

Welcome from the Chair and Chief Executive

Cardiff and Vale University Health Board (UHB) is one of the largest NHS organisations in the UK, providing healthcare services for 475,000 people living in Cardiff and the Vale of Glamorgan. Working with many professional groups, we promote healthy lifestyles whilst planning and providing healthcare in people's homes, community facilities and hospitals. In addition to considering the needs of the local population, the UHB also provides specialist care to the people of South Wales, Wales and for some services, the wider UK.

Caring for People; Keeping People Well is why we exist as a UHB, with a vision that **a person's chance of leading a healthy life is the same wherever they live and whoever they are.**

In beginning the journey to make this vision a reality, we have been working with staff, people who use our services and partner organisations to shape our strategic direction. At its heart our strategy has the desire to achieve joined up care based on home first, avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them.

In considering how to **Shape Our Future Wellbeing**, we have focused on the health and care needs of our local population, whilst recognising the need to work more collaboratively with our partners to provide sustainable services; including those which we provide to the wider Welsh population.

This document sets out how we intend to deliver our strategic objectives over the next ten years. It describes the challenges we face, the principles which will underpin the development of our services and the steps we intend to make to bring about the change required to achieve our vision. It recognises the need to take a balanced approach to achieving change for **our population, our service priorities, our sustainability and our culture.**

We are committed to working with our communities and partners to improve health outcomes for everyone, **delivering outcomes that matter to people**, and would like to thank all of you who have contributed. As the UHB takes the next steps to describing our future services, we are looking forward to working with you further.



Maria Battle, Chair



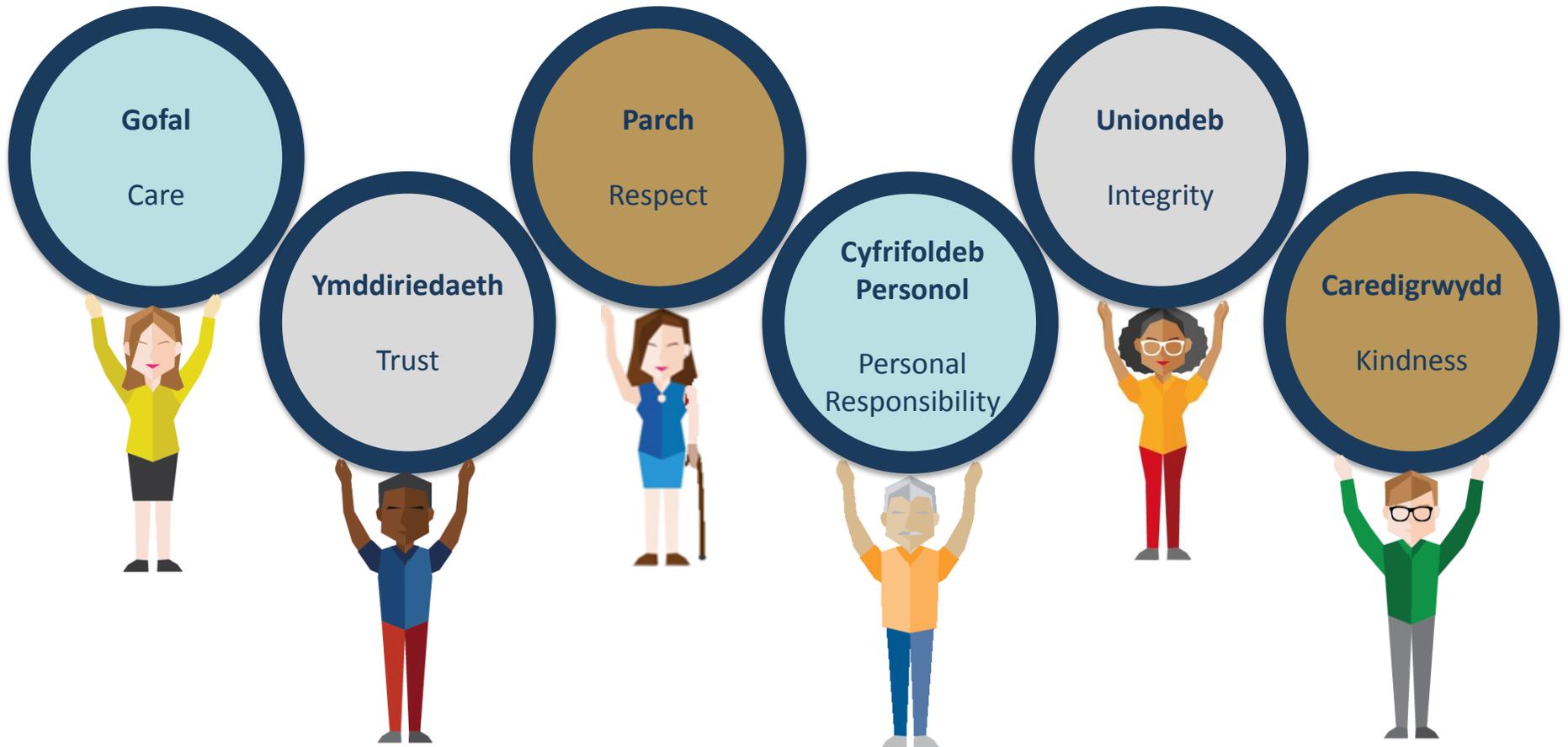
Professor Adam Cairns, Chief Executive

**CARING FOR PEOPLE
KEEPING PEOPLE WELL**



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board



Ein Gwerthoedd

Our Values

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Cardiff and Vale University Health Board

Responsibilities

To ensure we are **CARING FOR PEOPLE, KEEPING PEOPLE WELL**, the UHB must:

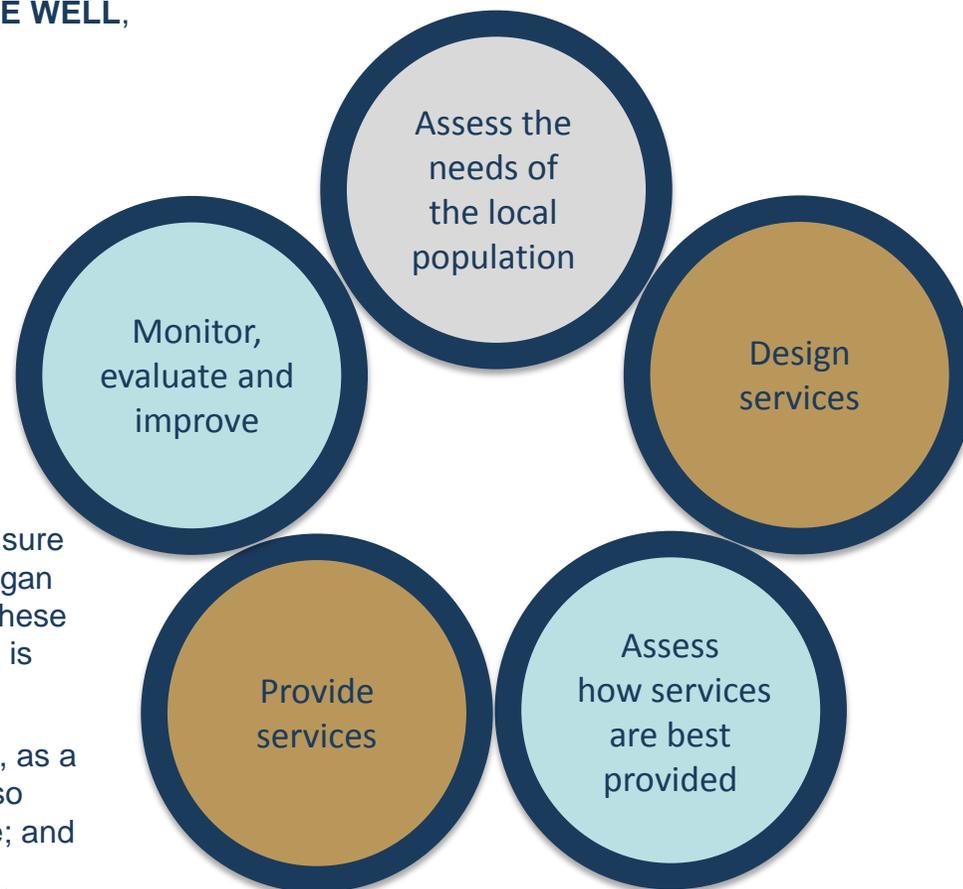
Assess the needs of the local population – the healthcare and wellbeing needs of Cardiff and the Vale of Glamorgan residents change over time and need to be considered jointly with public service partners;

Design services – services need to be developed with those who use our services and those who provide services, including: voluntary sector partners, public service partners and regional healthcare providers, with the aim of improving health, economic, social, environmental and cultural wellbeing;

Assess how services are best provided – the UHB must ensure that all the healthcare needs of Cardiff and the Vale of Glamorgan residents are met. However, it can not directly provide all of these services, therefore the UHB has to decide where each service is provided and by whom;

Provide services – having assessed which services the UHB, as a provider of local and regional services, will deliver, it must do so safely and effectively wherever they live and whoever they are; and

Monitor, evaluate and improve – having designed services to meet the needs of the local and regional population, the UHB must monitor and evaluate whether or not need is being met. This then informs a continuous improvement cycle.



What We Want to Achieve

Our mission: Caring for People, Keeping People Well

Our vision: A person's chance of leading a healthy life is the same wherever they live and whoever they are.

Our strategy is:

Achieve joined up care based on 'home first', avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them.

Empower the Person

- Support people in choosing healthy behaviours
- Encourage self-management of conditions

Home First

- Enable people to maintain or recover their health in or as close to home as possible

Outcomes that matter to People

- Create value by achieving the outcomes and experience that matter to people at an appropriate cost

Avoid harm, waste and variation

- Adopt evidence based practice, standardising as appropriate
- Fully use the limited resources available, living within the total
- Minimise avoidable harm
- Achieve outcomes through minimum appropriate intervention

Our strategic objectives are:

For Our Population - we will:

- reduce health inequalities;
- deliver outcomes that matter to people; and
- all take responsibility for improving our health and wellbeing.

Our Service Priorities - we will:

- offer services that deliver the population health our citizens are entitled to expect.

Sustainability - we will:

- have an unplanned (emergency) care system that provides the right care, in the right place, first time;
- have a planned care system where demand and capacity are in balance; and
- reduce harm, waste and variation sustainably making best use of the resources available to us.

Culture - we will:

- be a great place to work and learn;
- work better together with partners to deliver care and support across care sectors, making best use of our people and technology; and
- excel at teaching, research, innovation and improvement and provide an environment where innovation thrives.

Who We Are

Cardiff and Vale University Health Board (UHB) was established in October 2009 and is one of the largest NHS organisations in the UK. As a UHB, we have a responsibility for around 475,000 people living in Cardiff and the Vale of Glamorgan (from Trowbridge/St Mellons in the East to Llantwit Major/St Bride's Major in the West). This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres, community health teams and mental health services. Together with some services from other Health Boards and key partners, these provide a full range of health services for our local residents and those from further afield in both Wales and England who use our specialist services. To deliver these highly diverse and complex services, we spend over £1.2 billion every year and employ around 14,000 staff.

We are also a teaching Health Board with close links to Cardiff University, which boasts a high profile teaching, research and development role within the UK and abroad. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Together, we are training the next generation of clinical professionals in order that we develop our expertise and improve our clinical outcomes.

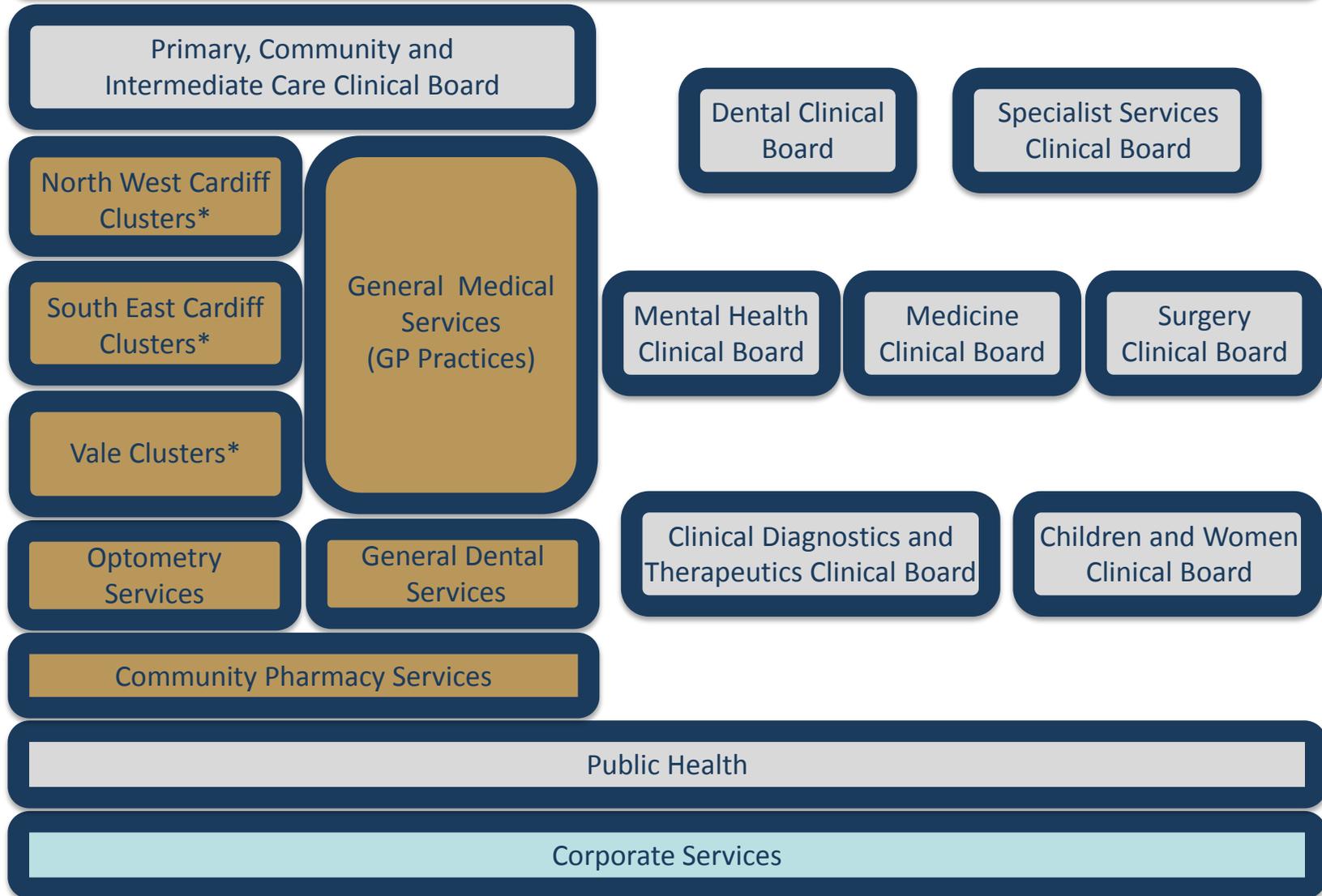
When many people think of the NHS they think of doctors and nurses, but it is important to remember the many varied roles that make all the care we provide possible. Allied healthcare professionals and health scientists comprise more than 40 different professions including dietitians, physiotherapists, radiographers, audiologists and laboratory scientists. Healthcare support workers play a key role in supporting staff to deliver direct clinical care and those providing non-clinical support include our portering staff, cleaning and catering staff, electricians and engineers, and many others.

