GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

A Healthier Mid and West Wales
Our Future Generations Living Well

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Contents

FOREWORD

We are delighted to publish our health and care strategy, *A Healthier Mid and West Wales: Our future generations living well.* This is the first time we have set out a vision for services fit for current and future generations. Health and care services are only one part of a complex system that needs to work better together to improve health and well-being outcomes for our population. Our vision has been developed from the shared ambitions of our partners as set out in the well-being plans of Carmarthenshire, Ceredigion and Pembrokeshire Public Services Boards. It seeks to empower communities to work together in areas they care about, and enabled to contribute to each other.

We recognise we are at the beginning of a long journey towards achieving our vision and strategic goals. We want to be ambitious. We want to deliver excellent clinical services (medical, nursing, therapeutic and others) for our population. We also want to maximise the contribution we make to the wider system, with partners and people, in tackling the causes of ill-health through promotion of health and well-being, prevention and early intervention. There are many milestones in our 20-year journey, however we must first develop the building blocks for success. Creating a movement for change through continuous involvement of our staff, patients, people in our communities and those delivering, or interested in, health, care and well-being will be fundamental to win hearts and minds. This is how we will support a change of culture moving to a wellness system, which involves every part of life that affects our health and well-being (a social model for health).

Our strategy signals this shift of focus. We know health and care services make an important contribution to overall health and well-being. Being only part of the picture it's important to recognise that other factors, such as education, housing, employment and leisure, together play a bigger part. To help achieve the strategic goals we set out in our long term vision, we will endeavour to influence and maximise the role the health service can play in keeping people well. A social model for health (see page 24 for more information), presents enormous opportunities for us to think and act differently in the way we deliver health and care services in collaboration with key partners such as the people who live and work in the Hywel Dda area.

We have only got to this point thanks to the involvement of a huge range of people as part of our transformation programmes – "Transforming Clinical Services" and "Transforming Mental Health". These have been clinically led and informed by engaging and consulting with our communities during the last two years and culminating in a formal consultation - Our Big NHS Change. From this we have agreed a set of recommendations for the transformation of health and care services, which we are now translating into a long-term strategy for how we meet the needs of the communities we serve.

This strategy outlines the principles we will follow to achieve this vision and is the next part of our transformation journey. It is not a detailed plan. It sets the context within which we will plan the necessary changes during the coming years, and make key decisions about the shape of services and how we will use our resources. Our detailed planning will enable us to deliver our strategy for future health and care. We have made a commitment to work closely with our communities. This will include a move to continuous engagement, supporting meaningful involvement of staff, public and communities in how services are designed and provided, and how we play our part in the wider system.

We have used our mid and west Wales family Teulu Jones, the Jones Family, throughout our transformation programme to test different changes to our health and care system through a person and family lens, and you will see them throughout this strategy to show how these changes will look and feel for families 20 years from now.

In this next step in our transformation programme, you will find an indication of our aspiration for the types of services you can expect to receive locally to you, based on what we have learned so far. We will also signal where we are already making changes or where you can expect to see these changes first. Nevertheless we do recognise the further scoping we have to do, which will rely heavily on our ongoing engagement with local people and staff. Our responsibility to sustain our services means our planning needs to be flexible enough to maintain quality and safety of care whilst also harnessing advantages that advancements can bring. For example, enhancements in technology, advances in clinical knowledge and understanding, and increasing utilisation of evidence based medicine to improve population health and well-being.

We have been guided by the Welsh Government's four goals for the health and care system in Wales (the Quadruple Aim) in prioritising the changes we need to make. These four aims are:

1. Improved population health and well-being
2. Better quality and more accessible health and social care services
3. Higher value health and social care
4. A motivated and sustainable health and social care workforce

These aims are reflected in the design principles set out in the **A Healthier Wales: our Plan for Health and Social Care 2018**, defining the Welsh Government's long term vision of a whole system approach to health and social care. It builds on the ambitions set out in Welsh legislation which directs how we should work together with our partners including the **Social Services and Well-being (Wales) Act 2014** and the **Well-being of Future Generations (Wales) Act 2015.**

At an early stage, our clinicians identified their commitment to design services that are **safe, sustainable, accessible and kind** for today and for future generations. Time and again we heard these themes echoed by patients and members of the public during our engagement and consultation exercises. These four words became our guiding principles and we used them to measure any proposals we made.

