teaching sessions for our acute nursing teams, so that they are better equipped to help patients and their families at end of life. • Seek to learn from these faith groups by asking them to participate in Chaplaincy and Chaplaincy volunteer training. • Hold review meetings with faith leaders to evaluate if our service has become more effective and inclusive through the initiatives we have put in place.

Strategy Goal 1d

Chaplaincy

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will provide emotional support from birth to end-of-life: the practice of loving kindness, empathy and tolerance, listening to 'what matters to you'.	• Train our team, both chaplains and volunteers, to understand the purpose and value of the 'What matters to you' conversation approach and to incorporate this approach as part of our assessment and ongoing provision of pastoral, religious and spiritual care to patients. • Incorporate ring fenced time in team meetings for our chaplains to further develop their emotional support skills through the discipline of reflective practice. • Explore the introduction of an 'I pray' badge for staff of faith who wish to support patients in this way.	• Introduce an annual training event for our chaplaincy volunteers and honorary chaplains that develops their pastoral and listening skills, enhancing the emotional support they give to patients. • Provide all newly recruited chaplaincy volunteers and honorary chaplains with supervision, so that they can grow their emotional support skills through reflection of practice. • Evaluate the effectiveness of supervision of all chaplaincy volunteers and honorary chaplains, to ensure that any gaps in emotional literacy are met and the practice of the wider chaplaincy team is improved.	• Evaluate the impact of the 'What matters to you' approach on chaplaincy provision. • Develop a training programme for chaplaincy volunteers and honorary chaplains that helps them develop their reflection of practice and that also equips them to provide peer support for each other.

Strategy Goal 1d

Chaplaincy

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will increase our chaplaincy capacity and reach by expanding our team of honorary chaplains and chaplaincy volunteers.	• Work collaboratively with faith communities/ leaders (including Humanist) not currently represented on the Trust's chaplaincy team, sharing what chaplaincy involves, and listening to their feedback and impressions of what they think their faith communities could contribute to our chaplaincy service. • Speak to leaders of faiths not currently represented on our chaplaincy team, to explain the role of honorary chaplains and explore any opportunities which might arise. • Outreach to our existing links in the Christian and Muslim communities to grow our current pool of chaplaincy volunteers and honorary chaplains.	• Offer training, supervision and ongoing support to members of faith communities who join our chaplaincy team. • Offer training, supervision and ongoing support to faith leaders who decide to become honorary chaplains. • Provide chaplaincy volunteer and honorary chaplain training, supervision and ongoing support for appropriate candidates for these roles.	• Run yearly cycles of recruitment and training of chaplaincy volunteers for minority faith groups. • Run yearly cycles of recruitment and training of Honorary chaplains for minority faith groups. • Run yearly cycles of recruitment and training of chaplaincy volunteers and honorary chaplains for Christian and Muslim faith groups.
4. We will contribute to education, training and research in spiritual and pastoral care within UHBW.	• Design ward posters explaining the role of chaplaincy and how to access it. • Develop a training programme on the religious/spiritual needs at end-of-life care for different faith groups. • Develop a patient/carer survey to gather feedback about the effectiveness of the UHBW chaplaincy service.	• Seek opportunities to educate clinical staff on the role of chaplaincy by having regular teaching sessions in preceptorship, induction, oversea nurse and new health care assistant training. • Deliver end-of-life spiritual care training programme to palliative teams/areas in UHBW. • Explore the possibility of setting up patient focus groups exploring key themes from the results of our feedback survey, which will further inform the development of our service.	• Offer divisions the opportunity to have yearly updates, as part of their teaching programmes, where we inform ward staff on the role of chaplaincy in providing pastoral care and spiritual support. • Widen end-of-life spiritual care training to Care of the Elderly and acute wards in UHBW. • Review our feedback survey with patients and carers to see how effective the changes we have implemented from the first survey and focus groups have been.

Strategy Goal 2

Listening and responding well

Aim: People who use our services will be able to give feedback in clear and accessible ways and our people and teams will have timely access to meaningful feedback to enable them to learn, improve and celebrate successes. We will listen respectfully, resolving concerns wherever possible, and identifying and embedding learning.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will increase the variety of ways in which we understand the experience people have of our care, in a way that shapes improvement work to ensure our services are inclusive and accessible for everyone.	• Raise awareness of national patient surveys and promote the surveys specifically to under-represented groups to understand their experience of care. • Create new opportunities to hear from a broader range of patients, with a focus on those from marginalised and under-represented communities and ensure inclusive and accessible feedback, PALS and complaints routes. • Implement 'Ask, Listen, Do' (ALD) to improve experiences and outcomes for children and adults who are autistic or who have a learning disability, their families and carers, when they need to make a complaint or want to give feedback. • Develop and launch a young person friendly feedback programme.	• Carry out touchpoint mapping to understand how patients feel at different points of their pathway, including waiting for treatment and care, transfer to a different ward and discharge from hospital. • Measure feedback and experience of people who require translating and interpreting services and continue to evaluate the service as part of quality assurance meetings with providers. • Undertake outreach engagement, including focus groups with marginalised and underrepresented communities to understand their experiences of making a complaint and giving feedback and to develop a more inclusive process. • Evaluate benefits of the young-person's feedback programme and explore opportunities for further development with the Youth Involvement Group (YIG).	• Shadow patients to understand their journey through our services. • Include a feedback link on all patient letters in order to increase survey response rates. • Demonstrate measurable, sustained improvement in the experience of underrepresented communities when they provide feedback. • We will extend the opportunities for hearing the voices of those with a learning disability and/or autistic people by working with community partners. • Establish an annual evaluation programme of Young Person impact, based around Young Ambassadors in order to set an annual action plan.

Strategy Goal 2

Listening and responding well

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will empower and support individuals and teams to act on and use feedback to improve services for our patients and communities.	• Ensure the Trust's Clinical Accreditation Programme includes standards describing how clinical services should collect, analyse and use feedback. • Ensure that all PALS and complaints staff complete NHS England 'Handling Difficult Situations' training and PHSO on-line complaints standards e-learning 'How to identify and resolve complaints early.'	• Utilise data from Clinical Accreditation process to identify wards and departments where further support is required in collecting, analysing and using feedback. • Ask all Trust staff who have responsibilities for investigating complaints to complete PHSO online complaints standards e-learning 'How to identify and resolve complaints early' and, where appropriate, attend PHSO training 'A Closer Look – how to carry out an investigation'.	• Demonstrate that all Trust staff with responsibilities for complaints are fully conversant with PHSO Complaints Standards, including processes and staff training.