Structure and Governance:

Led by the Chair and Chief Executive, the UHB Board is made up of Executive Directors, who are employees of the UHB, and Independent Board Members (IMs), who are appointed by the Minister for Health and Social Services via an open and competitive public appointments process. Health services are commissioned and provided within the UHB by eight Clinical Boards and a department of Public Health. Each Clinical Board is led by a Clinical Board Director, Head of Operations and Delivery, Clinical Board Nurse, Head of Finance and Head of Workforce and Organisational Development. Corporate services are aligned to Clinical Boards, providing professional expertise and support.

The UHB also works collaboratively to plan and deliver services with a number of NHS and partner organisations, including Welsh Health Specialised Services Committee (WHSSC), the South Central Acute Care Alliance (part of the South Wales Programme governance arrangements) and the Integrated Health and Social Care (IHSC) Partnership with Cardiff and the Vale Local Authorities.

Cardiff and Vale University Health Board



* Primary Care Clusters are collaborative groupings of GP Practices, General Dental Practices, Optometry Services and Community Pharmacies, supporting the UHB in planning and delivering services for local communities

On An Average Day....

we assess 39
people within
mental health
services

we carry
out 13,715
blood tests

community
staff have
contact with
1,843 patients

we provide
2,667 hospital
patient contacts

we support
the birth of
17 babies

we take 819
x-rays

we assess 350
people within
GP out of hours
services

we provide
350 dentist
appointments

we dispense
26,838
prescription
items*

we assess
378 people
within A&E

9,320 secondary
school pupils
walk or cycle to
school in Cardiff

Key facts and figures correct as an average for 2014

*Stats Wales: Prescription items and costs March 2013 – 2014

Strategy on a Page

Ein Cenhadaeth yw: (Dyma pam ein bod yn bodoli)

GOFALU AM BOBL CADW POBL YN IACH

Ein Gweledigaeth yw: (Dyma beth yr ydym eisiau ei wneud)

Bod siawns person o fyw bywyd iach yr un fath lle bynnag y mae'n byw a phwy bynnag ydyw

Ein Strategaeth yw: (Dyma fwrriadwn ei wneud)

Darparu gofal cydgyssylltiedig yn seiliedig ar 'gartref yn gyntaf', osgoi niwed, gwastraff ac amrywiad, grymuso pobl a rhoi canlyniadau sy'n bwysig iddynt

Ar Gyfer Ein Poblogaeth (Dyma beth yr ydym yn cynnig ei wneud)

Rhoi Canlyniadau sy'n Bwysig i Bobl

Rydw i eisiau deall fy newisiadau o ran gofal | Rydw i eisiau cael fy ngwella a lleddfu fy mhoen | Rhoi gobaith i mi | Rydw i eisiau bod yn iach | Rydw i eisiau i'm teulu a minnau gael cefnogaeth | Bod yno i mi ar ddiwedd fy oes

Ein Blaenoriaethau Gwasanaeth (Ar y rhain byddwn yn canolbwyntio fwyaf)

Cynnig gwasanaethau sy'n rhoi'r gwelliannau yn iechyd y boblogaeth y mae gan ein dinasyddion hawl iddynt ac y gallent eu disgwyl

Cancer | Strôc | Cyflyrau Hirdymor (Diabetes) | Dementia | Iechyd Meddwl | Iechyd y Geg a'r Llygad | Blynyddoedd Cynnar ac Iechyd Mamolaeth

Cynaliadwyedd (Dyma'r hyn yr ydym eisiau rhagori ynddo)

Cydgyssylltu'r hyn yr ydym yn ei wneud ar gyfer y bobl yr ydym yn eu gwasanaethu ac ymdrechu i sicrhau rhagoriaeth weithredol gan wneud y defnydd gorau o'r adnoddau sydd gennym

System newydd ar gyfer gofal heb ei gynllunio | Cydbwyso'r gallu a'r galw am ein holl wasanaethau | Osgoi niwed, gwastraff ac amrywiad

Diwylliant (Dyma'r profiad yr ydym am i bobl ei gael o weithio yma a gweithio gyda ni)

Gweithio'n well gyda'n gilydd ar draws sectorau gofal drwy bobl, arloesedd, gwelliant, ymchwil a thechnoleg | Bod yn lle gwych i weithio a dysgu

EIN GWERTHOEDD (Dyma beth sy'n bwysig i ni)

Gofal | Ymddiriedaeth | Parch | Cyfrifoldeb Personol | Uniondeb | Caredigrwydd

Our Mission is: (This is why we exist)

CARING FOR PEOPLE KEEPING PEOPLE WELL

Our Vision is: (This is what we want to do)

A person's chance of leading a healthy life is the same wherever they live and whoever they are

Our Strategy is: (This is our game plan)

Achieve joined up care based on 'home first', avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them

For Our Population (This is what we are offering to do)

Deliver Outcomes that Matter to People

I want to understand my care choices | I want to be healed and my pain eased | Give me hope | I want to be healthy | I want my family and me to be supported | Be there for me at the end of my life

Our Service Priorities (This is what we will focus on most)

Offer services that deliver the improvements in population health that our citizens are entitled to expect

Cancer | Stroke | Long Term Conditions (Diabetes) | Dementia | Mental Health | Oral and Eye Health | Early Years and Maternal Health

Sustainability (This is where we want to excel)

Join up what we do for the people we serve and strive for operational excellence making the best use of the resources we have

A new unplanned care system | Balance capacity and demand for all our services | Avoid harm, waste and variation

Culture (This is what we want working here and with us to be like)

Working better together across care sectors through people, innovation, improvement, research and technology | Being a great place to work and learn

OUR VALUES (These are what are important to us)

Care | Trust | Respect | Personal Responsibility | Integrity | Kindness

The Challenges

Health Boards in Wales are responsible for all of the health and wellbeing needs of their local population; however, no Health Board is able to directly provide all of the support and services required to meet these needs. As a consequence, a Health Board will provide most services directly and will work with key partners to ensure other services are available.

The challenges faced by the UHB drive the need to change what we do as both a commissioner and a provider of services to our local population and beyond. Our key challenges can be summarised as:

- how we best join up care to reduce inequalities in health which arise because of inequalities in society; particularly how we manage risk factors and conditions which will have the biggest impact on our local population now and in the future; and
- how we ensure that the services we provide now and those we expect to provide in the future are sustainable.

Commissioning for Our Growing Population

The population of Cardiff and the Vale of Glamorgan is growing and becoming more diverse. By 2025 we expect that an extra 50,000 people will need health and wellbeing services. This represents a 10% increase on today's figure. The shape of our population is also changing:

- the number of over 85s is increasing much faster than the rest of the population (32.4% increase by 2025); and
- unlike the rest of Wales, there is also predicted to be an increase in children under the age of 4.

This change in the population presents a unique set of challenges for the UHB, as these groups generally have a greater need for healthcare. Currently the NHS in Wales spends around £1,700 per person per year on health and wellbeing services with significantly more being spent in the first year of life and on people over the age of 65.

We also face many of the same challenges as other health services across the developed world, for example:

- there are inequalities in health and healthcare provision. In Cardiff and the Vale of there are differences between the most and least deprived areas, with up to 11 years difference in life expectancy and up to 22 years difference in healthy life expectancy;
- unhealthy behaviours are common. In Cardiff and the Vale around 1 in 5 adults smoke, nearly half drink above guidelines, over half are overweight or obese, two thirds do not have a healthy diet and three quarters do not get enough physical activity; and
- more people are living with a long term health condition. In Cardiff and the Vale nearly 1 in 10 adults are recorded as having asthma or chronic obstructive pulmonary disorder (COPD), and 1 in 25 with diabetes.



Responding to Government Policy and Keeping Pace with Regional Change

Over the course of 2014 – 2015, the Welsh Government brought into law two significant Acts, the **Wellbeing of Future Generations (Wales) Act** and **The Social Services and Wellbeing (Wales) Act**. This was alongside outlining important public service reform and, of particular relevance, the launch of **Prudent Healthcare** by the Welsh Minister for Health and Social Services.



At a more local level, key partners have announced the development of **Cardiff Capital Region – a confident, collaborative and connected region primed for economic growth**. Its aim is to enhance the potential economic development success and job creation opportunities of this region, building on the City of Cardiff's reputation as a top UK city for quality of life and workforce loyalty, alongside Cardiff University being rated as one of the UK's top 5 universities in terms of the quality and impact of its research.

For those, including the UHB, that provide public services to the population of Cardiff and the Vale of Glamorgan this means:

- thinking more about the longer term impact of change, working better with people and communities and each other, looking to prevent problems and take a more joined up approach;
- ensuring our actions contribute to a more healthy, resilient, prosperous, equal and globally responsible Wales, with cohesive local communities and a vibrant Welsh language;
- jointly assessing with key partner organisations the population needs for all ages, including those of carers, as well as assessing the range and level of services needed to meet those needs, with the aim of preventing, delaying or reducing people's need for care and support;
- membership of a Cardiff and Vale of Glamorgan Public Service Board, to drive forward collective action at a local level in support of UHB goals;
- greater support for community participation, in a way that properly reflects the diversity of communities, in some instances transferring the running of services over to community groups; and
- playing a greater part in growing the Cardiff Capital Region, demonstrating systems leadership to achieve large scale change.

Creating Sustainable Services and Managing Our Resources

The UHB aims to continually commission and provide services as efficiently and effectively as possible, saving £110m between 2012/13 and 2014/15 through improved ways of working. It has been predicted however, that the NHS in Wales could face a £2.5 billion funding gap within ten years, worth over 40% of its current budget¹. As the money available to deliver health services shrinks, the UHB must continue to become more efficient and effective and must also consider how it can provide services differently.

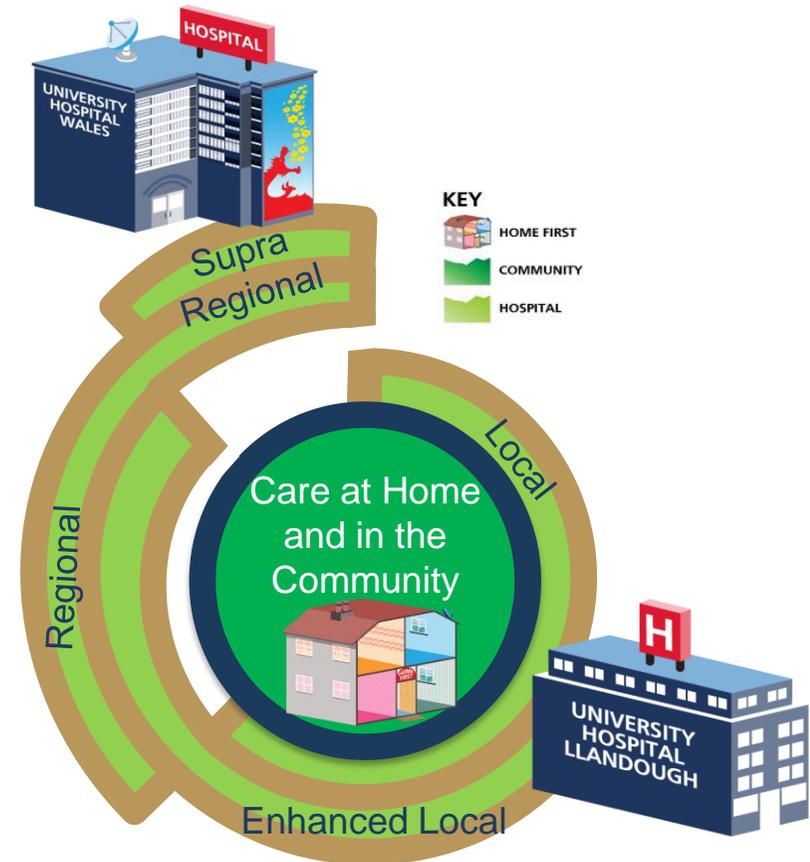
In addition to the financial challenges, recruitment to key clinical and training roles across the South Wales region is difficult. This includes staff who work in the community, for example GPs, as well as staff that work in the hospital environment, for example sonographers, who undertake and interpret ultrasound scans.

As the needs and demands of our local and regional population change, the way we currently provide our services is no longer sustainable. A squeeze on our resources only adds to this problem. To sustain safe and high quality services in the future we will need to reorganise and redevelop much of the routine care we provide. Services that have traditionally been provided in hospital may be more sustainable if provided in the community.

The South Wales Programme, agreed in 2012, aims to provide a new system where hospitals work together in South Wales and South Powys to provide some key services. Working collaboratively with our partners is essential to ensure that we collectively make the best use of our resources – people, facilities and technology.

As the UHB's responsibility for emergency and complex assessment from the wider region grows, we will need to plan and use our workforce differently across an integrated network of hospitals to deliver the outcomes that matter to our people.

An Integrated Network of Hospital and Community Care



Source 1: A Decade of austerity in Wales? Nuffield Trust June 2014



Keeping Pace with Technology and Changes in Clinical Practice

The UHB is committed to harnessing information and new technologies to achieve higher quality care and improve health outcomes for its population. Having accurate, comprehensive, secure and timely information available at the point of patient care is vital for the safe and effective functioning of services, as well as being fundamental for successful service improvement. As services become more mobile and treatments more complex maintaining high quality data is an increasing challenge.

Technology and advances in clinical knowledge also shape how we deliver care:

- information technology can enable us to become more efficient and effective, for example the use of digital health records;
- technology can entirely change how we deliver care, for example the widespread use of health apps on mobile phones and 'wearable devices' to act as pocket laboratories and enable wider use of point of care testing; and
- advancements in clinical knowledge can completely change clinical practice, for example personalised medicine based on an increasing understanding of genetics.

Supporting the right innovation is important to improve the quality of both the wellbeing and healthcare services provided to Cardiff and the Vale of Glamorgan residents; however, rapidly evolving technology and clinical knowledge can be challenging to adopt. In keeping pace with technology and changes in clinical practice the UHB must consider:

- how we improve interconnectivity of information systems across many sectors to enable integrated working;
- how to influence research and innovation through local and regional partnerships with leading national and international institutions; ensuring a focus on advancements which deliver outcomes that matter to people;
- how to ensure we have the skills to innovate and critically evaluate new practice and technologies, adopting and spreading the right ones to a community and workforce with the skills to use them; and
- how we support a regional or national approach for the adoption of expensive technologies based on multi-sector and multi-partner collaboration.

Working Together in 2015: Co-producing Change

Starting in March 2014, the Shaping Our Future Wellbeing programme has worked with more than 350 people from wide staff and clinical groups, local communities and voluntary sector, to jointly develop a strategy for the future. Starting with the principles on which to base change, through identifying key service priorities, and finally by developing shared visions of the future, the thoughts and opinions of people who use and provide our clinical services were listened to and used to shape our future service change.