We are enormously grateful to all those who have contributed to the development of our strategy, including: our staff, patients, families and carers, local people, Hywel Dda Community Health Council (CHC), our local authorities, neighbouring health boards, Welsh Ambulance Services NHS Trust (WAST), third sector organisations, local stakeholder and interest groups and many more. We are committed to continuing this conversation as we implement our strategy, through continuous engagement and co-design of the detailed plans.

Having this strategy in place means we can be sure that our immediate and medium-term planning is aligned to deliver our long-term vision. We hope our staff will see how they have and can continue to contribute to realising the vision. Our greatest asset is the people we employ to provide our services and care for our patients, those who work with us as volunteers and in work experience roles, and staff within partner organisations. We will continue to support our existing and future staff as the organisation transforms, so that staff are reassured of our commitment to them, are fully informed, involved and influence future service models.

Equally we hope local people will be able to understand and support the decisions and changes we make as we work together, towards our long-term vision.

We will return to our staff and population following approval of this strategy to explain more clearly what this strategy means to them and how they can be continuously involved. This will include a programme of engagement with our staff and the seven localities that make up Hywel Dda(which will mirror our existing primary care clusters but integrated more than primary care services where good structures and relationships are already in place), as well as publication of this strategy in a summary format, 'Easy Read' and other alternative versions.

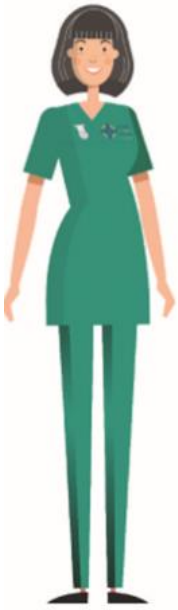
We share a passion and desire to live and work in a healthier mid and west Wales.

Dr Philip Kloer
Medical Director/
Director of Clinical Strategy

Mrs Ros Jervis
Director of Public Health

Mrs Libby Ryan Davies
Transformation Director

What will the future look like for our Hywel Dda family



Hello, my name is Sioned, my family and I live in west Wales. Yesterday I watched a documentary about what healthcare was like in 2018, which was 20 years ago. It got me thinking about how much has changed. The way things are today is so much better for me and my family.

My mum, Mari, has dementia and is getting quite frail. All care settings in the Hywel Dda area are dementia friendly, and all staff and volunteers have been trained to spot and assist people with dementia. Mum is listened to and respected, which means she is confident to ask questions and feels in control of her care. It's not just health and care services supporting mum, it's the whole community, as well as mum doing things to help herself.

Mum's village is a dementia friendly community. She does a number of things as part of her 'Stay Well' plan, which help her to stay independent and to keep involved in activities that support her health and well-being. I've been volunteering at the local school, helping the children with reading. While I was there I heard about a new scheme where the year five and six children spend time with local older people; - I must tell mum, she would love that. Mum enjoys going to the Memory Cafe where she meets up with others of her generation and their carers. She also loves her Knit and Natter group and would go every day if she could, her great grandson is never without a new jumper! We all benefit from the new baking recipes she learns at the community centre. It's great to see mum living well and being a valued member of her community.

My husband Rhys has always struggled with his weight and years of me nagging had no effect. Last year, after a heart scare, he started seeing a lifestyle coach and gradually gained the confidence to change. He's now lost three stone and given up smoking! As part of his health and well-being plan he now takes our grandson, Ben, swimming and the two of us have started dance classes. We have so much fun, we haven't laughed so much in ages, it's a real happiness boost. We won't be entering Strictly Come Dancing any time soon, but we've really benefitted from this quality time together and it's good for Ben to see us being active and taking care of ourselves.