Strategy Goal 2

Listening and responding well

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will encourage parents and carers to ask questions and raise concerns immediately and ensure that they receive an effective and timely response.	• Redesign and relaunch 'Listening To You' (a process which allows parents to seek a clinical review of their child if they are concerned) to include requirements of Martha's Rule that parents may request an objective second opinion in relation to their child's care which should be provided in a timely manner. • Re-establish parental escalation policy to include impact of new support programmes. • Establish a 'Family Forum' to create reference group for reciprocal communication, exploring patient experiences and developing and communicating service developments. .	• Audit effectiveness of 'Listening To You' process and supporting poster campaign. • Audit effectiveness of new parental escalation policy. • Review 'You said, We did' to ensure outcomes are visible to a wide range of families and service users.	• Evaluate awareness and impact of 'Listening To You' process, and supporting poster campaign using opportunities created through the hospital's 'Conversations' programme which encourages collaborative working across the hospital community (patients/parents/ staff) on topics of shared interest. • Evaluate awareness and impact of revised policies using 'conversations' ward-based activities • Gap analysis of 'Family Forum' to actively reach communities not yet engaged with the programme and explore alternative approaches to ensure the model is accessible.
4. We will actively listen to the voices of patients with a Learning Disability and / or autism.	• We will implement 'Ask, Listen, Do' and review the data in real time.	• Describe, through case studies, the changes made to our services based on the feedback we have received.	

Strategy Goal 3

Learning, Embedding and Spreading

Aim: We will deliver a step change in the way that we understand what matters most to the people we support, sharing this widely within the organisation and system and seeking greater clarity on what we have learned, spreading good practice and embedding and sustaining improvements.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will make better use of the feedback that has been shared with us by patients and carers.	• Establish process to theme survey feedback, complaints and compliments and qualitative data aligned to the Picker Principles of Person-Centred Care and develop new ways of sharing key themes from surveys, concerns, complaints and compliments with divisional staff. • Improve data sharing between the Trust and Healthwatch to bring together the themes of survey feedback and complaints with the feedback that Healthwatch has gathered from people and communities. • Embed and maximise the value of the Patient Feedback Hub (our first stop shop for experience of care data) along with data gathered from complaints. • Develop a solution to move from a reactive use of our quality and workforce datasets to a proactive 'smoke detector' approach whereby wards and departments are rapidly alerted to deteriorating trends in experience of care and quality.	• Use insight gathered from year one and work with improvement tools available from NHS and oth-er partners to improve our ability to identify key themes from our qualitative data. • Scope procurement exercise with NBT for an integrated feedback survey system supplier. • Review effectiveness of 'smoke detector' solution and improve based on feedback from wards and outpatient departments.	• Share thematic analysis routinely and in real-time with service leads via the Patient Feedback Hub. • Implement and embed new survey system and roll out training to teams. Scope options for a single system solution for survey data and complaint recording.

Strategy Goal 3

Learning, Embedding and Spreading

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will improve the confidence and skills of our staff in understanding and improving experience of care.	• Design staff training on Experience of Care including a focus on Person-Centred Care through collaboration with Picker Institute, patients, carers and community groups. • Design and implement an Experience of Care Champion role together with front-line staff to be based operationally within Divisions. • Develop an Experience of Care 'lunch and learn' roadshow for teams involving the voice of the patient to raise awareness and provide practical tools and resources. • Develop content for a single point of access for staff (on the intranet) for Experience of Care resources in readiness for the new UHBW intranet.	• Roll out Experience of Care staff training to key staff groups. • Bring together Experience of Care Champions into a Community of Practice to share ideas, learning and resources. • Deliver first year of a 2-year rolling programme of 'lunch and learn' Experience of Care roadshow to teams. • Implement new Experience of Care resources page on the UHBW intranet pages for staff.	• Continue roll out of staff training, seeking feedback on content and improving where required. • Evaluate Experience of Care champion role and improve and refine based on feedback. • Deliver second year of a 2-year rolling programme of 'lunch and learn' Experience of Care roadshow to teams and evaluate impact.

Strategy Goal 3

Learning, Embedding and Spreading

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will adopt a rigorous approach to following up on planned improvements to experience of care to make sure we embed learning.	• Work with Divisional Experience of Care Coordinators to create single improvement plans at a local level that collate and follow-up on all actions arising from complaints, surveys, Healthwatch feedback, Quality and Equality Impact Assessments (QEIAs) and qualitative engagement work. • Introduce a 'learning log' to Experience of Care Group (the main Trust-wide meeting for matters relating to Experience of Care) to record relevant Trust-wide learning and follow-up to check relevant Divisions have implemented in their local services. • Develop and hold first annual deliberative process event involving the people and communities we support and Healthwatch to prioritise improvement projects using Patient First methodology and seek feedback on approach.	• Introduce 6-monthly audit via a random sample of planned actions arising from complaints, surveys, QEIAs, Healthwatch feedback and qualitative engagement work to check these have been implemented. • Explore the feasibility of an automated follow-up system to remind and measure Divisions to embed relevant learning in practice. • Hold second annual deliberative process event (shaped by year one feedback).	

Strategy Goal 3

Learning, Embedding and Spreading

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
4. We will demonstrate the impact of what we have learned from feedback and what actions we have taken to improve our health services.	• Embed 'You said, We Did' process and posters to demonstrate learning and action and integrate complaints learning into the process, displaying feedback in wards and departments. • Produce an 'Experience of Care spotlight' case study template which provides the format for our teams to record, demonstrate and share improvement work and communicate internally and externally. • Develop concept for an annual showcase event to share best practice, impact and improvement work and progress in delivering the strategy. • Work with external feedback solution supplier to develop a live view of real-time patient feedback using our Patient Feedback Hub to be available on the Trust website to demonstrate an open and transparent organisational culture.	• Utilise data from Clinical Accreditation process to identify wards and departments where posters are yet to be created/ displayed and focus resources to ensure they are created/displayed. • Develop initiatives such as 'Feedback Friday' to spotlight service improvements that we make using experience of care feedback. • Hold inaugural Experience of Care showcase event and evaluate impact. • Publish live view of real-time patient feedback on the Trust website and seek views on impact.	• Work with Experience of Care Champions to ensure that projects and improvements are shared internally and externally and embedded in the Trust's Recognising Success Awards to share best-practice. • Refine live view of real-time patient feedback based on impact review.

Strategy Goal 4

Designing and Delivering Together

Aim: We will lead a dynamic and inquisitive culture of collaboration with the people and communities who use our services so that we design and deliver our services to meet the needs of our diverse population. We will listen to and work with people to design and deliver inclusive services.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will make it easier for people and communities to get involved in designing and delivering our services in ways that have a positive impact in the work of UHBW.	• Review and streamline our approach to recruiting and working with Experts by Experience (sometimes referred to as Lay Representatives). • Launch a "Participation Community" as a new model of working with people and community partners (including Carers) which will include specific consideration to the interests of Weston General Hospital and the community it serves. • Collaborate with system partners, the voluntary community and social enterprise (VCSE) sector and Health-watch to engage and collaborate with people and the communities we support more effectively so their voices are heard and have influence. • Develop and implement a new policy to recognise and reward the involvement of people and community partners.	• Grow the Participation Community by promoting widely across our diverse communities. • Launch a new collaborative model of outreach work across the health and care system reaching the people and communities we support with a focus on our work to tackle health inequalities. • Design and launch a mentoring programme for our Experts by Experience and community partners.	• Review the impact of the Participation Community model to date and develop recommendations for continuing to maximise its impact.