Strategic principles developed



Visual minutes recorded

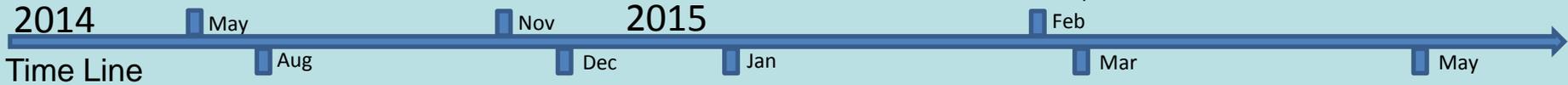


Workshop output refined with clinical experts

Vision for Cancer Care

Vision for Dementia Care

Vision for Dental and Eye Care



Key priorities identified

- Cancer
- Dementia
- Dental and Eye Care
- Long Term Conditions
- Maternal Health
- Mental Health

6 workshops completed



Service user and third sector feedback obtained



6 shared visions of the future created

Vision for Long Term Conditions

Vision for Maternal Health Services

Vision for Mental Health Services

Find out more about the Programme
www.bit.ly/SOFWHome

Working Together: Principles for Change

In building a strategy for the coming decade, the UHB has an agreed set of principles which provide the foundation for our vision that **a person's chance of leading a healthy life is the same wherever they live and whoever they are**. The principles ensure sustainable, cost effective, integrated services that are centred around the person. Shown below, these principles were developed in partnership through conversations between people who both use and provide services.



People at the Centre of Our Strategy

Whatever the clinical priorities of our strategy, the people using our services should be central to all that we do. Future change should be guided by their needs. When asked, people living in Cardiff and the Vale of Glamorgan were clear about what they wanted from their health service:

I want:

- to know how to minimise my risk of developing disease;
- to be supported to make any lifestyle changes that enable me to live a healthy life;
- to know about screening programmes which can help detect early disease and how to access them;
- rapid access to services which can diagnose my disease at an early stage;
- my condition explained clearly, in the detail that I want;
- to understand the available treatment options and be supported to choose one which is best for me, accounting for my personal, cultural and physical needs;
- treatment which gives me the best chance of cure;
- to be told about all services that may assist me;
- services that accommodate my needs as an individual, respecting the roles I play in my personal and family life;
- easy access to high quality advice. I want to be able to talk to people who know me and understand my disease and its treatment;
- to decide how and where my care is delivered at the end of my life; and
- to be treated with kindness, respect and always have my dignity maintained.

Empower the person



Throughout these pages the voice of the people who use our services is a golden thread. These voices have helped guide our strategy's development.

I need:

- to understand my condition and its treatments so that I can be involved in the planning of my care, play a role in monitoring my condition and recognise times where I need to access health care services;
- rapid access to knowledgeable healthcare professionals who can advise me what to do when my health deteriorates;
- care which is delivered close to where I live and work, so that I can continue to lead as normal a life as possible, whilst still working closely with clinical teams to ensure the best possible treatments; and
- my care to be co-ordinated so that every appointment has a clear purpose and none are wasted.

Home First

Outcomes that Matter to People

I want:

- to live a long and healthy life;
- to be quickly diagnosed when I develop any disease;
- to have treatments which give me the best chance of cure, or achieve the best possible outcome for me;
- treatments to be tailored to my needs;
- to have my symptoms and side effects managed effectively and compassionately;
- to be treated with kindness and respect and my dignity maintained at all points in my care;
- to maintain my independence and have the best quality of life possible;
- health professionals to value my time and ensure effective, efficient delivery of care; and
- to die comfortably in a place of my choosing.

“I’m kept informed and I have a single care plan for everything”



“I want to be safe and I want my baby to be safe”



“A coordinated service, including out of hours, so I don't repeat the same story”



“I want to have good quality care not just good enough care.”



Avoid Harm, Waste and Variation

I want:

- to always be offered the best, most effective treatments, regardless of where I live and which health professional I see;
- all decisions regarding my care to be made by experienced clinicians who have an understanding of my condition;
- to receive joined up care from a range of health professionals, who communicate effectively with each other and work as a team;
- to always receive the medication which is right for my condition and safest for me, understanding any potential risks and side-effects they may have;
- a single health record that enables all my health care providers to share information and avoid repetition; and
- to work in partnership with my health team to avoid futile treatments and, where necessary, develop a clear end of life plan.

Working Together: A Framework for Change

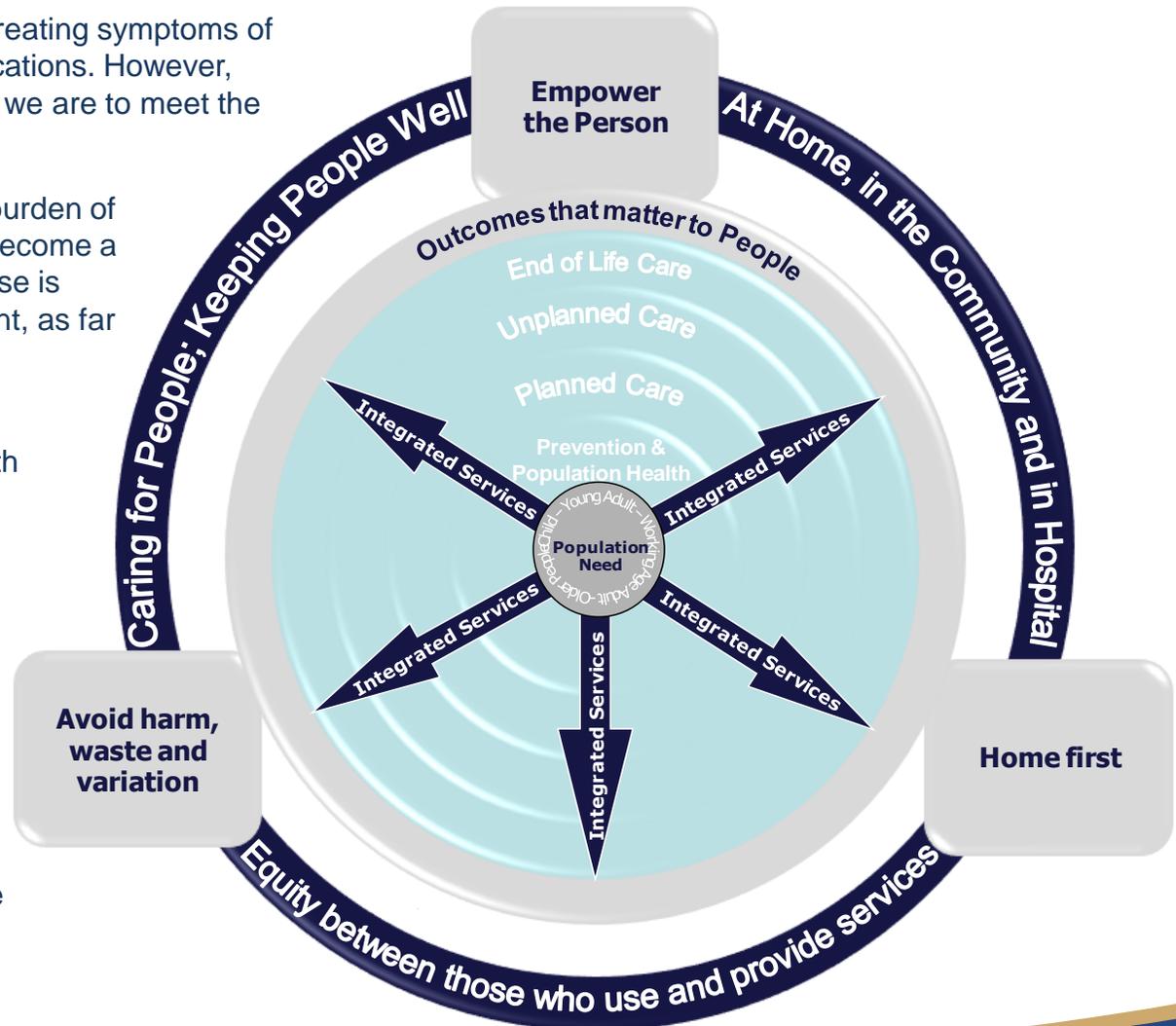
Health services have traditionally focussed on treating symptoms of disease and managing their emergency complications. However, this model of care is inadequate for the future if we are to meet the challenges facing the UHB.

Prevention of ill health will reduce the growing burden of disease affecting our population and needs to become a priority for all healthcare workers. Once a disease is established, it should also be a priority to prevent, as far as possible, a decline in a person's wellbeing.

New models of planned care are also required, with a focus on delivery in the community. Health professionals will need to work differently, breaking through the traditional boundaries of community and hospital based working.

Unplanned (emergency) care must be safe and effective. Care should be co-ordinated to ensure all needs are addressed in a timely fashion and the individual is supported to return to their community.

Care at the end of life must also be at the forefront of service design, ensuring that people die with dignity, in a place of their choosing, irrespective of their underlying disease.



Application of the strategic principles and framework enables a uniform approach to service design for the whole population of Cardiff and the Vale of Glamorgan, irrespective of a person's age, ethnicity, area of residence or indeed any specific disease. Providing a framework which gives equal consideration to prevention, planned, unplanned and end of life care, supports the UHB's ambition to deliver joined up care, placing the person firmly at the centre of service design. Some of the key elements of the framework are detailed below.

Prevention:

Many of the diseases which have the biggest impact on our local population have common risk factors, which are largely associated with lifestyle choices, for example smoking, diet and exercise. To improve the future health and wellbeing of our population we will create an environment in which individuals have a sense of personal responsibility for their health and are supported to adopt behaviours which reduce their risk of poor health. The UHB will recognise its responsibility to its employees, by supporting them in this regard, so that they become role models both at work and in the community in which they live. The UHB will also adopt different approaches to ensure that the chance of keeping well is equal in each community.

When disease does occur, both our population and our workforce will be better able to spot the early symptoms and signs. This will enable early diagnosis and effective treatment. The effectiveness of our approach will be seen in the reduction of health inequality across the population of Cardiff and the Vale of Glamorgan.

Planned Care:

All services will place the person at the centre of their own care. Individuals and their carers will be recognised as key healthcare partners and will be encouraged to participate in the planning of their own care and to make informed choices and decisions about their treatments. An individual will be able to take responsibility, where possible, for monitoring and managing their own condition. Feedback from people who use services will significantly influence each service's development. The UHB appreciates that family and friends play vital roles as carers in the community and will therefore offer them support, recognising carers not only as healthcare partners but also as individuals with their own personal and health needs.

In order to provide joined up care we will improve the way healthcare professionals communicate with each other across specialties and professions, and between the hospital and the community. Developing a single, electronic clinical record, that can be accessed by all health professionals as well as by the individual it concerns, is essential to the efficient delivery of multi-disciplinary care. This record should provide up to date information about the individual and empower the person to better co-ordinate their own care. Further improvements can be achieved by assigning to each person who needs it, a key worker who can signpost the individual to services across all sectors.

Unplanned Care:

A sudden deterioration in health is frightening for everyone involved. Care in an emergency will be easily accessible, effective and timely for all and will be provided by appropriately trained clinicians.

If an individual requires an urgent hospital admission it is essential that care is co-ordinated between the person's usual service providers and those delivering their emergency care, so that an individual receives a treatment plan that best suits them and enables their best possible recovery.

To enable a safe and timely return to the community, discharge from hospital will be co-ordinated with community services to ensure all necessary support is available when needed.



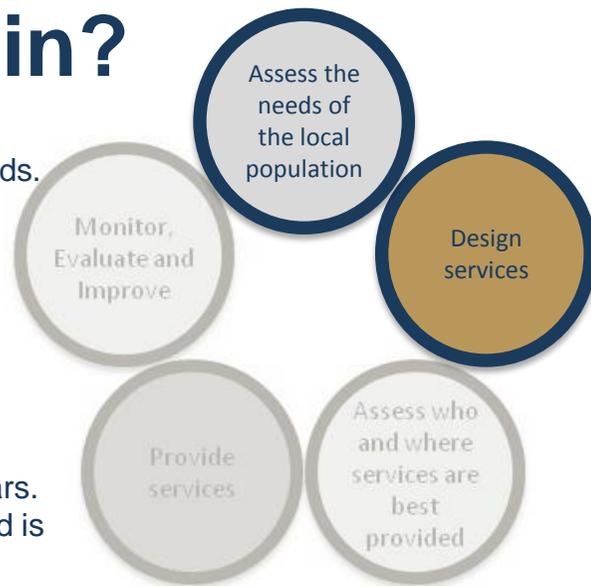
End of Life Care:

Care will ensure that the end of a person's life is dignified and focussed on achieving an individual's own goals and aspirations. People with life-limiting conditions will be supported to clearly describe their end of life wishes and needs. All healthcare professionals will be aware of these needs through a single electronic clinical record, which in turn will reduce the need for unnecessary repetition during this difficult time.

Many people want to receive their end of life care at home or in their local community. This will be made possible by making facilities and palliative care expertise in the community readily available, allowing people at the end of their life to remain close to their families and friends.

Working together: where to begin?

In order to determine where change will have the biggest impact in shaping the future health and wellbeing of our population, the UHB must consider the changing population and its needs. The Shaping Our Future Wellbeing programme has consulted with its staff and other stakeholders to prioritise change. These jointly agreed priorities are as follows:



Cancer

- Around 1 in 3 cancers in the UK are caused by unhealthy lifestyles and are avoidable with lifestyle modification.
- Lung cancer is the second most common cause of death in men and the third most common cause of death in women in Wales.
- The incidence of cancer in Cardiff and the Vale has increased by 10% in the past 10 years.
- Uptake of cancer screening is lower in Cardiff and the Vale than elsewhere in Wales, and is lowest in more deprived areas.
- Cancer accounts for nearly 7% of all NHS expenditure in Wales.

Dementia

- By 2025, nearly 7000 people will be living with dementia in Cardiff and the Vale.
- The risk of developing dementia is strongly age-related. As life expectancy increases so the total number of people with dementia is going to increase.
- Many people with dementia are undiagnosed and do not appear on GP registers. Early diagnosis can slow the progression of dementia and help individuals identify sources of support.
- Around 1 in 4 patients on hospital wards have a form of dementia.
- 1 in 5 cases of dementia may be preventable with exercise, diet, diabetes prevention, and early treatment of depression.

Dental and Eye Health

- Diets high in sugar are a significant contributory factor to poor oral health as well as the development of type 2 diabetes.
- Poor oral health can affect a number of conditions, including diabetes, cardiovascular disease and pregnancy.
- Approximately 40% of children aged between 5 and 12 years living in Cardiff and the Vale have experience of dental decay.
- The proportion of children with preventable decay is twice as common amongst those from deprived communities.
- There are nearly 100,000 people in Wales living with sight loss and this is predicted to double by 2050.
- More than 50 per cent of sight loss can be prevented through early identification and intervention.
- Uptake of sight tests in Cardiff and the Vale is below the Welsh average. The number of missed appointments are over twice as high in more deprived communities.

Long Term Conditions (LTCs)

- A long term condition is one that, at present, cannot be cured but which can be controlled by medication and other therapies.
- Half the adult population in Cardiff and the Vale reports having at least one long term condition, with nearly 1 in 25 having diabetes.
- The impact of long term conditions on individuals depends on where they live:
 - men in the least deprived parts of Cardiff and the Vale can expect to have 22 more years of healthy life than those in the most deprived areas; and
 - the number of people with type 2 diabetes in our most deprived communities is more than double that in the least deprived.
- Modifiable lifestyle risk factors which contribute to the development and progression of many LTCs are widespread:
 - around 1 in 5 adults smoke, nearly half drink above guidelines, over half are overweight or obese, two thirds don't have a healthy diet, three quarters don't get enough physical activity.