Rhys is also a convert to using technology. He wears a device that constantly measures his heart rate, blood pressure and breathing. His lifestyle coach has explained how it works: data are processed and this clever piece of kit sends information to his care team, building up a complete picture of his health that means that even a subtle change is immediately picked up and acted upon. 20 years ago we could just never have imagined all the technology and gadgets we have now to help support us to keep healthy and well. It's incredible to think that only a few years ago hospital doctors used to spend their time writing in large sets of notes, and how advanced we used to think we were with those early versions of mobile phones and also the tests you used to have to travel to hospital for that we can now get in our local communities. It means that his care is personalised and his GP has all the information she needs at her fingertips in Rhys' electronic notes. Rhys has even learned how to interpret the information himself, which helps him feel in control of his health. Most of his appointments are by phone or video call, which cuts down on travel and takes much less time out of his day. It's also meant that Rhys has started to get us outdoors for a walk much more, out into nature and it's amazing how he's become a real advocate for the environment and the sort of things we can do to help look after it for future generations.

My dad, Alun, had a fall and broke his hip earlier this year. We were so pleased that after 48 hours in the main hospital, he was discharged to his local hospital for rehab. This was a weight

off my mind as visiting was so much easier with him being close by. He was cared for by a large team, including nurses, a physiotherapist, occupational therapist, dietitian and a social worker. No matter who he saw, he didn't need to repeat his story because his shared electronic health record was updated every step of the way. He stayed in the local hospital for five days, until he was fit enough to return home with a bit of help from me and my daughter. He has since joined the healthy activity sessions in the local community centre, where he's met up with people he hasn't seen for years, and also made new friends. The advisers there have had a real impact on his daily routine, and he's much more conscious of his diet and daily activity.

I told my daughter Lianne about the documentary and she was struck by how much more available information and support there is to live healthier, happier lives. She said that she's had messages all around her (in school and college, on the television, in magazines) about the importance of the early years to lifelong health, which is why she tries to be a good role model to her son, Ben. He has a mild developmental delay which is likely to mean he will not be as quick to learn as others his age. But he enjoys nursery and he loves telling us all that he learns about healthy food, brushing his teeth, sharing worries, and so on. Even at age three Ben knows what helps us stay well and prevent illness. The teachers are already starting to teach him how food is produced and also how to cook from scratch ingredients – he's bringing home some lovely healthy bites for us all to eat and is helping me cook, although he makes a right mess in the kitchen but it's fun to do this with him. The changes in our neighbourhoods have also helped; it's now much easier and safer to be active outdoors. We have family friendly cycle routes, and we know where all the great walks are close by and near the beautiful seaside. We know how hard the walks are, how to get there if you don't drive and even what to wear on your feet! In the town the fast food outlets have made way for healthy options. The healthy choice is now the easy choice!

I think we now take more responsibility for our own health and well-being and a local community spirit has built up with people looking out for each other and the environment around us. At the same time, access to information, advice and support is readily available. If we need care or treatment, it's easy to access and most things are provided near to home. We hardly ever need to go to the main hospital now, whereas years ago the hospital seemed to always be the first port of call.

INTRODUCTION

Hywel Dda University Health Board (UHB) is one of seven health boards in Wales and serves the population of mid and west Wales. We plan, secure and deliver healthcare for 384,000 people in Carmarthenshire, Ceredigion and Pembrokeshire, managing and paying for the majority of care and support that people receive in hospitals, health centres, GP surgeries, dentists, pharmacists, opticians and other settings, including within the community. As we have a very large border with other counties, communities in south Gwynedd, north Powys and west Glamorgan also rely on our health services. Equally our population access health services, including more specialist care, at hospitals outside of the Hywel Dda area such as Morriston Hospital, in Swansea and University Hospital of Wales, in Cardiff.

The needs of people across Wales have changed significantly since 1948 when the NHS was established. Life expectancy was lower and the most common conditions people faced were infectious diseases, injuries, heart attacks and strokes. Now, more people live into older age and although this is great, it brings with it increasing health and social care issues. The most significant challenge is more people are living with mental health issues and chronic conditions such as diabetes, heart disease, chronic obstructive pulmonary disease and dementia, often in combination. We expect demand for care to grow even further because the population across the region is predicted to increase from around 384,000 residents in 2016 to approximately 410,000 in 2036. Despite all the advances we still have a large gap of over 10 years in in how long people stay healthy between the best off and the worst off in society.

WE HAVE FEWER PEOPLE AGED **25-44** AND MORE PEOPLE AGED **55-79** THAN OTHER PLACES IN WALES.