Strategy Goal 4

Designing and Delivering Together

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will create more opportunities for people and the communities we support to have influence and inspire our work.	• Co-create new Expert by Experience roles with an aim of six in the first year and use this as a model to bring the patient voice to other areas of work. • Scope options for a new on-line engagement portal to increase opportunities for involvement. • Develop our patient story to Trust Board process to reflect the life course model from birth to end of life and, develop a proposal for a patient story programme that is linked to training and development. • Increase awareness of the Youth Involvement Group through Trust membership newsletters, Newsbeat, GP communications and any other appropriate communication resources, developing closer links with work experience and wider engagement with the Integrated Care Board to offer support to system wide discussions which impact on young people. • Identify means of engaging with younger children (10 to 14 years) and seeking their feedback on a regular basis.	• Develop an approach to involving the people and communities, including Foundation Trust members, in our recruitment processes. • Implement a new on-line engagement portal to increase opportunities for involvement. • Implement a patient story programme for training and development. Evaluate (at end of year two) the impact of the patient story at Board approach and produce recommendations for year three delivery. • Seek out young people who are under-represented in the Youth Involvement Group and design programmes which will allow them to engage more effectively. • Evaluate impact of engagement for younger children and redesign 'You said, We did', to ensure outcomes are visible and patient friendly.	• Carry out gap analysis for groups which are under-represented and initiate targeted action to improve this. • Consider the engagement needs of younger children (6 to 10 years) and scope options for involving them more effectively in their health experience.

Strategy Goal 4

Designing and Delivering Together

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will support our staff and leaders to work effectively with people and communities so that they are involved in the design and delivery of services and service improvements.	• Adopt and apply the principles and learning from 'Common Ambition Bristol' and the NHS England 'Start with People' model of working differently with people and communities in our service improvement work. • Explore the value of independent user-centred design expertise to work with us to design and deliver services together with our communities. • Grow our "Community of Practice for Better Involvement" including access to online and in-person workshops, webinars and open discussion sessions, self-service resources, toolkits and examples of good practice. • Raise the profile of our involvement work both within and outside of the organisation including publication of case studies. • Improve the support that is available to the Continuous Improvement Team and colleagues leading service improvements so that the patient and community voice is central and influential to their work and in doing so, introduce a mandatory 'engagement and involvement gateway' check at the start of any new project.	• Develop an evaluation tool to understand the impact the patient voice has on service improvement projects. • Subject to year one milestone, develop a specification and partnership with an external provider to support with coproduction work with communities. • Develop an accredited facilitator network of internal and external participants expanding our ability to deliver, for example, effective patient focus groups. • Launch a support programme for senior leaders to be active in our community outreach work.	• Undertake evaluation and publish the impact of involvement activities on service improvement work.

Strategy Goal 5A

Birth and Maternity

Aim: Maternity patients and their families rating their care as good. Patients reporting that they have been treated with kindness and compassion and involved in decisions about their care.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	
1. We will continue to improve the way in which we act on the feedback from patients and their partners about their experience of maternity care.	• Routinely share the results of the annual National Maternity Survey and local monthly maternity survey with staff and Maternity and Neonatal Voices Partnership (MNVP). • Develop an action plan in partnership with the MNVP and staff, ensuring there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale (Refers to 3.11 of the Three-year delivery Plan, 2023). • Agree how we will measure improvements and monitor the progress of the action plan through the Women's Experience Group.	• Ensure the results of the maternity surveys and progress made in delivering the improvement plan are adequately and meaningfully reported to Trust Board and shared with the public. • Triangulate the results of the surveys with other sources of feedback and clinical outcomes data to understand 'what good looks like' to best meet the needs of our local population and to learn from when things go well and when they do not. • Monitor the progress of the action plan and review performance against the outcome measures through the Women's Experience Group.	• Ensure positive and proactive engagement where responses to the results of the maternity surveys are more appropriately led at a Local Maternity and Neonatal System (LMNS) level across the whole of Bristol, North Somerset and South Gloucestershire (BNSSG). • Share maternity feedback and survey results routinely with health partners to support the Integrated Care Board (ICB) in their ambitions to ensure more personalised and safer care, to improve continuity of carer and provide information to help pregnant people make choices about their care. • Work in partnership with the MNVP and respond to service user feedback in a way which reflects our healthy and compassionate organisational culture.

Strategy Goal 5A

Birth and Maternity

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	
2. We will embed the use of personalised care and support plans (PCSPs) to ensure the service user remains an active partner in planning their care and to ensure that safe and high-quality care is delivered in alignment with their needs and wishes.	• Audit to understand who does and who doesn't use maternity Personalised Care and Support Plans (PCSPs) by conducting an audit. • Review the design and accessibility of PCSPs jointly across the LMNS in partnership with the MNVP. • Actively participate in the South-West Regional Enhancing Personalised Care Collaborative to share best-practice, learning and resources.	• Increase the numbers of service users who chose to use a PCSPs (aiming to achieve the minimum standard of 90% as set out in module 4 of the Core competency framework Version 2 (2023). • Promote the uptake of PCSPs using the support package provided by the South-West Regional Enhancing Personalised Care Collaborative. • Gather targeted feedback regarding people's experiences of personalised care and the use of PCSPs, using an equitable approach to access the voices of a diverse cross section of the maternity population.	• Continue to increase the numbers of service users who chose to use a PCSPs (aiming to achieve over 95% as set out in module 4 of the Core competency framework Version 2 (2023). • Act on the feedback and audit results to further improve the experience of personalised care and the uptake of PCSPs. • Evaluate the impact of our improvement work through a further audit of the uptake of the PCSPs.

Strategy Goal 5A

Birth and Maternity

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will continue to promote inclusion and equity	• Continue to grow the pool of Maternity staff who undertake the Black Maternity Matters programme. • Develop the leadership role and resource for the dedicated 'Inclusion and Diversity' Practice Education Facilitator. • Continue to support families to access our maternity services through the delivery of enhanced maternity support. This support focuses on families racialised as black or families who reside within a geographical area which may put them at higher risk of health inequalities.	• Provide services that facilitate informed decision-making by our local populations. This will include, for example, choice of pain relief in labour where we know there are inequalities. (Refers to 1.10 of the three-year delivery plan, 2023). • Ensure improved access to interpreting services and compliance with the Accessible Information Standard in maternity and neonatal settings. (Refers to 1.10 of the three-year delivery plan, 2023). • Work with the MNVP to collect and disaggregate local birth outcomes data and feedback by population groups to understand differences in access, experience and outcomes for women and babies from different backgrounds (including the social determinants of health). (Refers to 1.10 of the three-year delivery plan, 2023).	• Utilise our local feedback to address any inequity or inequalities identified across services or pathways, to improve care (continuous improvement). (Refers to 1.10 of the three-year delivery plan, 2023). • Work positively and proactively to support the LMNS in achieving their ambitions to improve equity and equality in maternity services across the local footprint (NHSE, Equity and equality guidance for Local maternity systems, 2021). • Mitigate against digital exclusion, e.g., by ensuring PCSPs (see objective 2) are available in hard copy for those that need it. (NHSE, 2021, Equity and equality guidance for Local maternity systems).