Maternal Health

- Cardiff and the Vale has a younger and more ethnically diverse population than the rest of Wales.
- Cardiff and the Vale has a birth rate three times higher than the Wales average (around 6,000 children born each year), the majority being born in a hospital setting (maternity unit or midwifery-led unit).
- Smoking is a principal cause of pregnancy complications and low birth weight, and a key contributor to persistent health and social inequalities in society, as children who are born with a low birth weight are at higher risk of ill health themselves.
- Rates of teenage pregnancy among under 18s is higher in Cardiff than the Wales average.

Mental Health

- 1 in 4 adults experience mental health issues during their lifetime and 1 in 10 children between the ages of 5 and 16 have a mental health problem.
- Around 4,200 people in Cardiff and the Vale currently have a diagnosis of a serious mental illness.
- Mental health issues are most common between the ages of 14 and 20, so with a younger population than the rest of Wales, Cardiff and the Vale is likely to have a greater incidence of mental illness.
- Community mental health caseloads, admissions and bed occupancy in Cardiff and the Vale are all above the UK average.
- Rates of suicide in Wales are higher than any English region.
- Poor mental health and mental illness have a significant impact on individuals, society and the economy overall.

Stroke

- Stroke is one of the top three causes of death and a leading cause of adult disability in Wales.
- During 2025, nearly 11000 people over the age of 16 will receive treatment for stroke, in Cardiff and the Vale.
- People from less well off communities face more chance of having a stroke and do not make such a good recovery as people from better off areas.

Standards for Our Service Priorities

The use of a strategic framework enables feedback from staff and our communities to be combined with existing UHB service plans, Welsh Government delivery plans, National service frameworks, and International working group predictions, to create a shared vision of the future. In this way, work already underway in the UHB to improve prevention, planned, unplanned and end of life care can continue and be further built upon. Each vision was formed from a series of service standards against which the UHB will be able to monitor progress. Some of the key documents used to inform the service standards are listed below, and should be read in conjunction with this document.

The shared visions and service standards created through the Shaping Our Future Wellbeing programme and ongoing Stroke work can be found online by clicking on the circles below or in the appendices of this document.



Meeting the Challenges

A Balanced Approach

Having clear strategic principles and service standards enables the UHB to design services fit for the future. However, assessing who is best placed to provide these services and determining where each service should be located is a complex responsibility with many conflicting priorities. The solution to one challenge often complicates another and meeting one alone rarely satisfies all stakeholders, be they our citizens, staff or key partners.

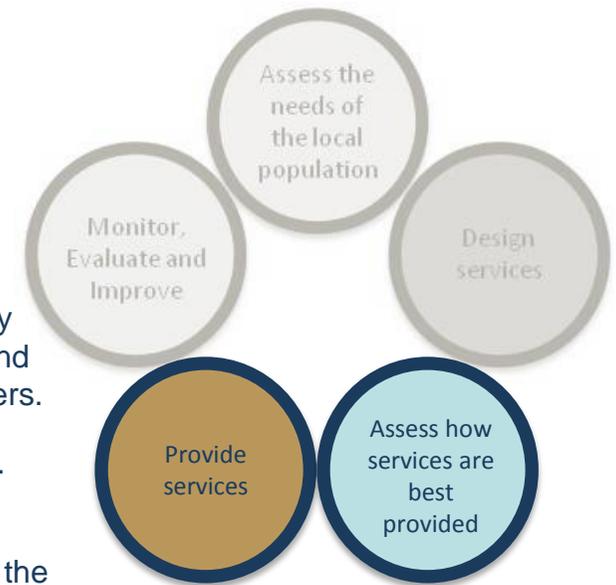
The UHB is committed to taking a **balanced approach** to meeting the challenges it faces. This means considering the **outcomes** we want to achieve from 4 different perspectives:

Our Population: Everything the UHB does must add value to the health and wellbeing of the people that we serve, both locally and in the wider UK. The care we provide must deliver the outcomes that are important to both individuals and their families, as well as the population as a whole. To do so, those who receive our care should share the responsibility for their own health and be viewed as equal partners in the planning of current and future services.

Service Priorities: How the UHB designs and delivers its services is key to whether we are successful in keeping our population well. Future services must address need across the whole cycle of care, including prevention, planned, unplanned and end of life care. By embracing technology, working across traditional boundaries, redesigning our workforce, and developing regional networks the UHB can create integrated clinical services that provide person centred care.

Sustainability: The challenges faced by the UHB place increasing pressure on its resources. To maintain the health and wellbeing of our population it is vital that we achieve a sustainable health system within a sustainable Wales. Inefficiencies and errors in the way we deliver our services can result in harm to those who need our help the most, and creates waste and variation in care. By striving for excellence in all that we do, the UHB can make best use of its resources, reduce harm, waste and variation, and create a system which safely does more with less.

Our Culture: The UHB has over 14,000 staff who work hard to deliver services to our population. The culture in which these staff work and develop influences how they behave and the care they provide. As a great place to work and learn, the UHB will create an environment where innovation and research thrive. Through sharing of knowledge and skills, we will work better together across care sectors to develop a highly skilled workforce who provide the very best care.



For Our Population (This is what we are offering to do)

Deliver Outcomes that Matter to People

Strategic Objectives:

- Reduce health inequalities
- Deliver outcomes that matter to people
- All take responsibility for improving our health and wellbeing

Health inequalities is a term used to describe the difference in health between two or more different groups of people. Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. These differences are important because they result in a significant gap between the health experienced by people in our most deprived communities, and those in the least deprived.

In 2015
the UHB uses
patient stories to
learn from real life
experiences

Currently a person living in one of our most deprived communities can expect up to 22 fewer years of healthy life than someone living in our least deprived communities. To reduce this gap, whilst providing universal services, we must target our key actions in the most deprived areas and to those in highest need, working more closely with these communities to understand and address their needs and work in partnership to improve their health and wellbeing.

In 2015 the
UHB uses clinical
audit and quality
improvement to
drive clinical
practice

Some of the things which cause inequalities the UHB can directly influence in the NHS – things such as ensuring access to health services in line with need in different communities, and some aspects of healthy behaviour (smoking, for example, is a key driver of health inequalities). However, many of the causes of inequalities relate to an individual's education and employment opportunities, the environment people live and work in, and social networks. Whilst these causes are outside the direct influence of the NHS they have a huge impact on the health of a population. The UHB will therefore work closely with statutory and third sector partners to address these 'wider determinants' of health.

Outcomes are the result of choices and actions made. Delivering outcomes that matter to people moves beyond just focusing on how quickly we deliver healthcare to considering its quality, and understanding that sometimes it is small changes that are the most important to people. Outcomes should cover the full cycle of prevention, planned, unplanned and end of life care, and track the longer term results after people have finished a specific intervention or treatment, to see whether they have benefitted. The most important outcome to a person may change at different stages of their care, be it the status of their health, the quality of care experienced or their level of independence. All must be understood in order to deliver outcomes that matter to people.



In 2015
the UHB uses
Patient Reported
Outcome Measures
to improve
services



In 2015
the UHB helps
improve the chance
of successful surgery
with the Optimising
Outcomes
Policy

Health-related behaviours such as diet, exercise, tobacco and alcohol use have a significant impact on the outcomes that matter to people. While we all have a responsibility to maintain and improve our own health and wellbeing, the factors which cause us to do things which can have a negative impact on our health are complex, and often don't involve a conscious choice. The UHB will help people who want to change their behaviour, but also work on making the healthy choice the easy choice in Cardiff and the Vale – the choice we make without thinking. Much of this relates to the physical environment and how our friends and peers act.

Empowering people to make care choices that are right for them means making good decisions in collaboration – being an equal in the team providing care. Shared decision making (SDM) is the conversation that happens between an individual and their health professional to reach a joint decision on how best to manage their condition. What is 'best' will be different for everyone, so this conversation needs patients and professionals to understand what is important to each other, and each to bring their expertise to the conversation.

Offering support for non-health issues can also improve general health. People who receive welfare advice experience lower anxiety, better general health, better relationships and housing stability. The right advice at the right time helps people manage their own lives, and promotes better physical and mental health.



In 2015
the UHB leads
the way in shared
decision making
with MAGIC (making
good decisions in
collaboration)

Summary of actions:

- Target our services to those most in need, working with key partners on wider determinants of health, to reduce health inequalities
- Help individuals lead healthier lives, making the healthy choice the easy choice
- Ensure the voice of the individual is heard at all levels within the organisation and drives improvement; requiring continued working together with the people who use and deliver our services
- Ensure we have effective methods of identifying those at risk of developing disease and actively manage that risk
- Spread the awareness and use of shared decision making tools and the personalising of care plans
- Build outcomes that matter to people into the organisation's every day performance measurement processes

Measureable outcomes in delivering a balanced approach for *Our Population*



Our Service Priorities (This is what we will focus on most)

Offer services that deliver the improvements in population health that our citizens are entitled to expect

Strategic Objective:

- Offer services that deliver the improvement in population health that our citizens are entitled to expect

In 2015 the UHB community diabetes model provides joined up care in the community

In 2015 the UHB Cystic Fibrosis Team use video conferencing for home based care

Our service priorities (cancer, dementia, dental and eye health, long term conditions, maternal health, mental health and stroke) have been selected because these are the areas where service change could have the biggest impact on our future population health. By applying our strategic principles and framework to these areas, as described on page 20, service standards have been agreed that describe what using our services should be like by 2025. Alongside these standards are a set of outcomes agreed for each service priority.

Key to implementing these service standards is the development of integrated, multidisciplinary, multi-organisational teams focussed around each service priority. The team, virtually or co-located, will take responsibility for the whole cycle of care including prevention, planned, unplanned and end of life. Importantly, the whole team will measure outcomes and costs in the same way and work towards shared goals. In support, the UHB will develop a commissioning framework which prioritises health and care services by rewarding achievement of the outcomes that matter to people and stopping interventions which do not.

In moving from our traditional focus of treating symptoms of disease and their emergency complications we will ensure that, for our service priorities in particular, our services are designed to identify and support individuals based on their risk. As described on page 23, this starts with identifying those at risk of developing disease, supporting them to adjust their health related behaviours and then, based on the control they have of their condition and its progression, moves to establishing levels of support appropriate for the individual.

In 2015 the UHB has developed a patient centred workforce model in Stroke Rehab

In 2015 the UHB has Phase I of a community focussed health and wellbeing centre at CRI

Part of the infrastructure the service priority teams will use to move healthcare services into the community will be UHB established Health and Wellbeing Centres. The UHB provides primary and community care through 9 Primary Care Clusters (groupings of GP Practices – see page 4) which come together into 3 Localities; the Vale, Cardiff South and East, and also Cardiff North and West. Each Locality will have its own Health and Wellbeing Centre which will provide services tailored to the needs of the local community, supporting health promotion, prevention and a reduction in health inequality. They will provide a range of facilities and technologies to enable services to be delivered close to home wherever possible. Alongside offering a community space, these centres will provide services in conjunction with key partners to deliver more integrated and co-ordinated services for our local population. This recognises that welfare advice provision in primary health settings can reduce, by an estimated 15%, the time GPs spend on benefits issues, and leads to fewer repeat appointments and fewer prescriptions.

Each service priority team will be designed to work across traditional boundaries of social, voluntary, community, primary, secondary and tertiary care. To do so, the UHB will support the use of new technology and develop, where necessary, new roles and skills within each team, ensuring that team members only perform tasks that they alone can do. Development of secure and confidential technology that improves communication both with the patient and between care and support providers will be prioritised, enabling people to remain safely in their homes as much as possible.

In 2015 the UHB and Velindre NHS Trust are working to transform Cancer Services in South East Wales

Summary of actions:

- Work with Local Partners in the design and future delivery of primary and community care utilising Health and Wellbeing Centres
- Ensure that staff have the correct skills to support services which focus on population health, for example motivational interview techniques
- Ensure patients with multiple conditions have the support of a key worker to help co-ordinate care and signpost to services across all sectors, making every contact count
- Invest in technology that improves communication both with the patient and between care and support providers and which enables people to remain safely in their home. Work will initially focus on delivery of a Community Care Information System
- Access where and by whom services are best provided by undertake outcomes based commissioning, prioritising health and care services based on delivering the outcomes that matter to people

Measureable outcomes in delivering a balanced approach for *Our Service Priorities*

People are aware of and are supported in minimising their risk of disease through healthy lifestyle choices

People receive fast, effective treatment and care so they have the best possible chance of cure

People who care for family members or friends, as well as clinical staff, are supported to maintain their health and wellbeing, with local services which are easy to understand and navigate

Disease is detected quickly where it occurs or recurs

People are placed at the heart of their care with their individual needs identified and met so that they feel well supported and informed, and able to manage the effects of their disease

The end of a person's life is dignified and care is directed at achieving each person's own goals and aspirations

Sustainability (This is where we want to excel)

Join up what we do for the people we serve and strive for operational excellence making the best use of the resources we have

Strategic Objectives:

- Have an unplanned care system that provides the right care, in the right place, first time.
- Have a planned care system where demand and capacity are in balance
- Reduce harm, waste and variation sustainably making best use of the resources available to us

In 2015 the UHB is working with Paramedics to improve emergency mental health care

Development of a new unplanned care system requires development of an effective planned care system, where demand and capacity are in balance .

Planned care starts in people's homes and community and must ensure that people with a diagnosed condition have an individual care plan in place that sets out the steps required of the person and a multidisciplinary team should urgent care be required. If this requires an admission to hospital a pathway will be in place which provides timely access to a team with specialist knowledge of the condition.

Working with partners in health and social care across South Wales, the UHB will establish hospital and community based care networks.

In 2015 the UHB Community Resource Teams provided targeted support to older people

Within each locality the UHB will establish Health and Wellbeing Centres (as described on page 26). These will provide a central point for a network of clinical services and facilities, supporting the continued sustainability of general medical practice and primary community care, whilst improving overall accessibility to services.

The UHB will also develop its existing work with the local councils in Cardiff and the Vale to provide a single point of contact (one phone number) for both health and social care for the whole of Cardiff and the Vale, so that people can be directed to the right teams and services appropriately deployed.

In 2015 the UHB and Vale of Glamorgan Council has a single point of access for some community services

In 2015
the UHB has
centralised Upper
GI Cancer care
providing a
sustainable
service

To successfully provide sustainable hospital care in our region the UHB will work with other Health Boards and Trusts to design and deliver safe, effective hospital care. Operating within a network of hospitals, the University Hospital of Wales will act as a regional centre providing tertiary, specialist and complex care for a local, regional and national population. University Hospital Llandough will continue to have a vital role in the provision of local acute and mental health services, forming part of an integrated regional hospital network.

Planning hospital services in this way will enable the consideration and organisation of key elements of the workforce, supporting equipment and facilities to ensure the best outcomes for patients and the optimal use of resources. By focusing and specialising hospital service provision in this way we will avoid unnecessary duplication and enable our hospitals to become centres of excellence for the services they provide.