This directly impacts on the services we provide and creates specific challenges for how we organise and deliver care across the Hywel Dda area. Our workforce challenges are at a critical level, as despite huge effort we continue to find it difficult to recruit and retain the number of permanent staff that we need to deliver our health and care services as they are currently organised. It is one of the main reasons we have not been able to provide services within budget. Some services rely on temporary staff to operate and whilst everyone tries to provide the best care possible, we know that temporary staff cannot provide the same levels of quality and safety as permanent staff. We need to reorganise the way we do things and attract more highly motivated and skilled people to work with us. We also have an ageing estate with many outdated buildings, facilities and digital systems making it difficult to provide care within a modern environment, or to take full opportunity of developments in digital technology that will become vitally important in the years to come.

We share the Welsh Government's vision for everyone to have long, healthy, happy lives. We want people to have control of their own health and well-being, in an environment that enables them to look after themselves and others. We need to make sure we have the right health and social care services to help people stay well, to get better when they are ill, and to live the best life possible when they have problems that will not improve. As a public service, we must offer value for money within budget, and at the same time we have to ensure the care we deliver is safe and of high quality. It is a fine balancing act and if things continue as they are, we face a greater risk of causing harm to those who access the care we provide.

This strategy is our direct response to the challenges we face as a health board and what we have heard from our engagement and consultation so far. Here we share our aspirations and describe how we will transform and deliver health and care services that are fit for the future for everyone. We will accelerate our joined-up work with our partners to deliver integrated health and social care that will improve people's health outcomes and well-being. It requires 'whole system' change, which means addressing every aspect of life that can impact on a person's health and well-being. This whole-system can include hospital services, community services, primary care (such as GP surgeries), social care, people's homes, education, employment, leisure, food and the environment. There is a range of organisations across public, voluntary, independent and private sectors, in multiple settings, involved in these areas, demonstrating the critical need to work together (see page 22 for a full description of the whole system).

We are committed to work in an integrated way across health and social care at a regional and locality level, this could include, where appropriate, single line management at various levels. This strategy sets out an ambition to work in this way across all services and across the whole region. The leadership of the NHS and social care will work closer together than ever before. This is in the spirit of wanting to improve the services we provide, reduce duplication, work differently and join forces on shifting our services towards promoting wellness. Where it makes sense we will consider bringing together our teams in both formal and informal ways. This has already started informally at the executive level and has been happening at the front line for many years. Our commitment is to consider all parts of the system becoming integrated so that it feels like one service for those who need and use health and care.

Because we are setting a direction of travel for the next 20 years, you will not find detailed plans within this document. This will be developed in our short and medium term planning during the coming months and years, and influenced by continuously engaging with people in our seven locality areas. Importantly, Hywel Dda Community Health Council (CHC) has asked us to undertake further work before making any final decisions on changing specific services. This continued work will be driven by the principles and models we set out in this strategy.

In summary, the document covers the following sections:

- **How we developed the strategy** - what is directing our work, the journey we have been on to develop this strategy and how we have remained focused on local people every step of the way

- **Our commitment to the people of mid and west Wales** - including our vision and goals, changing our culture towards a focus on wellness and prevention of ill-health by using our local strengths and resources, and developing health and care services for everyone at all stages of life

- **Our people and communities at the heart** - the direction of travel for developing integrated health and care services which are seamless, across community and hospital services, and across different organisations involved in providing health and care