Strategy Goal 5A

Birth and Maternity

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
4. We will continue to promote inclusion and equity to reduce inequalities in access, experience and outcomes.	• Continue to grow the pool of Maternity staff who undertake the Black Maternity Matters programme. • Develop the leadership role and resource for the dedicated 'Inclusion and Diversity' Practice Education Facilitator. • Continue to support families to access our maternity services through the delivery of enhanced maternity support. This support focuses on families racialised as black or families who reside within a geographical area which may put them at higher risk of health inequalities.	• Provide services that facilitate informed decision-making by our local populations. This will include, for example, choice of pain relief in labour where we know there are inequalities. (Refers to 1.10 of the three-year delivery plan, 2023). • Ensure improved access to interpreting services and compliance with the Accessible Information Standard in maternity and neonatal settings. (Refers to 1.10 of the three-year delivery plan, 2023). • Work with the MNVP to collect and disaggregate local birth outcomes data and feed-back by population groups to understand differences in access, experience and outcomes for women and babies from different backgrounds (including the social determinants of health). (Refers to 1.10 of the three-year delivery plan, 2023).	• Utilise our local feedback to address any inequity or inequalities identified across services or pathways, to improve care (continuous improvement). (Refers to 1.10 of the three-year delivery plan, 2023). • Work positively and proactively to support the LMNS in achieving their ambitions to improve equity and equality in maternity services across the local footprint (NHSE, Equity and equality guidance for Local maternity systems, 2021). • Mitigate against digital exclusion, e.g., by ensuring PCSPs (see objective 2) are available in hard copy for those that need it. (NHSE, 2021, Equity and equality guidance for Local maternity systems).

Strategy Goal 5B

Children and Young People

Aim: Child and family support services will be a core part of multi-disciplinary conversations and introduced to patients and families at the start of their journey and children and young people with complex needs will have improved and coordinated care that meets their needs.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will increase the cohesion of medical and support services to ensure that families are offered the support they need at the earliest opportunity.	• Distribute Child and Family Support Services (CCFS) posters to increase family awareness of support available. • Establish an action plan to ensure effective ongoing recruitment for CCFS roles. • Increase the number of friends for parent volunteers to improve signposting to support services.	• Deliver CFSS awareness days for hospital staff. • Deliver family awareness sessions, a 'meet the team' event and a social media promotion programme. • Establish a sustainable family support package to incorporate consideration of practical, financial and psychosocial needs for both inpatient and outpatient families.	• Map any remaining gaps in service or communication and establish how they can be filled. • Evaluate the impact of CFSS involvement in core Multi-Disciplinary Team settings. • Evaluate the impact of the established support package and explore opportunities for development.
2. We will ensure that our services are able to meet the needs of children and young people with complex needs and ensure the communication processes that support this are appropriate.	• Identify ways of increasing training uptake for staff regarding disability, autism and learning disability and complex needs and offer support where needed. • Identify support groups in the community with an interest in working with healthcare professionals. • Review hospital passport process to identify opportunities for improvement.	• Re-establish a disability reference group to encourage reciprocal communication, exploring patient experiences and agreeing and communicating service development. • Review the use of 'You said, We did' information to ensure outcomes are visible and shared more widely. • Increase universally available tools to support admission planning which are co-designed with families including social stories, videos etc.	• Seek out those who are under-represented and redesign or create new programmes to allow them to engage. • Review complex care provision, ensuring user involvement, to establish how well it meets the needs of the people we support. • Review impact of reasonable adjustments for children and young people with complex needs to identify any actions required to improve their experience.

Strategy Goal 5C

Transitions

Aim: Transition planning to start at an appropriate time with all relevant young people in UHBW to ensure safe and supported movement to Adult services in UHBW and the South West. The focus will be on early engagement with responsibility and decision making moving to the young person. Their voice and opinion will be central and integral to the Transition trajectory and process.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will appoint a Trust-wide Nurse Specialist for Transition and embed the role into the coordination and practice for clinical teams over the next three years.	• Recruit to a new Clinical Nurse Specialist role for Transition. • Develop a governance model to support Transition pathways between UHBW services and with other health and care providers. • Benchmark and derive best practice across all teams currently working with young people and families.	• Develop clear cross Divisional processes and embed into practice. • Develop key consistent roles and responsibilities which follow the young person on their Transition pathway, developing documentation. •Continuation of benchmarking against national Transition standards and best practice and embed learning in the UHBW process.	• Support quarterly Transition meetings within specialities with the young person's voice central to all the decision making. • Full transparency of needs for the young person and the clinical teams of where the young person is on the Transition pathway. What is working well and what needs improving. • All best practice identified and embedded and continuous learning takes place. • Sharing good practice locally and nationally.
2. We will develop and implement an inclusive and clear process for the supportive transition of young patients to Adult Services that places the patient at the centre of the planning and decision-making process.	• Clarify and further develop a clear process to enable a smooth transition into adult care. • Clarification and development of what is expected of each member of the Multi-Disciplinary Team role to support the process. • Ensure internal and external stakeholders are aware of transition and expectations that this pathway is seamless for the young person.	• Benchmark nationally and embed local best practice into the current process – refining documents and ensure a consistent approach by the clinical teams involved in the young person's care. • Identification of who has the current level of skill, do they have capacity and the skill set to support. • Develop and agree the process amongst all stakeholders including the regional (tertiary) remit.	• Organisational change needs to happen to embed national best practice Standardise documentation and process. • Fully enabled process that delivers clear and measurable results against the objective that each young person will transition into adult care in a safe patient centred way. • Dynamic transitioning of roles and responsibilities which are responsive to where the young person is in real-time on the pathway and exists across organisation boundaries.

Strategy Goal 5C

Transitions

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will develop ourselves as a regional leader in delivering a responsive and individualised transition pathway for all our patients.	• Scope the regional current situation in transition and develop a communication plan for the patient, their family and the team involved in their care. • Benchmark best-practice within UHBW within our regional (tertiary remit) and nationally. • Explore technology available to support the Transition process.	• Develop processes and approval from all stakeholders on how we will communicate with the patient and the multi-disciplinary teams that are involved in the patients care. • Undertake training needs analysis across all teams and develop an appropriate training plan. • Extend technology to tertiary centres to improve efficiency and transparency.	• Fully developed and approved processes for transition into Adult Services. • Fully enabled and upskilled staff within UHBW to provide a seamless transition into adult care for the patient. • If “off the shelf“ software not available, investigate the feasibility of developing a bespoke system to share care required for the patient and provide a platform for virtual transition clinics.

Strategy Goal 5D

Sexual and Reproductive Health

Aim: Develop an equitable service that meets the needs of the patient population

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will develop tailored support for groups most at risk of poor sexual and reproductive health outcomes.	• Develop a list of potential partnership organisations working in the community with groups identified by a local needs assessment as most at risk of poor sexual and reproductive health. • Continue to work with Common Ambition Bristol multi-partnership team to evolve specialist clinics at Charlotte Keel Health Centre and Montpelier Health Centre. • Establish baseline data for attendances by people from under-represented groups, ensuring data gaps are filled in a new Electronic Patient Record system and facilitate continuous and inclusive data collection.	• Develop an action plan to engage effectively with other under-represented groups (including work with voluntary and community sector organisations). • Identify champions for each under-represented group to lead an improvement project. • Identify one priority group to start co-production process to develop services which better meet their needs drawing on the learning from Common Ambition Bristol.	• Support quarterly Transition meetings within specialities with the young person's voice central to all the decision making. • Full transparency of needs for the young person and the clinical teams of where the young person is on the Transition pathway. What is working well and what needs improving. • All best practice identified and embedded and continuous learning takes place. Sharing good practice locally and nationally.
2. We will develop and implement an inclusive and clear process for the supportive transition of young patients to Adult Services that places the patient at the centre of the planning and decision-making process.	• Review and improve our rolling patient feedback survey to better understand experience of care. • Implement new inclusive ways of collecting feedback from service users from marginalised communities. • Re-establish a focus on service user engagement with support of UHBW Experience of Care and Inclusion team.	• Survey community partners to obtain feedback about services and suggestions for improvement. Agree methods for engaging them in an iterative feedback process. • Ensure service and community partner feedback is used to drive service development programmes •Ensure all new pathways are reviewed and critiqued by service users before and during implementation.	• Develop a real-time feedback response by service system. For example, instant online web-based chat.