In 2015
the UHB has
over 1000 staff
trained in
improvement
methodology

By striving for excellence in all that we do the UHB can make best use of its resources, reduce harm, waste and variation, and create a quality system which safely does more with less. The Leading Improvement in Patient Safety (LIPS) programme aims to build capacity and capability within UHB teams to improve patient safety. In doing so the culture of patient safety and service quality is being recognised as a key priority for the UHB, making quality improvement part of everyday practice. This has already led to a standardised hip and knee arthroplasty follow up pathway, gathering Patient Reported Outcomes Measures (PROMs) and providing advice on further treatment via virtual clinics.

Continued focus on patient safety will ensure:

- there is zero tolerance of Never Events (serious, largely preventable patient safety incidents) and Hospital Acquired Infection;
- patient safety priorities are embedded, owned, understood and acted on by staff at all levels of the organisation; and
- we are recognised as a leading UK organisation for our work on patient safety initiatives and the application of improvement methodology.

Summary of actions:

- Continue to develop an agreed single point of access to health and social care services for users and professionals across Cardiff and the Vale of Glamorgan
- Work with other Health Boards in the design and future delivery of acute hospital care
- Separate planned and unplanned care systems to optimise efficiency, working with primary care teams to shape and manage access to our planned care resources

- Build a flexible clinical workforce working across partner organisations
- Ensure evidence based practice is routinely applied and robust systems are in place to reliably monitor outcomes in patients across all specialities
- Put robust governance processes in place that demonstrate learning from the depth and breadth of quality, safety and patient experience sources.
- Train all staff in improvement methodology, which will become integrated in day to day activities
- Invest in an expert specialist patient safety team who can support and work alongside teams to respond rapidly when things go wrong, supporting patients, family and staff and to ensure that actions are taking to prevent harm again in the future.

Measureable outcomes in delivering a balanced approach for *Our Sustainability*



Culture (This is what we want working here and with us to be like)

Working better together across care sectors through people, innovation, improvement, research and technology

Being a great place to work and learn

Strategic Objectives:

- Be a great place to work and learn
- Work better together with partners to deliver care and support across care sectors making best use of our people and technology
- Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives

In becoming a great place to work and learn, the UHB aims for a healthy and engaged workforce focusing on a number of key themes:

- engaging leaders and culture change;
- a flexible and sustainable future workforce;
- a productive, efficient and high performing workforce;
- building capacity and capability; and
- promoting health and wellbeing.

Developed through conversations within the organisation, the UHB has a set of values which inform everyday staff behaviour: **Care, Trust, Respect, Personal Responsibility, Integrity and Kindness.**

The UHB will apply these values to everything it does: recruitment, induction, and the personal appraisal and development review (PADR) processes, with feedback through regular staff surveys. We will develop training programmes to support the embedding of our values and behaviours within the workforce and we will recognise and reward staff who exemplify them. In doing so, we will make the measurement and monitoring of our behaviours the norm.

When behaviour and care raises concern, the UHB and staff will take responsibility for putting it right. This could be informally, leading by example and taking action, or by talking to colleagues and managers; or more formally by reporting serious incidents or through policies such as the Whistleblowing Policy, which gives staff some protection in law. Where staff feel it is the right course of action, a **Safety Valve** through to the UHB Chair will always be available.

In 2015
the UHB trained
123 Foundation
level Junior
Doctors

In 2015
the UHB is
training staff in
'healthy chats' to
promote healthy
lifestyles

Working with Universities and partners, we will train the next generation of staff and healthcare professionals, to ensure that the right number of appropriately skilled staff, aligned to our values, are available to support our services. The UHB will improve the environment within which its staff works, improving access to healthy food, active travel, and smoking cessation support. By encouraging staff to become role models, we will support a positive work life balance and the adoption of healthy lifestyles.

In 2015 the UHB, as part of Families First, is helping families who need extra support

We can only deliver improvements in population health across all our services if we work differently and work more collaboratively with our communities and our partners. Our ambitions echo duties now based in law through the **Wellbeing of Future Generations Act** which requires the UHB, as a public body and a **Cardiff and Vale of Glamorgan Public Service Board**, to work collaboratively to improve the social, economic, environmental and cultural wellbeing of our area. This legislation supports the new, more integrated way of working which the UHB is already adopting, recognising that many different aspects of people's lives impact on whether they can live a healthy life e.g. education, housing and employment.

The UHB is already working with Cardiff Council, the Vale of Glamorgan Council, Glamorgan Voluntary Services and Cardiff 3rd Sector Council to consider the best way of building upon the work undertaken to integrate community health and social care services across Cardiff and the Vale of Glamorgan. In August 2015 the **Integrated Health and Social Care Partnership** confirmed an agreement to fast track a far reaching programme which will provide our local population with joined up services across the region. Initially the work will focus on bringing together services for older people to prolong independence in their own homes and provide sustainable care within the community. In the future, the work may be extended to services for other population groups in need of specific care and support within our region.

In 2015 the UHB and partners are working together to improve the emotional wellbeing of young people

In 2015 the UHB supports WIMAT, a world leading training centre and ideas incubator

The UHB recognises the importance of searching for and applying innovative approaches to delivering healthcare and these approaches must become integral to the way we do business. We know that our success in adopting innovation helps support growth in life science industries and bio technology, which in turn leads to investment in developing technologies and other products by both the UHB and the NHS more widely. Building on our clinical innovation partnership with Cardiff University, under a Joint Director of Clinical Innovation, a collaborative team will be responsible for developing a clinical innovation centre. This will create a prime location for researchers to come together and test and progress research and ideas. Through this approach, the UHB can maximise the opportunities presented by the creation of a **Cardiff Capital region – a confident, collaborative and connected region primed for economic growth.**

Summary of actions:

- Agree the behaviours which represent our values and embed them throughout the organisation
- Further understand staff engagement, as measured by the engagement index, through regular staff surveys
- Agree plans to drive forward the UHB Equality and Diversity objectives
- Build an environment which attracts staff to train in Wales and the UHB
- Agree and deliver an implementation plan to integrate priority service areas across health and social care for older people in the community, extending this work to other groups where it makes sense to do so
- Develop a Clinical Innovation Framework building on the success of the Quality Improvement Faculty and Clinical Innovation Partnership
- Develop an overarching approach to maximising the opportunity presented by the creation of the Cardiff Capital Region

Measureable outcomes in delivering a balanced approach for *Our Culture*

Quality trained staff who are fully engaged in delivering excellent care and support to me and my family

People in our community have care and support when and where they need it without duplication, confusion or delay, in a way that prevents avoidable delay

Interventions to improve my health are based on good quality and timely research and best practice

Next Steps

As a result of working together with the people who use and provide our services to shape the UHB's next ten years, the **Shaping Our Future Wellbeing Strategy** is already informing many of the decisions we make in the UHB. Each one of us is now more able to see the impact we can have on achieving the UHB's vision that **a person's chance of leading a healthy life is the same wherever they live and whoever they are.**

Every year, as part of a continuous planning process, the UHB updates and refreshes its 3 year Integrated Medium Term Plan (IMTP). It is through this planning process that the UHB will embed use of its strategic principles and framework, describing the detailed actions we will take to make the outcomes described in our strategy a reality. Our 2016/17 Integrated Medium Term Plan will reflect priorities of this strategy as well as Welsh Government priorities and targets.

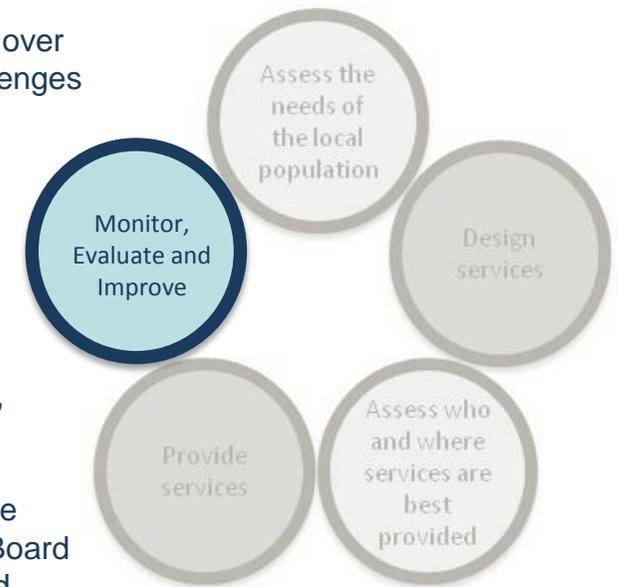
In continuing the approach developed through the Shaping Our Future Wellbeing Programme the UHB will work with people who use and provide our services and key partners to underpin this strategy creating or revising key frameworks. We will also review and update governance arrangements for key parts of the strategy, including the service priorities, planned and unplanned care.



Throughout this document, we have described the outcomes the UHB wishes to achieve over the next ten years. On page 21 we describe our balanced approach to meeting the challenges faced by the UHB, describing the 4 different perspectives which need to be considered:

- **Our Population** – delivering outcomes that matter to people
- **Our Service Priorities** – offering services that deliver the population health our citizens are entitled to expect
- **Sustainability** – joining up what we do for the people we serve and striving for operational excellence making the best use of the resources we have
- **Our Culture** – working better together across care sectors through people, innovation, improvement, research and technology

For each of our outcomes, we have an agreed set of measures which combine to produce a **balanced scorecard**. This balanced scorecard will be reviewed monthly by the UHB Board and will guide decisions to ensure our Shaping Our Future Wellbeing strategy is delivered.



This strategy will lead to a very different future for Cardiff and Vale UHB and our population, a future where **a person's chance of leading a healthy life is the same wherever they live and whoever they are**. For the UHB this means:

- local services planned and delivered through a network of neighbourhoods (based on our nine GP clusters), with integrated primary and community care services providing seamless care across the health and social care spectrum;
- local services delivered in partnership with our local authorities and voluntary sector, which promote health improvement, wellbeing and independence, and reduce health inequalities; services that reflect our strategic principles: home first, empower the person, outcomes that matter to people, and avoiding harm, waste and variation;
- service delivery supported by the most advanced technology resulting in people only needing to travel when absolutely necessary (both staff and patients) - helping to reduce our carbon footprint;
- specialist services delivered in partnership with neighbouring health boards, where clinicians work in teams that span organisations, and where necessary, patients will receive highly specialist treatment and care in a specialised hospital with all of the necessary infrastructure and support;
- services able to recruit the very best in the field, with strong research, excellent teaching and patient outcomes that compare with the best in the world - a leading academic medical centre delivered in partnership with Cardiff University; and
- relationships with local industry partners as part of our Clinical Innovation Partnership which generates new ideas, products and technology - contributing to the growth of the local economy and bringing wealth into the region.

In **Caring For People; Keeping People Well**, Cardiff and Vale UHB is committed to working with our communities and partners to improve health outcomes for everyone, **delivering outcomes that matter to people**. As the UHB takes its next steps on this journey, we are looking forward to working with you further.



Service Standards

SHAPING OUR FUTURE WELLBEING - CANCER

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



THIS IS OUR VISION OF CANCER CARE OVER THE NEXT 10 YEARS, CREATED BY PEOPLE WHO BOTH USE AND PROVIDE CURRENT CANCER SERVICES

PREVENTION

We will support the people of Cardiff and the Vale and the employees of the Health Board to adopt healthy lifestyles, creating an environment that encourages good health and wellbeing. People will have an increased awareness of the causes of cancer and will be able to spot its early warning signs. Effective and accessible methods of ensuring the early detection of cancer will be accompanied by clear signposting of where to seek help. By focussing our care where it is most needed, we will work to reduce health inequalities.

PLANNED CARE

The needs of each person with cancer will be central to their care. We will ensure rapid diagnosis and delivery of evidence based treatment, with clear signposting of services and support. Healthcare professionals will support people to monitor and manage their condition. Care will be co-ordinated by a key worker and offered in the community where possible. People will be supported to live with the impact that cancer has on their physical, psychological and social wellbeing. Their feedback will be integral to development of future services. Support will be offered to carers, recognising their role as vital healthcare partners.

UNPLANNED CARE

The cancer service will provide advice and support for people with cancer who require emergency care. It will work with health care professionals during any hospital admission to ensure that each person's medical needs are met. With these needs as a focus, health care professionals will work together with each individual to enable the best possible outcome. Discharge from hospital will be co-ordinated with community services and carers/family by a key worker and facilitated by the rapid provision of any required support and equipment.

END OF LIFE CARE

The end of a person's life will be dignified and focussed on achieving his/her own goals and aspirations. The person will be able to choose where they would wish to receive care at the end of their life and we will ensure that staff and facilities are available at home, in the community and in hospital which allow people to remain with their families and friends.

For more information visit www.bit.ly/SOFWHome

CARING FOR PEOPLE, KEEPING PEOPLE WELL



Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board

KEY



HOME FIRST

COMMUNITY

HOSPITAL

Cancer Outcomes

People are aware of and are supported in minimising their risk of cancer through healthy lifestyle choices

People receive fast, effective treatment and care so they have the best possible chance of cure

People who care for family members or friends, as well as clinical staff, are supported to maintain their health and wellbeing, with local services which are easy to understand and navigate

Cancer is detected quickly where it occurs or recurs

People are placed at the heart of cancer care with their individual needs identified and met so they feel well supported and informed, and able to manage the effects of cancer on their lives

The end of a person's life is dignified and care is directed at achieving their own goals and aspirations

Cancer Service Standards

Cancer - Prevention

- People in Cardiff and the Vale will be supported to take opportunities that improve their health and wellbeing.
- We will work with key partners to improve the environments (access to healthy food, active travel, smoking cessation support, etc) within which our communities live and work.
- We will have effective methods of identifying those at risk of developing cancer and we will actively manage that risk.
- We will work to reduce health inequalities and to reduce the greater impact of mortality from cancer in our most deprived communities.
- There will be clear programmes and policies to reduce preventable cases of cancer and support offered to those with established risks. Starting early with families and in schools, and at regular intervals throughout life, this will be in a manner best suited to the needs of each community.
- We will have effective methods for ensuring early detection of cancer, which are accessible to our whole population.
- All health professionals will take an active 'Making Every Contact Count' approach to the prevention and early recognition of cancer.
- The UHB will support employees to adopt healthy lifestyles both in and out of work, encouraging a positive work/life balance.



“Give people the right information to enable them to make choices”

“I want to feel in control.”



“What can I do to help myself?”



Cancer - Planned Care

- Anyone with a symptom suggestive of cancer will be able to access a healthcare professional without delay.
- Cases of suspected cancer will be urgently referred to a diagnostic service, where there will be immediate or rapid access to all necessary investigations to enable diagnosis and staging of the cancer.
- Anyone who is diagnosed with cancer will receive clinical, psychological and social support when needed, at any point in their care in order to enable their best possible health and wellbeing. Available services will be clearly signposted and will include services and support offered by our partners in the community.
- Anyone with cancer will be considered an active health care partner who is central to the planning and delivery of their own care.
- Anyone with cancer will be supported to monitor and self-manage their condition to a level agreed in partnership with their health care professional, resulting in an individualised care plan available 24 hours a day.
- Access to cancer care will be fair and equitable, being suited to an individual's cultural and/or social needs.
- Cancer treatment will be evidence based, offering the best chance of cure, whilst causing the least possible harm. There will be clear evidence of multi-disciplinary team involvement and timely access to surgical interventions where needed.
- Care for each cancer will be standardised and delivered to national standards. Clinical trials will be offered where available, and people will be supported to make informed decisions about their participation.
- Anyone receiving cancer care will be fully informed of the potential complications of their treatment and underlying condition and be able to access advice, support and assessment 24 hours a day.
- Cancer care will be co-ordinated and delivered in the community when clinically safe to do so.
- Young people transferring from children's to adult cancer services will have a transition that is purposeful, planned and supported.
- When a cancer is incurable there will always be the opportunity to have the prognosis explained and for engagement with the palliative care services.
- Survivors of cancer will have a clear, written care plan and receive the support they need to lead as healthy and active a life as possible, for as long as possible.
- A carer for someone with cancer will be considered a healthcare partner who is vital to the planning and delivery of care. They will be empowered to access advice 24 hours a day. Their needs will be acknowledged and respite care offered accordingly.
- Anyone who has experienced cancer services in the UHB will be encouraged to offer feedback about their experiences and to contribute to the development of future services.