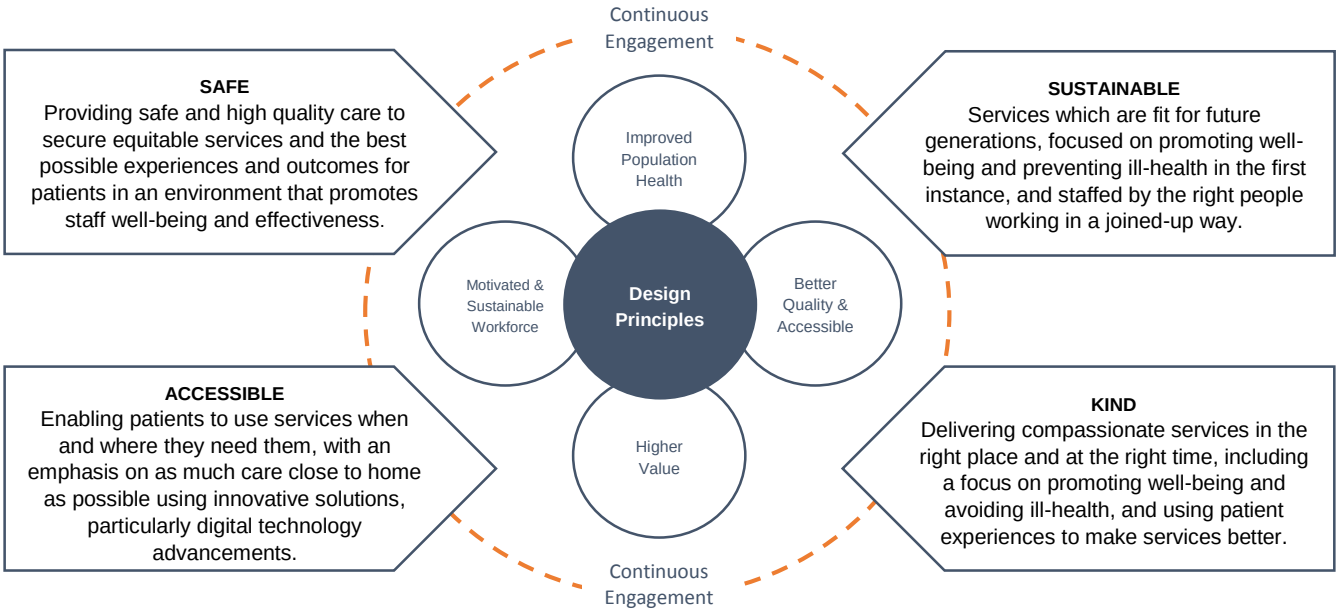
- **Making it happen** - how we organise the work needed to deliver the changes to realise our strategy including our workforce, transport and access, money, our buildings and capital assets, the use of technology, and quality improvement

- **How you can get involved** - our commitment to continuous engagement through a partnership with our staff, patients and people in our communities and those delivering or interested in health, care and well-being

HOW WE DEVELOPED THE STRATEGY

To start this journey we embarked on a transformation programme, led by our health professionals, called Transforming Clinical Services. Our programme has involved listening to what really matters to people and using this to design how we can do things differently in the future to address our challenges. Throughout the programme we have listened to what is important to people and have used the guiding principles that everything we do should be towards delivering **safe, sustainable, accessible and kind** health and care services. This has kept us focused on how we meet the changing needs of our local population both now and in the future.

These principles resonate clearly with the Quadruple Aim and the 10 National Design Principles contained within **A Healthier Wales** - the Welsh Government's plan for delivering a long term future vision of a 'whole system approach to health and social care' (see page 22), focused on health and well-being and preventing illness. Our strategy is aligned to the aims and principles in this national approach and give us a foundation on which to build future models of care for our area. We have explained what this means for the Hywel Dda population on page 20.