Strategy Goal 5D

Sexual and Reproductive Health

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will ensure that access to innovative and novel pathways is equitable.	• Ensure all access options and triage pathways are reviewed by the UHBW Learning Disability and Autism team. • Ensure there are walk-in face to face alternatives to any innovative digital access options. • Implement existing learning from community organisations or from people who struggle to access services.	• Ensure service users and/or their advocates, particularly from under-represented groups, are involved in the design, development, and delivery of new pathways from the outset. • Work with Health Promotion team to disseminate all service access options to primary care and secondary care partners. • Liaise with other Trust departments who are doing similar work to share learning.	• Develop new volunteer roles to facilitate access to clinics making all service users feel welcome. • Develop videos to illustrate patient journeys for different groups who experience health inequity.
4. We will raise the profile of HIV and STI (sexually transmitted infections) testing across other Trust specialities.	• Work with the Emergency Departments across the Trust on implementation of opt-out HIV testing. • Implement training for all grades of junior doctors highlighting the importance of increasing testing. • Promote the 'Hearts and Minds' HIV awareness training programme more widely for staff at UHBW and North Bristol NHS Trust (NBT).	• Offer training sessions for other specialities on presentations of Sexually Transmitted Infections (STI) and HIV in their departments . • Develop rapid access pathways for other specialities to refer into sexual health services. • Develop rapid access advice access for other specialities.	• Implement National Institute of Clinical Excellence HIV testing guidance in full.

Strategy Goal 5E

Cancer

Aim: Develop equitable access to inclusive cancer services at UHBW.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will ensure all UHBW patients living with cancer have access to a cancer clinical nurse specialist (CNS) and a cancer support worker (CSW).	• Review all cancer teams and identify any gaps in provision and access to CNSs and CSWs. • Develop a process to raise patient awareness of the information and support resources available to them (including being able to access CNSs and CSWs).	• Progress local area plans to secure sustainable funding and recruit into the remaining gaps in CNS / CSW provision. • Check that the revised 'awareness raising' process is working and patients have greater awareness of information and support resources available to them.	• Repeat review of all cancer teams and identify any new or unresolved gaps in provision and access to CNSs and CSWs. • Analyse patient feedback to evidence any improvements made in access and experience.
2. We will ensure equitable access to cancer services, for people with pre-existing neuro-diverse conditions and sensory impairment.	• Engage with local neuro-diverse and sensory impaired communities to better understand their experience of cancer care and support at UHBW and what could be done to make their experiences better in the future. • Gather staff feedback of their awareness and experience of offering 'reasonable adjustments' to cancer patients with neuro-diverse conditions.	• Together, patients and staff will co-design a toolkit of 'reasonable adjustments' that can be offered to support cancer patients with neuro-diverse conditions. • Focus on staff awareness raising and training on using the 'reasonable adjustments' toolkit in cancer services and link to the mandatory Accessible Information Standard training programme.	• Collect feedback from patients and staff using the toolkit, to see if the toolkit is useful and if any further developments are needed. • Year 3 milestone to be developed following evaluation of feedback from patients and staff.

Strategy Goal 5E

Cancer

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will engage with community partners to ensure people living with cancer are able to access support in the community.	• Engage with community partners including those in the Integrated Care System, GP and practice nurse forum and Voluntary and Community Sector (VCSE) Alliance. • Gather additional patient feedback to identify priorities, for example via local surveys relating to the cancer Clinical Nurse Specialist and Allied Health Professional teams. • Improve joint working between hospital cancer staff and GP and Health Centre staff in the community.	• Review annual National Cancer Patient Experience (NCPES) survey results to identify improvements and prioritise actions to take forward. • Explore the feasibility and funding options for Bristol, North Somerset and South Gloucestershire Cancer Community Navigator roles. • Develop an approach to raise patient awareness on how to access available support in the community.	• Review annual NCPES results to identify improvements and prioritise actions to take forward. • Explore opportunities for local cancer information outreach in community hubs and other local venues. • Year 3 milestone to be developed following evaluation of feedback from patients and staff.

Strategy Goal 5F

Carers

Aim: Create an environment where carers are identified proactively, as soon as possible in the patient journey to optimise opportunities for improved support, embedding a culture or carers being visible and valued partners in care and creating innovative ways for carers to be involved in service planning and development.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will improve communication with carers of all ages, colleagues and the Carers Liaison Team to create an increasingly carer-friendly environment.	• Increase staff awareness of the support available from the Carer Liaison Team. • Improve the visibility and understanding of the role carers have in the hospital environment including scoping a Carer Passport scheme so that carers are recognised and receive support to be involved more in a patient's care. • Map how we currently identify carers, at what stage in the care pathway and how their information is stored and shared across specialities and hospitals. • Map the concessions carers may benefit from and work to align those with North Bristol Trust.	• Establish a dedicated resource area for carers and the Carers Liaison Team. • Review the information that carers receive and develop new information to help carers navigate our hospitals. • Launch the Carers Trust toolkit to improve the hospital discharge experience for patients and their carers. • Co-create a solution with carers and staff across UHBW and North Bristol Trust to improve how we identify carers and share information across specialities and healthcare providers.	• Use the Pulse survey to understand staff confidence, their development needs and to identify further improvement priorities. • Explore how technology can be better used to improve communication with carers around issues such as patient bed moves.
2. We will develop new training and support to ensure our staff are skilled in identifying and supporting carers of all ages to be partners in care.	• Undertake a training needs assessment and scope the current training offer to staff in UHBW with respect to carers. • Work with Bristol and Weston Hospital Charities to develop a video to raise awareness of the role carers have as partners in care.	• Deliver a shared training offer for staff working in UHBW and North Bristol Trust. • Develop the role of a 'Carers Champion' network so that frontline staff are empowered to be able to support and signpost carers to the correct and timely help that they need.	• Evaluate training provision and the impact of this training both on staff and carers. • Aligned with the Trusts Volunteer Strategy, review and make recommendations to develop the role of Volunteers in supporting carers in the hospital environment.

Strategy Goal 5F

Carers

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will improve the ways in which we understand and act on the experience of carers of all ages including improving the carers voice in service improvement.	• Embed the carers' voice in our Carers Steering Group by recruiting and supporting Experts by Experience. • Design and implement a new way of collecting feedback to capture the experience of carers in the Trust and use this to prioritise areas for improvements in years two and three of strategy delivery. • Explore setting up a "Young Carer Voice" group together with the Bristol Royal Hospital for Children's family support service (LIAISE) and the hospitals Youth Involvement Network.	• Scope and establish a single Carers Steering Group across UHBW and North Bristol Trust including community partner representation. • Develop a shared carer experience feedback process with North Bristol Trust. • Create an annual carers workshop, co-delivered with carers, to understand the needs of carers and use that information for continuous improvement.	• Publish an impact report on the influence of the carers' voice in the Trust including a "perception survey" to understand how our community partners view the carers support at UHBW.