Cancer - Unplanned Care

- Anyone with a diagnosis of cancer who accesses emergency health services will have immediate access to support from the acute oncology team, with co-management where needed.
- Anyone who accesses emergency health services, where initial investigations are suggestive of cancer or its complications, will have access to an urgent diagnostic service.
- Anyone with cancer who is admitted to hospital will be cared for in an environment that supports and enables them to remain independent and actively involved in their own care.
- Anyone with cancer who requires admission to hospital will have a timely and safe discharge, co-ordinated with community services, carers and their family, and facilitated through rapid provision of support and equipment in the community.

“You know your own body”



“Don’t be judgemental when people make their choice.”



“Clinicians understand my problems as well as clinical priorities”



“I need a coordinated service, including out of hours, so I don't need to keep telling the same story”



Click to return to ‘Standards for Service Priorities’

Cancer - End of Life Care

- Anyone who is recognised as having incurable cancer will be supported to make an Advance Care plan. This plan may evolve over time, but will always have the needs/desires of the patient and their carer at its core.
- Support and equipment to facilitate home care will be provided to anyone who has an incurable cancer, if so desired.
- Anyone with terminal cancer will have a dignified end to life, in a location of their choosing, with all treatment decisions focussed on the individual’s goals/aspirations.
- End of life symptoms will be managed at home, if so desired, by appropriately trained healthcare professionals.

SHAPING OUR FUTURE WELLBEING - DEMENTIA

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



VISUALISING 2025

THIS IS OUR VISION OF DEMENTIA CARE OVER THE NEXT 10 YEARS, CREATED BY PEOPLE WHO BOTH USE AND PROVIDE CURRENT SERVICES

PREVENTION

We will support the residents of Cardiff and the Vale and the employees of the Health Board to adopt healthy lifestyles, creating an environment that encourages good health and wellbeing. People will have an increased awareness of the causes of dementia and be able to spot its early warning signs. By focussing our care where it is most needed, we will work to reduce health inequalities.

PLANNED CARE

The needs of the person with dementia will be placed at the centre of their care and services developed according to their feedback. We will ensure early detection, rapid diagnosis and delivery of evidenced based treatment. Clear signposting of all services and support available and the continued development of dementia friendly communities will ensure that people with dementia can remain living in their own homes. Dementia care will be co-ordinated by a care navigator and delivered through a multi-disciplinary approach, aiming to achieve outcomes that matter to people. Families and friends caring for someone with dementia will be supported in that role.

UNPLANNED CARE

People with dementia who become medically unwell will receive rapid community assessment and treatments which may minimise the need for hospital admission. When this is unavoidable, hospital care will be provided in a dementia-friendly environment by suitably trained health professionals. Discharge from hospital will be co-ordinated with community services and carers/family by a key worker and facilitated by the rapid provision of any required support and equipment.

END OF LIFE CARE

The end of a person's life will be dignified and focussed on achieving his/her own goals and aspirations. The person will be able to choose where they would wish to receive care at the end of their life and we will ensure that staff and facilities are available at home, in the community and in hospital which allow people to remain with their families and friends.

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CARING FOR PEOPLE, KEEPING PEOPLE WELL



Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board

KEY



DIGITAL/INTERNET



ELECTRONIC PATIENT HELD RECORD



HOME FIRST



COMMUNITY



HOSPITAL

Dementia Outcomes

People are aware of and are supported in minimising their risk of dementia through healthy lifestyle choices

Dementia is detected quickly where it does occur or recur, with people receiving timely, effective treatment and care so they have the best possible chance of maintaining cognitive ability

People who care for family members or friends, as well as clinical staff, are supported to maintain their health and wellbeing, with local services which are easy to understand and navigate

Dementia care and support is available across the organisation, with all staff trained to be confident and capable in identifying and responding appropriately to dementia related needs

People are placed at the heart of dementia care with their individual needs identified and met so they feel well supported and informed, and able to manage the effects of their own, or a loved one's dementia

The end of a person's life is dignified and care is directed at achieving their own goals and aspirations

Dementia Service Standards

Dementia - Prevention

- People living in Cardiff and the Vale of Glamorgan will be supported to take opportunities that improve their health and wellbeing.
- We will have effective methods of identifying those at risk of developing dementia and we will actively manage that risk, working to reduce health inequalities.
- There will be clear programmes and policies to reduce preventable cases of dementia and support offered to those with established risks. This will begin in the early years, through school and into adult life, in a manner best suited to the needs of each community.
- We will have effective methods for ensuring the early detection of dementia. These will be focussed in the areas of greatest need but will be accessible by our whole population.
- All health professionals will take an active 'Making Every Contact Count' approach to the prevention and early recognition of dementia.
- The UHB will support employees to adopt healthy lifestyles both in and outside of work, encouraging a positive work/life balance.
- Through an improved understanding of dementia, our local communities will be able to support people with dementia to remain living at or close to home.



“I don’t want to be lonely.”

“I want to live in a community that helps me and remembers me.”



“The advantage of being at home for my husband is that he feels safe and secure.”



Dementia - Planned Care

- Anyone with a symptom that is suggestive of dementia will be able to access a GP for assessment and diagnosis, with referral, as appropriate, to a specialist memory service.
- Anyone who accesses community health services, who has signs of dementia, will be referred to appropriate dementia services.
- Anyone diagnosed with dementia will be assigned a care navigator.
- Dementia care will be equally accessible and accommodating to all, and will be suited to their individual cultural or social needs.
- Anyone who is diagnosed with dementia will receive clinical, psychological, psychiatric and social support when needed to enable their best possible health and wellbeing. Available services will be clearly signposted and will include services and support offered by our partners in the community.
- People with dementia will have access, where appropriate, to treatments that limit the deterioration in their memory.
- Anyone with dementia will be considered an active health care partner who is central to the planning and delivery of their own care.
- Anyone with dementia will be supported to monitor and self-manage their condition to a level agreed in partnership with their health care professional, resulting in an individualised care plan that is accessible 24 hours a day to support their care.
- Anyone with dementia will have access to co-ordinated care, delivered in a place where that person feels safe. This will be predominantly in the community.
- A person's dementia will be managed in conjunction with other medical conditions through a multi-disciplinary approach.
- Dementia care will be evidence based with the aim of maintaining independence for as long as possible, whilst causing the least possible harm.
- Anyone receiving dementia care will be fully informed of the potential complications of their condition and its treatment, and will be empowered to access advice 24 hours a day.
- Anyone who has dementia alongside other health and social problems will receive co-ordinated care through their care navigator.
- Anyone with dementia will be encouraged to write, with the support of family/carers, an Advance Care plan. They will be supported to access information concerning legal and ethical issues.
- A carer for someone with dementia will be considered a healthcare partner who is vital to the planning and delivery of care. They will be empowered to access advice 24 hours a day. Their needs will be acknowledged and respite care offered accordingly.
- All residential and nursing home placements will be supported by staff with dementia training. These staff will be empowered to access advice for people with dementia 24 hours a day.
- Anyone who has experienced dementia services in the UHB will be encouraged to offer feedback about their experiences and to contribute to the development of future services.

Dementia - Unplanned Care

- Anyone with dementia who develops an acute medical problem will receive assessment and care in the community, where safe to do so.
- Anyone with dementia who is admitted to hospital will receive care for their dementia alongside their additional medical problem by staff experienced in dealing with dementia.
- Anyone who is admitted to hospital and suspected of having a dementia diagnosis will be rapidly assessed, diagnosed and referred to the appropriate services.
- Anyone with dementia who is admitted to hospital will be cared for in an environment that supports and empowers them to remain independent.
- Anyone with dementia who requires admission to hospital will have a rapid but safe discharge, co-ordinated with their carer/family/care navigator and facilitated through the rapid provision of support and any necessary equipment in the community.

“To be a respected as an individual.”



“All I want is a way to live life positively and as normal as possible”



“I want to have choices even if those choices are perceived to be wrong or misguided.”



“Carers need accurate up-to-date information about services and entitlements.”



Click to return to ‘Standards for Service Priorities’

Dementia – End of Life Care

- The Advance Care plan of a person with dementia will be acknowledged and respected.
- Everyone with dementia will have a dignified end to life, in a location of their choosing, with all treatment decisions focussed on the individual’s goals/aspirations.
- End of life symptoms will be managed at home, if so desired, by appropriately trained health care professionals.

SHAPING OUR FUTURE WELLBEING - DENTAL & EYE CARE

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



THIS IS OUR VISION OF DENTAL AND EYE CARE OVER THE NEXT 10 YEARS, CREATED BY PEOPLE WHO BOTH USE AND PROVIDE CURRENT SERVICES

PREVENTION

We will support the residents of Cardiff and the Vale and the employees of the Health Board to adopt healthy lifestyles, creating an environment that encourages good dental and eye health and wellbeing. Through the success of existing and the development of new prevention programmes our people will have an increased awareness of the causes and early warning signs of dental and eye conditions. Early detection of disease will be accompanied by clear signposting of where to seek help. By focussing our care where it is most needed, we will work to reduce health inequalities.

PLANNED CARE

The needs of an individual with a dental or eye condition will be central to their care. Their feedback will be integral to the development of future services. Equal access to care and information will be assured for anyone with a sensory loss. We will ensure rapid diagnosis and delivery of evidenced based treatment, with clear signposting of all services and support available to maintain psychological social and physical wellbeing. Care will be co-ordinated by a key worker and delivered in the community where possible. Support will be offered to carers, recognising their role as vital healthcare partners.

UNPLANNED CARE

Anyone with a dental and/or eye condition who becomes medically unwell will receive rapid community assessment and treatments from a multidisciplinary team. All health care professionals will ensure that the dental and eye care needs of any individuals admitted to hospital or staying in residential care will be met, working together with each individual to enable the best possible recovery. Discharge from hospital will be co-ordinated with community services and carers/family by a key worker and facilitated by the rapid provision of any required support and equipment.

END OF LIFE CARE

The end of a person's life will be dignified and focussed on achieving his/her own goals and aspirations. The person will be able to choose where they would wish to receive care at the end of their life and we will ensure that staff and facilities are available at home, in the community and in hospital which allow people to remain with their families and friends.

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Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
Cardiff and Vale
University Health Board

KEY



DIGITAL/
INTERNET



ELECTRONIC PATIENT
HELD RECORD



HOME FIRST



COMMUNITY



HOSPITAL

ACHIEVE JOINED UP CARE BASED ON 'HOME FIRST', AVOIDING HARM, WASTE AND VARIATION, EMPOWERING PEOPLE AND DELIVERING OUTCOMES THAT MATTER TO THEM.

Dental and Eye Health Outcomes

People are aware of and are supported in minimising their risk of dental and eye conditions through healthy lifestyle choices

People receive fast, effective treatment and care so they have the best possible chance of maintaining their vision and oral health

People who care for family members or friends, as well as clinical staff, are supported to maintain their health and wellbeing, with local services which are easy to understand and navigate

Dental and eye conditions are detected quickly where they occur or recur

People are placed at the heart of dental and eye care with their individual needs identified and met so they feel well supported and informed, and able to manage the effects of dental and eye conditions on their lives

The end of a person's life is dignified and care is directed at achieving their own goals and aspirations

Dental And Eye Health Service Standards

Dental and Eye - Prevention

- People living in Cardiff and the Vale of Glamorgan will be supported to take opportunities that improve their health and wellbeing.
- We will have effective methods of identifying those at risk of developing dental and/or eye conditions and we will actively manage those risks, working to reduce healthcare inequities.
- We will build on the success of existing prevention programmes (Designed to Smile, Diabetic Retinopathy Screening Service for Wales) to support the dental, eye and general health of our population. This will begin in the early years, through school and into adult life, in a manner best suited to the needs of each community.
- We will develop an eye health public awareness and education campaign to encourage people to have regular sight tests. Raising awareness of the importance of eye health and the need to use eye care services is essential to preventing sight loss and improving eye health.
- We will have effective methods for ensuring the early detection of dental and eye conditions, which are accessible to our whole population and thus aim to reduce inequity of access to healthcare.
- All health professionals will take an active, 'Making Every Contact Count' approach to the prevention and early recognition of dental and eye conditions.
- Effective oral and eye care will be provided to all UHB in-patient admissions and to all residential and care home residents.
- The UHB will support employees to adopt healthy lifestyles both in and outside of work, encouraging a positive work/life balance.



“Treat people as individuals.”

“Important care priorities should be pain management in an emergency.”



“Inform patients of the inevitable waiting time to decrease patient anxiety.”



Dental and Eye - Planned Care

- All people with dental or eye conditions will be considered as the primary health care partner and will be central to the planning and delivery of their own care.
- Anyone with a dental and/or eye condition will be supported to monitor and self-manage their condition to a level they are comfortable with, agreed in partnership with their health care professional, resulting in an individualised care plan available 24 hours a day to support their care.
- Dental and eye care will be equally accessible and accommodating to all, and suited to an individual's cultural or social needs.
- Everyone will have equal access to care and information when affected by a sensory loss.
- Everyone will receive co-ordinated dental and eye care which is delivered predominantly in the community, by a multidisciplinary team from both primary and secondary care.
- Anyone who is diagnosed with a dental or eye condition will receive clinical, psychological, and social support when needed, at any point in their care in order to enable their best possible health and wellbeing. Available services will be clearly signposted and will include services and support offered by our partners in the community.
- Dental and eye care will be evidence based and delivered according to current national standards, causing the least possible harm and ensuring minimum waste.
- Anyone who is diagnosed with dental or eye cancer will receive care that fulfils the UHB's 10 year vision of care for cancer.
- Anyone receiving dental and eye care will be fully informed of the potential complications of their treatment and underlying condition and be able to access advice 24 hours a day.
- Young people transferring from children's to adult dental or eye services will have a transition that is purposeful, planned and supported.
- A carer for someone with a dental or eye condition will be considered a healthcare partner who is vital to the planning and delivery of care. They will be empowered to access advice 24 hours a day. Their needs will be acknowledged and respite care offered accordingly.
- Anyone who has experienced dental and eye services in the UHB will be encouraged to offer feedback about their experiences and to contribute to the development of future services, paying particular attention to sensory losses.

Dental and Eye - Unplanned Care

- Everyone will have access to predominantly community based services for dental and eye conditions, supported by a co-ordinated hospital based service.
- There will be 24 hour access to advice and assessment if indicated.
- Anyone with a dental or eye condition who is admitted to hospital will be cared for in an environment that supports and empowers them to remain independent.
- Anyone admitted to hospital will receive care for their dental or eye condition alongside their additional medical problem(s).