Strategy Goal 5G

Learning Disability and Autism

Aim: Provide an environment that enables engagement and inclusivity within our learning disabled and autistic population, providing reasonable adjustments to improve access to UHBW services.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will offer reasonable adjustments to our learning disabled (LD) or autistic population.	• Accessible Information Standard Steering Group and Outpatient Services to review current outpatient letters and agree a way forward to introduce easy read letters. • Work with Voluntary Services to determine the training needs and feasibility of providing volunteers to support autistic people or those with a learning disability in clinical areas. • Develop an online training module for staff explaining how to deploy reasonable adjustments. • Work with Legal Services to develop training materials for Mental Capacity Act, Best Interests and Power of Attorney. • Work with Mental Health services to identify where they can support clinical areas with reasonable adjustments for autistic patients or those with a learning disability.	• Develop and pilot easy read Outpatient appointment letters with target group. • Develop a training programme for volunteers supporting patients with a LD and autistic people. • Identify key clinical staff and add training module to online training platform and launch to staff. • Identify key clinical staff and add training module to online training platform and launch to staff. • Ensure staff and patients have access to Mental Health Support Workers in ward areas where needed.	• Roll out easy read letters approach to ensure patients receive information in an accessible way, in either electronic or printed formats according to their needs. • Introduce volunteers who have a special interest in supporting autistic people or those with a learning disability with reasonable adjustments. • Audit reasonable adjustments and staff undertaking training module. • Audit to ensure staff have completed training to equip with Mental Capacity Act knowledge and skills and can demonstrate safe care.

Strategy Goal 5G

Learning Disability and Autism

Aim: Provide an environment that enables engagement and inclusivity within our learning disabled and autistic population, providing reasonable adjustments to improve access to UHBW services.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will ensure our environment meets the needs of people with a learning disability, autistic people, those with a physical disability and those with complex needs.	• Planning in new or existing buildings will include Changing Places as detailed in the Equality Act (2010). • Conduct scoping of outpatient areas to determine where bleepers or a similar system could be utilised. • Develop a signage improvement programme based on recommendations taken from the autism audits led by experts with lived experience.	• A review of current Changing Places and gaps will be undertaken by our Estates Department and areas identified for inclusion of Changing Places. • Implement communication systems in pilot areas which will include feedback from the people we support. • Continue programme of signage improvement.	• Changing Places will increasingly be provided in areas across our hospitals based on priorities sites identified. • Rollout communication system to other areas. • Repeat of autism audit to determine progress and identify any outstanding areas.
3. We will offer an inclusive approach to recruitment.	• Engage with local service users and self-advocacy partners to determine the feasibility of embedding experts with lived experience in the UHBW recruitment process.	• Identify roles which would be most positively impacted by the inclusive approach. • Autistic people or those with a learning disability will be recruited to support the interview process.	• Interview panels for key staff roles will routinely have access to autistic people or those with a learning disability to enhance the interview experience.

Strategy Goal 5H

Mental Health

Aim: People from our local, regional or national patient groups attending UHBW and who may need support with their Mental Health care needs, will receive high quality psychological or psychiatric care, in line with National Guidance.
As unique as the individuals in our communities, care will be person or family centred, strength's based and provided in Mental Health safer spaces and environments. Care provision will be seamless as patients' transition from child-to-adolescent-to-adult services.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will provide training and development of staff skills to support better Mental Health care.	• Deliver specialist Mental Health training for Staff working with patients with Mental Health care needs of all ages. • Ensure that principles of 'Trauma Informed' care is included in relevant training. • Ensure that 'Mental Health Champions' are in every area; ensuring they contribute and learn from shared education events.	• Evaluate ongoing staff Mental Health training needs and to deliver specific condition related training for key areas. • Link with Integrated Care Board (ICB), National Health Service England (NHSE) and local education institutions to offer accredited courses for eligible staff working in Mental Health areas. • Work with the Mental Health Champions to foster a culture of empathy and understanding with Staff through regular training and education events.	• Promote a culture of continuous learning and shared professional development within the Trust and with system partners, offering ongoing training opportunities, seminars and education days, research conferences, and online resources on Mental Health care topics. • Review and evaluate Mental Health training needs in-line with the Integrated Care Board and system partners education and training provision.
2. We will develop a workforce that provides the right care in the right way and at the right time to patients of any age.	• Engage with local service users and self-advocacy partners to determine the feasibility of embedding experts with lived experience in the UHBW recruitment process.	• Agree and establish a model for Mental Health care delivery for all-ages across UHBW sites. • Develop Band 4 Senior Mental Health Support Worker posts to improve the quality of care available to patients and to identify a career pathway for Mental Health Support workers. • Link with Integrated Care Board (ICB) and system partners to establish a Mental Health nurse apprenticeship pathway.	• Embed an all-care model for Mental Health care across all UHBW sites. • Link with North Bristol Trust (NBT) and Integrated Care Board (ICB) to ensure alignment of model of Mental Health care in Acute Hospitals. • Promote a positive culture of parity of esteem for patients with Mental Health care needs within the ethos of delivering the 'right care, in the right way and at the right time'.

Strategy Goal 5H

Mental Health

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will ensure that our care environments can support the delivery of safer Mental Health care for patients of any age.	• Review and audit all care environments from a Mental Health perspective including inpatient, outpatient and assessment areas. • Promote a Mental Health 'safer' ethos for staff via education and training including Ligature Awareness and Suicide Prevention. • Identify unsafe areas that should not be used for Mental Health care. • Scope the role of a Trust wide Mental Health Harm Reduction Steering Group to oversee the review and improvements to care environments.	• Work with clinical leads and Estates to identify which care environments can be adapted to ensure safer Mental Health care. • Identify how assessment areas can be adapted to ensure safer Mental Health care. • Ensure a process for an annual environmental Mental Health risk assessment is embedded.	• Ensure that projects to adapt and improve care environments areas are prioritised in Divisional financial planning. • Ensure that new wards and services are designed with a focus on a 'Mental Health Safer' ethos. • Link with North Bristol Trust (NBT) and Integrated Care Board (ICB) to ensure alignment of environmental harm reduction strategies including preparing an annual report of activity.