Dental and Eye - End of Life Care

- Anyone with less than 6 months to live will be supported to write an Advance Care plan that includes their dental and/or eye care needs. This plan may evolve over time, but will always have the needs/desires of the patient and their family/carers at its core.
- An Advance Care plan of a person with a dental or eye condition will be acknowledged and respected.
- Everyone with a dental or eye condition will have a dignified end to life, in a location of their choosing, with all treatment decisions focussed on the individual's goals/aspirations.
- End of life symptoms will be managed at home, if so desired, by appropriately trained health care professionals.

“Where do I go for help when I have a problem?”



“I want more info about how to manage my condition without a hospital visit”



“Avoid wasting people's time.”



“Try not to interfere so greatly with the day-to-day living of patients and their families.”



Click to return to
‘Standards for
Service Priorities’

Long Term Conditions Outcomes

People are aware of and are supported in minimising their risk of long term conditions through healthy lifestyle choices

People receive fast, effective treatment and care to minimise the impact that a long term condition may have on their general health and wellbeing

People who care for family members or friends, as well as clinical staff, are supported to maintain their health and wellbeing, with local services which are easy to understand and navigate

Long term conditions are detected quickly where they occur or recur

People are placed at the heart of care for long term conditions with their individual needs identified and met so they feel well supported and informed, and able to manage the effects of long term conditions on their lives.

The end of a person's life is dignified and care is directed at achieving their own goals and aspirations

Long Term Conditions Service Standards

LTC- Prevention

- People living in Cardiff and the Vale of Glamorgan will be supported to take opportunities that improve their health and wellbeing.
- We will identify an individual's risk of developing long term conditions and will support people to manage their risk.
- We will work to reduce health inequalities and to reduce the greater risk of death from long term conditions in our most deprived communities.
- There will be clear programmes and policies to reduce preventable long term conditions, which offer support to those with established risks. This will begin in the early years, through school and into adult life, in a manner best suited to the needs of each community.
- We will have effective methods for ensuring the early detection of long term conditions. These will be focussed in the areas of greatest need but will be accessible by our whole population.
- All health professionals will take an active 'Making Every Contact Count' approach to the prevention and early recognition of long term conditions.
- The UHB will support employees to adopt healthy lifestyles both in and outside of work, encouraging a positive work/life balance.



"Help me to make the right choices."

"Give me relevant advice when I need it."



"I want to take part in my own care."



LTC - Planned Care

- A person with a long term condition will be considered an active health care partner who is central to the planning and delivery of their own care.
- Services for people with long term conditions will be equally accessible to all, and suited to an individual's cultural and/or social needs.
- Healthcare appointments will be coordinated so that each appointment has maximum benefit and none are wasted.
- Anyone with a long term condition will be supported to monitor and self manage their condition to a level agreed in partnership with their health care professional, resulting in an individualised care plan available 24 hours a day to support their care.
- Everyone will be empowered to take responsibility for their own long term condition, and, where desired, make fully informed choices about its management.
- A person with a long term condition will be fully informed of the potential complications of their condition and its treatment. They will be empowered to access timely advice and support as needed.
- Care for long term conditions will be holistic, coordinated and delivered predominantly in the community, by a multidisciplinary team.
- Anyone who is diagnosed with a long term condition will receive clinical, psychological, and social support as needed, at all points in their care to enable their best possible health and wellbeing. Available services will be clearly signposted and will include services and support offered by our Partners in the community.
- Care for individual long term conditions will be standardised, evidence based and delivered to national standards, whilst causing the least possible harm and ensuring minimum waste.
- Young people transferring from children's to adult services will have a transition that is purposeful, planned and supported.
- A carer for someone with a long term condition will be considered a healthcare partner who is vital to the planning and delivery of care. They will be empowered to access advice 24 hours a day. Their needs will be acknowledged and respite care offered accordingly.
- Anyone who has experienced services for long term conditions in the UHB will be encouraged to offer feedback about their experiences and to contribute to the development of future services.

LTC - Unplanned Care

- Anyone with a long term condition who has an acute medical problem will receive assessment and care in the community where safe to do so.
- Anyone with a long term condition who is admitted to hospital will be offered timely access to a team with specialist knowledge of their condition.
- Anyone with a long term condition who is admitted to hospital will be cared for in an environment that enables them to remain independent.
- Anyone with a long term condition who requires admission to hospital will have a timely and safe discharge, co-ordinated with community services, carers and their family, and facilitated through the rapid provision of support and any necessary equipment in the community.

LTC - End of Life Care

- Anyone diagnosed with a long term condition, whose life expectancy is less than 6 months, will be supported to develop an Advance Care plan. These plans may evolve over time, but will always have the needs/desires of the patient and their carer at its core.
- The Advance Care plan of a person with a long term condition will be acknowledged and respected.
- Everyone with a long term condition will have a dignified end to life, in a location of their choosing, with all treatment decisions focussed on the individual's goals/aspirations.
- End of life symptoms will be managed at home, if so desired, by appropriately trained health care professionals.

“Ask what matters to the patient and their family.”



“It is important to be treated like a person not just the condition.”



“I want to be well informed about my care.”



“Minimise the impact on my life.”



Click to return to 'Standards for Service Priorities'

SHAPING OUR FUTURE WELLBEING - MATERNAL HEALTH

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



THIS IS OUR VISION OF MATERNAL HEALTH CARE OVER THE NEXT 10 YEARS, CREATED BY PEOPLE WHO BOTH USE AND PROVIDE CURRENT SERVICES

PREVENTION

We will support the people of Cardiff and the Vale and the employees of the Health Board to adopt healthy lifestyles, creating an environment that encourages good physical and sexual health and, where this is the best option, supports the mother to breastfeed. People will have an increased awareness of lifestyle factors that are associated with causing complications during pregnancy and birth. We will work with women and their families to reduce their particular risks. We will work to improve awareness and the identification of maternal mental health conditions, ensuring early identification and offering support and treatment to affected mothers. By focussing our care where it is most needed, we will continue to reduce health inequalities.

PLANNED CARE

The physical and psychological needs of a pregnant woman will be central to the planning of their maternity care and services will be developed in response to their feedback. Care will be safe, effective and evidence based and delivered predominantly in the community. A woman will be supported by a named midwife to make decisions about their care, to monitor their own health and where necessary, that of their unborn child. With a focus on supporting natural birth and limiting unnecessary intervention, a woman and her family will be empowered to make informed decisions that give their baby the best start in life.

UNPLANNED CARE

The physical and psychological needs of a pregnant woman will be central to the planning of their maternity care and services will be developed in response to their feedback. Care will be safe, effective and evidence based and delivered predominantly in the community. A woman will be supported by a named midwife to make decisions about their care, to monitor their own health and where necessary, that of their unborn child. With a focus on supporting natural birth and limiting unnecessary intervention, a woman and her family will be empowered to make informed decisions that give their baby the best start in life.

END OF PREGNANCY CARE

We will continue to support women and their families following the birth of their child, recognising that postnatal mental health issues in particular can occur beyond the immediate post partum period. All women whose pregnancy and/or birth have been complicated or traumatic in nature will be treated with dignity and compassion, and offered access to a counselling service. The opportunity to meet with a health care professional will enable parents and their family to better understand the events that occurred and to minimise pregnancy risks in the future.

For more information visit www.bit.ly/SOFWHome

CARING FOR PEOPLE, KEEPING PEOPLE WELL



KEY

- DIGITAL/INTERNET
- ELECTRONIC PATIENT HELD RECORD
- HOME FIRST
- COMMUNITY
- HOSPITAL

Maternal Health Outcomes

Women are aware of and are supported to make healthy lifestyle choices to ensure the health of themselves and their babies during pregnancy

Women receive safe, effective treatment and care so they have the best possible chance of a healthy pregnancy, baby and start to their baby's life

Parents at the end of pregnancy feel confident to care for their baby

Women who have had prior complications in pregnancy or who have medical conditions that confer a risk to a future pregnancy will be given sufficient information and support pre-conceptually to maximise the safety of future pregnancies

Women are placed at the heart of their pregnancy care with their individual needs identified and met so they feel well supported and informed, able to manage any side effects of pregnancy

Parents whose baby dies during pregnancy or in the post natal period are treated with dignity and compassion, and are supported to understand the events that took place and to effectively plan for the future

Maternal Health Service Standards

Maternal Health- Prevention

- Women within Cardiff and the Vale of Glamorgan will be supported to take opportunities that improve their own reproductive health and to ensure the best possible wellbeing for themselves and their babies.
- We will address the risk factors for low birth weight in the community, including factors such as smoking and substance misuse, to reduce the number of low birth weight babies and reduce inequalities.
- All pregnant women will be aware of, and offered, all relevant vaccinations against serious illness for both themselves and their unborn child/children.
- We will have effective methods of identifying those at risk of pregnancy/birth complications and we will actively manage that risk in partnership with the pregnant woman, working to reduce health inequities.
- There will be clear programmes and policies to improve the reproductive health of women. Young people will be fully supported to improve sexual health and wellbeing and reduce the number of unwanted pregnancies.
- There will be an environment and culture within the UHB and local community that empowers, promotes and supports mothers to breast feed where this is the best option for the mother.
- There will be improved awareness and identification of maternal mental health conditions, with services in place to support early identification and treatment of affected mothers.
- Partners of pregnant women will be involved in prevention and care discussions wherever possible and appropriate, and in line with the wishes of the woman, to ensure the newborn baby is brought into a supportive and engaged family environment.
- The UHB will support employees to adopt healthy lifestyles both in and outside of work, encouraging a positive work/life balance.



“Children should learn about pregnancy and birth in school.”



Maternal Health- Planned Care

- A pregnant woman will know how to access and register with midwifery services and will feel empowered to do so.
- A pregnant woman will be considered an active partner in the planning and delivery of her own maternity care. She and her family will be supported in making informed decisions about this care.
- A pregnant woman will have a named midwife to provide support appropriate to her and her family's needs.
- Care for a pregnant woman will be safe, effective and evidence based, aimed at supporting natural birth and limiting unnecessary intervention.
- A pregnant woman will receive care which is family centred, responsive to her needs, and predominantly delivered in the community.
- A pregnant woman who has a pre-existing medical condition will receive coordinated care from a multi-disciplinary team, including health care professionals with specialist knowledge of that condition.
- Pregnant women will be empowered and supported to monitor their own and, where necessary, their unborn baby's health, and to access advice, support and assessment 24 hours a day.
- Building on our work to reduce health inequalities, we will offer education and support that enables families to provide their baby with the best start in life.
- All women will receive appropriate support throughout and following pregnancy to maintain their psychological and mental wellbeing.
- All women will be supported to make an informed choice about the preferred location of birth. This plan may evolve over time, but will always have the needs/desires of the mother at its core.
- Women who access maternity services when in suspected or active labour will receive the same standard of care 24 hours a day, 7 days a week, wherever they live.
- A woman who has booked for antenatal care in the UHB and subsequently develops complications of pregnancy requiring pre-term delivery, will give birth in the UHB unless extraordinary pressures preclude.
- Anyone who has experienced maternity services in Cardiff and Vale UHB will be empowered to offer feedback about their experiences and to contribute to the development of future services.

Maternal Health- Unplanned Care

- A pregnant woman and her family who have concerns during pregnancy or the post-partum period will have access to high quality advice 24 hours a day.
- A pregnant woman will be empowered to access assessment when they are concerned about their wellbeing or that of their unborn child, and will be regarded as equal partners by those who assess them.
- A pregnant woman who accesses emergency health services will receive care from healthcare professionals who are trained to recognise the symptoms and signs of major complications in pregnancy, and who are able to arrange the best outcome for a mother and her baby.
- A pregnant woman who is admitted to hospital will be cared for in an environment that supports and enables her to remain independent and actively involved in her own care.

End of Pregnancy Care

- We will recognise that postnatal depression can occur beyond the immediate post-partum period and will offer and support women and their families to access mental health services beyond this time.
- All women and their partners who have been traumatised by their pregnancy or suffered an adverse pregnancy outcome will be offered post-natal counselling.
- All women who have long term medical conditions, inheritable conditions or who have suffered medical or pregnancy related complications in a previous pregnancy will be offered pre-pregnancy counselling and planning.
- A family whose baby dies at any point during pregnancy or following delivery, will be treated with compassion and dignity. Parents will be offered bereavement counselling and an opportunity to meet with health care professionals at a time most suited to their needs.

“I want to be safe and I want my baby to be safe.”



“There needs to be a change of culture, treating the mother as the expert”



“A good birth requires more than just surviving birth.”



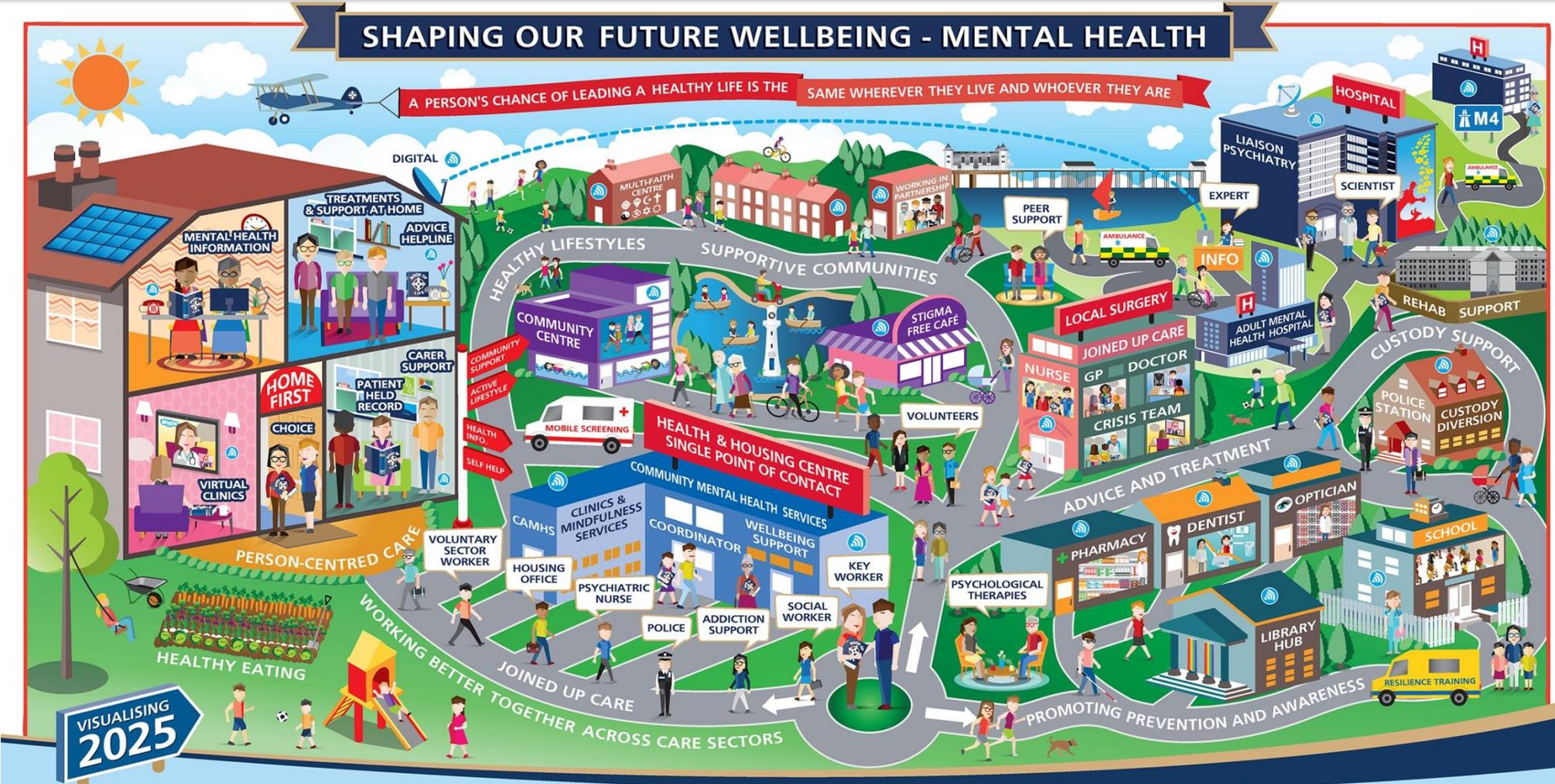
“Husbands and birthing partners should feel empowered too.”