Strategy Goal 5J

People living with a Dementia

Aim: Provide high quality, person centred, equitable and holistic care for all persons living with dementia.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will improve communication with our patients, carers and colleagues to enhance dementia care.	• Ensure involvement of people with dementia, family and carers in personalised care planning and completion of the “All About Me” document. • Encourage and improve interdisciplinary collaboration and communication among professionals and care teams involved in the care of people with dementia. • Collect patient and carer feedback on their experience (specific to people with a dementia) and use feedback to make continuous improvements.	• Set-up a system wide working group to look into working towards shared documentation and core information standards for patients with dementia. • Increase staff awareness of support available in the community to allow for improved signposting for patients and carers to the correct services to meet their needs. • Offer advanced communication workshops to carers, volunteers and staff focusing on difficult conversations, grief support, and maintaining connections as dementia progresses.	• Create an ability to share appropriate care plans with colleagues across the Bristol, North Somerset and South Gloucestershire (BNSSG) system. • Establish a peer support network for staff across Bristol, North Somerset and South Gloucestershire (BNSSG) who support people with dementia, providing opportunities for sharing experiences, top tips, and emotional support. • Expand the number of volunteers to include caregivers of people with dementia for peer mentoring programmes, where experienced caregivers provide guidance and support to other volunteers and staff who are new to working with people with dementia.

Strategy Goal 5J

People living with a Dementia

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
2. We will provide training and development of staff skills to support better dementia care.	• Provide training and education to staff working with people with dementia on reducing distress, agitation, and behaviours that challenge. • Provide training and development opportunities (including volunteers) to support and enhance the experience of care for persons with dementia. • Improve the dementia care training offer to staff providing Enhanced Care Observation.	• Organise skills development workshops focusing on practical caregiving skills, including activities of daily living assistance, safe transfer techniques and reducing deconditioning tailored to persons with dementia. • Ensure all eligible staff complete Dementia tier 2 training. • Implement a comprehensive 'effective communication strategies' training programme for staff working with persons with dementia.	• Explore partnerships with local universities and other institutions to offer accredited courses or degrees in dementia care for healthcare professionals seeking specialised training. • Foster a culture of empathy and understanding among healthcare staff and volunteers through regular communication training sessions and role-playing exercises. • Promote a culture of continuous learning and shared professional development within the Trust and with system partners, offering ongoing training opportunities, seminars and education days, research conferences, and online resources on dementia care topics.
3. We will provide care in an increasingly dementia-friendly environment.	• Roll-out and increase the use of dementia friendly café and outdoor sensory gardening ctivities across Bristol and Weston sites. • Work with Bristol and Weston Hospitals Charity and volunteers to provide activity boxes on care of the elderly wards. • Complete audits in inpatient and outpatient areas to identify areas for improvement in creating dementia friendly environments.	• Ensure there are 'Dementia Champions' in every area and ensure they contribute and learn from one another in annual education days. • Make activity boxes available on all wards that potentially admit persons with dementia. • Work with Estates and Facilities and charity partners and volunteers to make dementia-friendly modifications to enhance the environment such as clear signage, non-glare lighting, calming colours.	• Explore innovative technologies and design solutions to further enhance the dementia-friendly features of care environments, such as activities, virtual reality simulations, and assistive devices for navigation and communication. • Identify ways to reduce bed moves for people with dementia to avoid disorientation and constant adjustments to a new environment. •Create spaces for safe walking areas for people with dementia to reduce deconditioning and encourage activities.

Strategy Goal 5i

Older People including those living with frailty

Aim: An improved experience for our older population and those living with frailty through age-friendly and age-appropriate provision.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will screen all patients over 65 for frailty on admission to our hospitals ensuring that all patients aged over 65 with a clinically frail score 6 or more will receive a prompt comprehensive geri-atric assessment by a specialist team.	• Assess all patients over 65 for frailty on admission using the clinical frailty score. • Review our 'front-door' frailty service and establish the workforce and investment required to deliver this service into the emergency department 70 hours a week to reach the national standard. • Develop a Same Day Emergency Care service for frail older patients who present acutely to urgent and emergency care. • Develop pathways for direct admission to the Older Persons Assessment Unit (OPAU) treating and caring for the complex and holistic needs of patients.	• Develop a method of electronically capturing the frailty score on the Electronic Patient Record. • Develop surgical liaison services to ensure frail older patients who need an operation have access to a specialist Frailty Advanced Practitioner.	• Work with our partner organisations to develop shared documentation and core information standards for older patients living with frailty.
2. We will develop a workforce that understands the needs of frail older people.	• Work with our Practice Education Facilitators to agree a set of core competencies for staff working on our care of the elderly wards, deliver training and development sessions in line with these and monitor uptake. • Provide training and development opportunities (including to volunteers) to support and enhance the experience of care for older people living with frailty.	• Embed this training across our ward areas. • Develop links with clinical teams who are working with frail older patients in the community so that we can better align clinical pathways including strengthening our work with community part-ners to support patients to stay at home, where possible, by providing specialist advice and support as part of NHS@Home.	• Ensure all eligible staff complete training in frailty. • Promote a culture of continuous learning and shared professional development within the Trust and with system partners, offering ongoing training opportunities, seminars, and education days.

Strategy Goal 5i

Older People including those living with frailty

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will ensure our ward environments support the needs of frail older people.	• Work with Estates and Facilities to audit all care of the elderly wards with respect to clear signage and non-glare lighting and develop a two-year improvement plan. • Work with teams for the eye hospital and audiology department to review our existing equipment and identify areas for improvement. • Work with 'experts by experience' and community partners to understand how we can better support those with sensory impairment whilst in hospital, prioritising areas for improvement.	• Increase the availability of meaningful activities for patients on care of the elderly wards to reduce boredom whilst in hospital by working with the Voluntary Services and Arts and Culture teams. • Work with the eye hospital and the audiology department to offer support to patients who have hearing loss and/or a visual impairment so that their needs are met to enable them to participate fully in their care. • Begin to deliver an improvement plan based on the priorities for improvement agreed in 2024/25.	• Improve access to communal spaces where patients can socialise and eat meals together.

Strategy Goal 5K

End of Life Care

Aim: All patients will receive high quality, compassionate end of life care that is individualised to their specific needs (and the needs of those closest to them) and is provided by the right staff with the right skills at the right time.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will ensure that end of life care is valued and underpinned by strong leadership.	• Review the membership of the End of Life Steering Group to ensure that all teams throughout the hospital can have their feedback heard and acted upon. Use communications channels to continue to promote and champion the importance of high-quality end of life care. • Develop an accessible and sensitive method of seeking feedback from the bereaved and use this to guide improvement to care.	• Identify a non-executive lead who will promote end of life care at Board level as per guidance from national regulatory bodies (e.g Care Quality Commission). • Implement a new method for seeking feedback from families and bereaved relatives across the Trust and begin to prioritise areas for improvement.	• Co-design an end of life care strategy to provide clear direction for end of life care in the Trust and ensure improvements are maintained. • Deliver on improvements based on feedback and monitor whether these have improved experience of end of life care.
2. We will ensure we have a workforce that is confident and able to provide individualised end of life care.	• Develop and recruit to adult end of life educator roles who will work with staff across the Trust to upskill them in best end of life care practices. • Roll out end of life care e-learning training (initially for registered staff) to ensure staff are up to date with training needs specific for their role. • Recognise the need for staff to have emotional and psychological support in order to provide the best care for patients and those closest to them at end of life by evaluating and improving the current resource available to staff in adults and children's services.	• Continue to develop the educator role to provide training, with a focus on groups where this will have high impact such as newly qualified staff and international graduates. • Develop e-learning training packages for other staff groups, such as healthcare support workers. • Highlight current provision of support and resources for staff and make plans to develop support in areas where there are gaps.	• Utilise feedback from patients and those closest to them to ensure their experience is a key driver of education provided at all times. • Review staff uptake of training and based on feedback, continuously keep training materials up to date. • Raise awareness with teams to ensure all staff have knowledge on how to access appropriate wellbeing support.

Strategy Goal 5K

End of Life Care

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will ensure equitable access to specialist palliative care services 7 days a week.	• Ensure a focus on teamwork so that specialist palliative care services across Bristol and Weston Hospitals is equitable and accessible.	• Work towards ensuring staff cover to provide specialist palliative care services 5 days a week.	• Develop a plan to achieve 7-day face to face service for patients across all hospitals to improve end of life care across the week.
4. We will introduce a new volunteer role to provide compassionate support to people and those closest to them at end of life.	• Review national and local best practice and use this to develop volunteer role profile and see funding from charity partners to implement. Recruit to volunteer coordinator role.	• Recruit first cohort of volunteers, deliver training and operationalise volunteer role across wards, supported by End of Life Care Leads.	• Evaluate the impact of the volunteer role for patients, those closest to them and staff and seek funding for sustainable delivery model.

Strategy Goal 5L

Waiting Well

Aim: Patients will experience seamless care between their GP and the hospital, with excellent communication, reduced waiting and feel more empowered in their care.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will provide our patients acknowledgment that their referral has been received and is being appropriately managed. The aim of this is to provide reassurance that they, their families, and carers are in safe hands and that they have not been overlooked.	• Improve what patients can see regarding their appointments on the NHS App. • Implementation of digital solution to provide patients with confirmation that their referral has been received. • Full roll out of digital letters to ensure timely communication with patients about appointments, addressing any language needs and accessible requirements.	• Stop using administrative systems that mean that patients can see appointments in the NHS App that are not real ones, which may cause unnecessary confusion or anxiety. • Confirm with patients, via a digital system, where they are on a waiting list, and that their preferences have been acknowledged. • Extend the use of the system that allows patients to initiate follow-up whilst making sure patients understand where they are in the system and know how to seek help (if required).	• Patients can see accurate information about all their hospital appointments on the NHS app. • Ensure that when we collect information from patients via our digital systems, we only ask patients to give answers to questions once, when they have multiple appointments.
2. We will improve communication with our patients to ensure that they have a positive experience of interacting with our services.	• Implementation of digital solution to allow patients to have two-way messaging admin teams or clinicians. • Review the use of appointment reminders for outpatients and admissions to ensure that they are being used where appropriate. • Implementation of digital solution to allow patients to request the rescheduling of their appointment.	• Consider the benefit of centralising and standardising our approach to outpatient administration through the 'Outpatients 2025' programme. • Consider improvements to our call handling function and the introduction of a modern, comprehensive call handling system across all services. • Introduction of digital solution to allow patients to directly rebook appointments.	• Implementation of digital solution to make it easier for patients to initiate follow-up, and to access care and advice.

Strategy Goal 5L

Waiting Well

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will point patients in the right direction so that they can find information about how to best manage their care.	• Continue to improve and develop the content on our Waiting Well webpages, including the introduction of specific Children and Young People's content. • Revise the content on the national NHS website called 'My Planned Care' to provide a comprehensive list of specialties and redirect patients to the Trust's Waiting. • Ensure that, where appropriate, patients can access physical and mental wellbeing services before their treatment to improve their physical and mental health before their planned procedure and supporting them to return to health after their procedure. This is called Prehabilitation or Prehab Well webpages.	• Consider using the NHS App to offer patients waiting for common procedures or treatments with specific information about preparing for their procedure. • Work with our community partners to identify how we can deliver prehabilitation services closer to the homes of our patients so that they do not need to come to hospital to access these services.	• Waiting W ell support information and contact details integrated into digital communication. • Deliver prehabilitation services jointly with our community partners so patients are able to choose the location of the services they access.

Strategy Goal 5M

Transfer of Care (Hospital flow and discharge)

Aim: Enable people to access hospital services when they need it by making sure more patients can go home from hospital without delay. We will work together with our health, social care and Voluntary, Community and Social Enterprise (VCSE) partners to support patients to continue their recovery out of hospital, improving wellbeing in our communities.

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
1. We will ensure more patients are able to return home from hospital to live independently for longer with wrap around support from Health and Social Care.	• Ensure that as a multidisciplinary team, we are assigning or allocating a patient to the correct discharge pathway getting it right first time. • Explore opportunities with the Voluntary, Community and Social Enterprise (VCSE) sector to support patients to live independently for longer at home and reduces the risk of readmission. • Expand the trial of technology - enabled care in Bristol to support patients to return home with reduced care needs or no care needs while reducing risks. Explore opportunities with North Somerset Council and Weston General Hospital to extend.	• Undertake system demand and capacity modelling to support commissioning decisions on patient population needs. • Contributing to the 'Active Hospital Programme' to reduce patients losing muscle strength through lack of exercise whilst in hospital. • Strengthening relationships with care homes and other support providers to smooth the transition from hospital.	• Establish an integrated care record for patients with complex needs between health and social care. • Operate within the commissioned bed base for those requiring community-based rehab beds or a residential care or nursing care placement, as an increasing proportion of people can return home. • Establish a single referral process for technology enabled care across all three Local Authorities areas in Bristol, North Somerset and South Gloucestershire.
2. We will ensure all patients are able to access acute services when needed by ensuring those patients who no longer require an acute bed are discharged in a timely manner.	• Embed a team structure which specialises on Acute, Complex and Delayed wards to provide expertise and consistency to patients and their discharge plans. • Ensure there is a robust case management and escalation process to reduce patients waiting in hospital. • Reduce longest and complex waiting patients via a senior executive escalation process with partners.	• Develop a communication plan to keep care homes updated on resident's progress while in hospital to avoid delay on discharge. • Embed a platform and process for lessons learned approach with case studies and system action plans relating to discharge of patients. • Strengthen and establish robust links with NHS@Home and Sirona Community partners to facilitate more timely discharge.	• Create a system approach to discharge which is flexible and responsive to the increasing acuity and complexity of need of the local population. • Using artificial intelligence and predictive analytics to establish more accurate estimate dates of discharges to provide a greater patient experience and the proactive management of hospital flow.

Strategy Goal 5M

Transfer of Care (Hospital flow and discharge)

Objectives	Milestones for 2024/2025	Milestones for 2025/2026	Milestones for 2026/2027
3. We will ensure all patients and families are well-informed about the discharge pathways and clear communication is provided regarding the pathway they will be discharged on.	• Fully embed the role of 'Discharge and flow' coordinators on allocated wards. • Develop, embed and monitor a patient and families discharge communication plan which will follow the patient through their journey in hospital, providing consistent communication regarding next steps in leaving hospital. • Embed Educator role, linking with the existing Therapy service training and extending education to ward teams such as junior doctors, nursing staff etc.	• Focus resources to improve discharge related questions on the UHBW monthly inpatient Survey by 10% based on 2022 scores. • Embed the use of technology to increase accessibility and facilitate earlier conversations with patients and families about discharge plans, reducing delays due to availability or travel. • Develop a discharged-focussed centralised resource for all staff to learn and develop their discharge knowledge and find out where to get support.	• Develop a page on the UHBW external website which provides information for patients and families around discharge.