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SHAPING OUR FUTURE WELLBEING - MENTAL HEALTH

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



VISUALISING 2025

THIS IS OUR VISION OF MENTAL HEALTH CARE OVER THE NEXT 10 YEARS, CREATED BY PEOPLE WHO BOTH USE AND PROVIDE CURRENT SERVICES

PREVENTION

We will support the residents of Cardiff and the Vale and the employees of the Health Board to adopt healthy lifestyles, creating an environment that encourages good health and wellbeing. Health professionals will work to remove the stigma of mental health conditions. Effective and accessible methods of ensuring the early detection of mental health conditions will be accompanied by clear signposting of where to seek help. By focussing our care where it is most needed, we will work to reduce health inequalities.

PLANNED CARE

The needs of the person with a mental health condition will be central to their care. We will ensure rapid diagnosis and delivery of evidence based treatment, with clear signposting of all services and support available. People will be supported to monitor and manage their condition in partnership with their healthcare professionals. Care will be co-ordinated by a key worker and delivered in the community where possible. People will be supported to live with the impact that their mental health condition has on their physical, psychological and social wellbeing. Their feedback will be essential to the development of future services. Support will be offered to carers, recognising their role as vital healthcare partners

UNPLANNED CARE

People with an established or new onset mental health condition who require emergency assessment will have access to 24 hour specialist advice, triage and assessment. Anyone accessing emergency health services, whose symptoms and investigation are suggestive of a mental health condition, will have immediate access to a mental health assessment service. Anyone with a known mental health condition who presents to emergency health services will be diverted, if safe and effective to do so, into mental health services. If accessing emergency health services, a person with a known mental health condition will be immediately co-managed by a specialist mental health team. Discharge from hospital will be co-ordinated by a key mental health worker.

END OF LIFE CARE

The end of a person's life will be dignified and focussed on achieving his/her own goals and aspirations. A person will be able to choose where they wish to receive care at the end of their life and we will ensure that staff and facilities are available at home, in the community and in hospital which allow people to remain with their families and friends.

For more information visit www.bit.ly/SOFWHome

CARING FOR PEOPLE, KEEPING PEOPLE WELL



Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board

KEY

- DIGITAL/INTERNET
- HOME FIRST
- COMMUNITY
- HOSPITAL
- ELECTRONIC PATIENT HELD RECORD

Mental Health Outcomes

People are aware of and are supported in minimising their risk of mental health issues through healthy lifestyle choices

People receive fast, effective treatment and care so they have the best possible chance of cure

People who care for family members or friends, as well as clinical staff, are supported to maintain their health and wellbeing, with local services which are easy to understand and navigate

Mental health issues are detected quickly where they occur or recur

People are placed at the heart of mental health care with their individual needs identified and met so they feel well supported and informed, and able to manage the effects of mental health issues on their lives

The end of a person's life is dignified and care is directed at achieving their own goals and aspirations

Mental Health Service Standards

Mental Health - Prevention

- People living in Cardiff and the Vale of Glamorgan will be supported to take opportunities that improve their own health and wellbeing.
- We will have effective methods of identifying those at risk of developing mental health conditions and we will actively manage that risk, working to reduce health inequalities.
- There will be clear programmes and policies to ensure the mental health of our population. This will begin in the early years, through school and into adult life, in a manner best suited to the needs of each community. Those at greatest risk will be identified early and offered appropriate psychological and/or medical interventions.
- We will have effective methods for ensuring early detection of mental health conditions. These will be focussed in the areas of greatest need but will be accessible by our whole population.
- Community based resources will provide self help information and support to people with early symptoms of mental health disorders, in order to prevent progression to more significant conditions.
- We will work to remove the stigma of mental health conditions within both the UHB and the population it serves.
- All health professionals will take an active 'Making Every Contact Count' approach to the prevention and early recognition of mental health conditions.
- The UHB will support employees to adopt healthy lifestyles both in and outside of work, encouraging a positive work/life balance.



“I want to see the right person and get the right care.”

“I want to feel confident in the support being offered.”



“I want to be safe and feel safe.”



Mental Health - Planned Care

- Anyone with a symptom suggestive of a mental health condition will be able to access a health care professional without delay. Following contact with a suitable clinician, emergency referrals will be seen by a mental health specialist within 4 hours of referral.
- Anyone who is diagnosed with a mental health condition will receive clinical, psychological and social support at all points in their care to enable their best possible health and wellbeing. Available services will be clearly signposted and will include services and support offered by our partners in the community.
- Anyone with a mental health condition will be considered an active health care partner who is central to the planning and delivery of their own care.
- Anyone with a mental health condition will be supported to monitor and self-manage their condition to a level agreed in partnership with their healthcare professional, resulting in an individualised care plan, which will be available 24 hours a day, to support their care.
- Anyone with a mental health condition will have holistic care delivered by a multidisciplinary team. This care will be evidence based and delivered according to current national standards, offering the best chance of cure/long term remission whilst causing the least possible harm.
- Care for a person with a mental health condition will be equally accessible and accommodating to all, and suited to an individual's cultural and/or social needs.
- Everyone receiving mental health care will be fully informed of the potential complications of their condition and its treatment, and will be empowered to access advice, support and assessment 24 hours a day.
- Everyone with a mental health condition will receive co-ordinated care delivered in a place where that person feels safe. This will be predominantly in the community.
- Anyone with a mental health condition who needs urgent assessment will be referred, 24 hours a day, to a specially trained health care professional.
- Anyone who has a mental health condition alongside other health or social problems will receive co-ordinated care between mental health and other health and social care services.
- Young people transferring from children's to adult mental health services will have a transition that is purposeful, planned and supported.
- A carer for someone with a mental health condition will be considered a healthcare partner who is vital to the planning and delivery of care. They will be empowered to access advice 24 hours a day. Their needs will be acknowledged and respite care offered accordingly.
- Anyone who has experienced mental health services in the UHB will be encouraged to offer feedback about their experiences and to contribute to the development of future services.

Mental health - Unplanned Care

- Anyone with either a new onset or established mental health condition will have access to a specialist service providing 24 hour triage and assessment of emergency mental health disorders. Following triage, an assessment will take place within 4 hours for emergency cases, 48 hours for urgent cases and 4 weeks for routine referrals.
- There will be 24 hour access to mental health advice for anyone who has a mental health condition, their carer, or a health care professional with concern.
- If accessing emergency health services, anyone with a known mental health condition will be immediately co-managed by a team with specialist knowledge of mental health conditions.
- When accessing emergency health services, anyone whose initial investigations are suggestive of a mental health condition, will have immediate access to a mental health assessment service.
- Anyone with a known mental health condition who presents to emergency health services will be diverted, if safe and effective to do so, into mental health services.

“I want to be respected and valued as an individual and be able to shape my own support plan.”



“People should be supported to live their life to its full potential.”



“It is important that I have a good discharge plan and support network when I leave hospital.”



“I want to know that support is accessible and available when I need it.”



Mental Health - End of Life Care

- Anyone who has a mental health condition whose life expectancy is less than 6 months will be supported to develop an Advance Care plan. Developed in partnership with mental health services this plan may evolve over time, but will always have the needs /desires of the patient and their carer at its core.
- An Advance Care plan of anyone with a mental health condition will be acknowledged and respected.
- Anyone with a mental health condition will have a dignified end to life, in a location of their choosing, with all treatment decisions focussed on the individual's goals /aspirations.
- End of life symptoms will be managed at home, if so desired, by appropriately trained health care professionals.

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SHAPING OUR FUTURE WELLBEING - STROKE

A PERSON'S CHANCE OF LEADING A HEALTHY LIFE IS THE SAME WHEREVER THEY LIVE AND WHOEVER THEY ARE



THIS IS OUR VISION OF STROKE CARE OVER THE NEXT 10 YEARS, CREATED BY PEOPLE WHO BOTH USE AND PROVIDE CURRENT SERVICES

PREVENTION

We will support the people of Cardiff and the Vale and the employees of the Health Board to adopt healthy lifestyles, creating an environment that encourages good health and wellbeing. People will have an increased awareness of the causes of stroke and will be able to spot early warning signs. Effective and accessible methods of ensuring the early detection of stroke will be accompanied by clear signposting of where to seek help. By focussing our care where it is most needed, we will work to reduce health inequalities.

PLANNED CARE

The needs of the person who has had a stroke will be placed at the centre of their care and services developed according to their feedback. We will ensure rapid diagnosis and delivery of evidence based treatment, with clear signposting of all services and support available. People will be supported to monitor and manage their condition in partnership with their healthcare professionals. Care for people who have had a stroke will be co-ordinated by a key worker and delivered in the community where possible, aiming to achieve outcomes that matter to people. Families and friends caring for someone who has had a stroke will be supported in that role.

UNPLANNED CARE

People who have had a stroke who become medically unwell will receive rapid community assessment and treatments which may reduce the need for hospital admission. To enable the best possible outcome, anyone who has a stroke who is admitted to hospital will be offered timely access to a team with specialist knowledge of their condition. Discharge from hospital will be co-ordinated with community services and carers/family by a key worker and facilitated by the rapid provision of any required support and equipment.

END OF LIFE CARE

The end of a person's life will be dignified and focussed on achieving his/her own goals and aspirations. The person will be able to choose where they would wish to receive care at the end of their life and we will ensure that staff and facilities are available at home, in the community and in hospital which allow people to remain with their families and friends.

For more information visit www.bit.ly/SOFWHome

CARING FOR PEOPLE, KEEPING PEOPLE WELL



Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board

KEY



DIGITAL/INTERNET



ELECTRONIC PATIENT HELD RECORD



HOME FIRST



COMMUNITY



HOSPITAL

ACHIEVE JOINED UP CARE BASED ON 'HOME FIRST', AVOIDING HARM, WASTE AND VARIATION, EMPOWERING PEOPLE AND DELIVERING OUTCOMES THAT MATTER TO THEM.

Stroke Outcomes

People are aware of and are supported in minimising their risk of stroke through healthy lifestyle choices

People receive fast, effective treatment and care to minimise the impact that a stroke may have on their health and wellbeing.

People who care for family members or friends, as well as clinical staff, are supported to maintain their health and wellbeing, with local services which are easy to understand and navigate

People recognise the signs of stroke and strokes are detected quickly when they occur

People are placed at the heart of care for stroke and their individual needs identified and met so they feel well supported and informed, and able to manage the effects of stroke on their lives

The end of a person's life is dignified and care is directed at achieving their own goals and aspirations

Stroke Service Standards

Stroke - Prevention

- People living in Cardiff and the Vale of Glamorgan will be supported to take opportunities that improve their own health and wellbeing, minimising the risk of stroke.
- We will identify an individual's risk of developing stroke and will support people to manage their risk.
- We will work to reduce health inequalities and to reduce the greater risk of death from stroke in our most deprived communities.
- There will be clear programmes and policies to reduce preventable stroke, which offer support to those with established risks. This will begin with lifestyle choices and will be tailored to the community.
- The management of cardiovascular risk, including smoking and blood pressure control as well as atrial fibrillation detection are key areas of focus.
- We will have effective methods for ensuring the early recognition and detection of stroke. These will be focussed in the areas of greatest need but will be accessible by our whole population.
- All health professionals will take an active 'Making Every Contact Count' approach to the prevention and early recognition of stroke.
- The UHB will support employees to adopt healthy lifestyles both in and outside of work, encouraging a positive work/life balance.



"Everyone should be able to identify the signs of a stroke."

"Make it easier for me to take more exercise."



"I want to know when I'm at risk of a stroke."

Stroke – Care Planning

- A person living with stroke will be considered an active health care partner who is central to the planning and delivery of their own care.
- Services for people living with stroke will be equally accessible to all, and suited to an individual's cultural and/or social needs.
- Anyone living with stroke will be supported to self manage their condition to a level agreed in partnership with their health care professional, resulting in an individualised care plan available 24 hours a day to support their care.
- Everyone will be empowered to take responsibility for managing their life after stroke and, where desired, make fully informed choices about on going care.
- A person living with stroke will be fully informed of the potential complications and its on going treatment. They will be empowered to access timely advice and support as needed.
- Care for people living with stroke will be holistic, coordinated and delivered predominantly in the community, by a multidisciplinary team working with social care, local authorities and voluntary sector organisations..
- Anyone living with stroke will receive clinical, psychological, and social support as needed, at all points in their care to enable their best possible health and wellbeing. Available services will be clearly signposted and will include services and support offered by our Partners in the community.
- Care for people living with stroke will be standardised, evidence based and delivered to national standards, whilst causing the least possible harm and ensuring minimum waste.
- A carer for someone living with stroke will be considered a healthcare partner who is vital to the planning and delivery of care. They will be empowered to access advice 24 hours a day. Their needs will be acknowledged and respite care offered accordingly.
- Anyone who has experienced services for stroke in the UHB will be encouraged to offer feedback about their experiences and to contribute to the development of future services.

Stroke -Unplanned Care

- Anyone living with stroke who has an acute medical problem will receive assessment and care in the community where safe to do so.
- Anyone living with stroke who is admitted to hospital will be offered timely access to a team with specialist knowledge of their condition.
- Anyone living with stroke who is admitted to hospital will be cared for in an environment that maximises independence.
- Anyone living with stroke who requires admission to hospital will have a timely and safe discharge, co-ordinated with community services, carers and their family, and facilitated through the rapid provision of support and any necessary equipment in the community.

Stroke – End of Life Care

- Anyone diagnosed with stroke, whose life expectancy is less than 6 months, will be supported to develop an Advance Care plan. These plans may evolve over time, but will always have the needs/desires of the patient and their carer at its core.
- The Advance Care plan of a person who has had a stroke will be acknowledged and respected.
- Everyone who has had a stroke will have a dignified end to life, in a location of their choosing, with all treatment decisions focussed on the individual's goals/aspirations.
- End of life symptoms will be managed at home, if so desired, by appropriately trained health care professionals.

“Support me to regain as much function as I possibly can”



“I want the best stroke care, when I need it.”



“Support me in my life after a stroke.”



“I want to feel comfortable when discussing the end of my life.”



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To find out more about the **Shaping Our Future Wellbeing Strategy**, please visit our website at:

www.bit.ly/SOFWHome

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