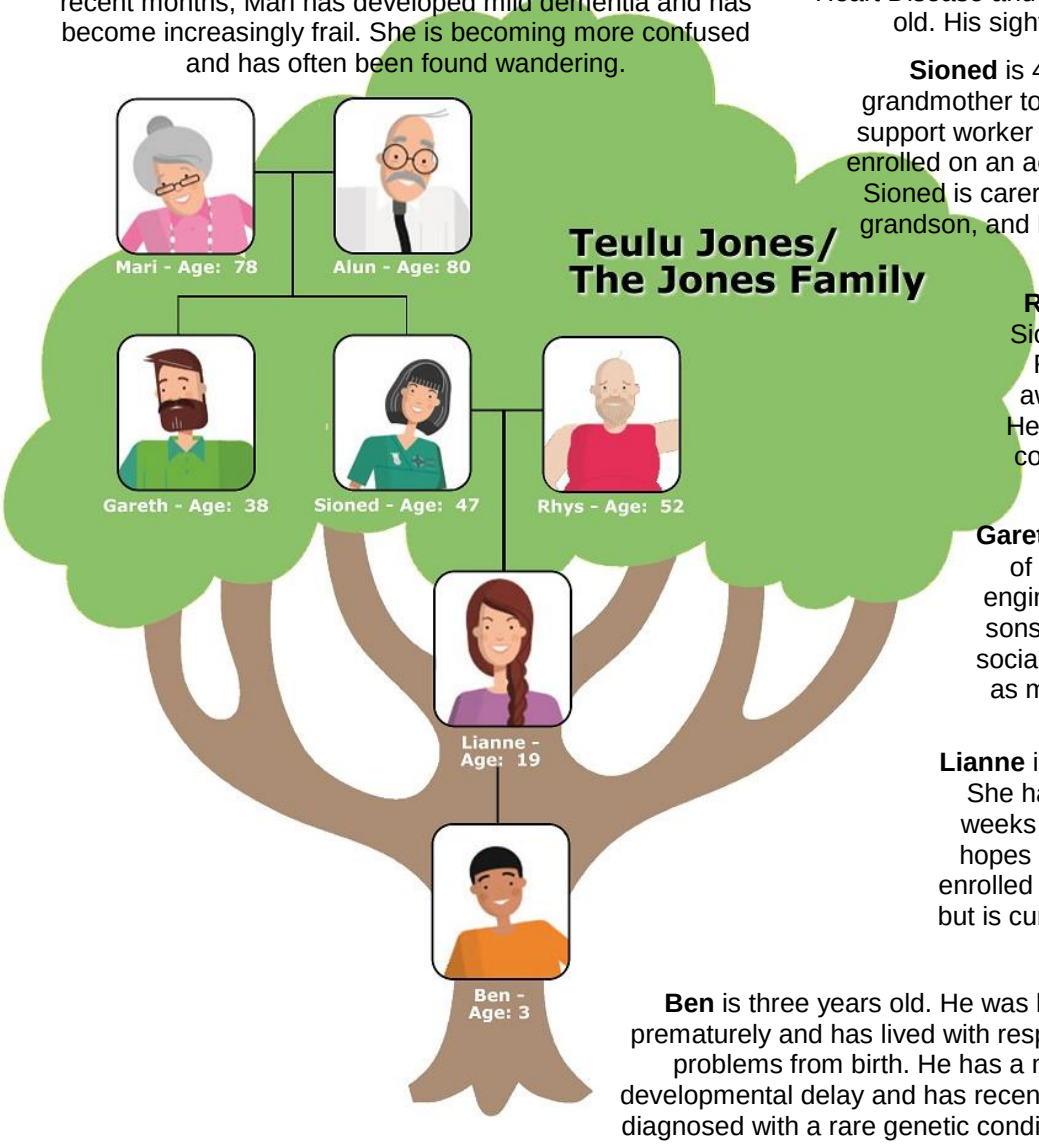
Introducing Teulu Jones

Teulu Jones, the Jones Family, is our mid and west Wales family which we created during an early stage of our work on the strategy to test and challenge our ideas and models of health and care. It is not a real family, but we had real people living in our communities who we come into contact with in mind when they were created. They have been designed using information about health and well-being across the Hywel Dda area and they are typical of many people in our population. There are seven family members, spanning each of the key life phases.

We developed Teulu Jones to test what the different changes to our health and care system could mean for families living in our area, and they accompanied us through our public consultation in the summer of 2018.

You will see stories about Teulu Jones throughout this document as their circumstances will help demonstrate how the health and care system will look and feel for families 20 years from now, when the changes that we describe in our strategy are fully embedded.

Mari is 78 years old and lives at homes with Alun, her husband of 50 years. She is a retired teacher and is former President of the local Women's Institute which she still attends. She loves cooking, especially baking cakes. In recent months, Mari has developed mild dementia and has become increasingly frail. She is becoming more confused and has often been found wandering.



Alun is 80 years old. He is husband to Mari and is a retired electrician. Alun enjoys his daily walk to the local shop to get the newspaper. He is a Non-Insulin Dependent Diabetic and takes medication to control it. He has a history of Ischaemic Heart Disease and had a heart attack when he was 70 years old. His sight is starting to fail due to a cataract.

Sioned is 47 years old and is mum to Lianne and grandmother to Ben. She works part-time as a healthcare support worker at her local District General Hospital and is enrolled on an access to nursing course at her local college. Sioned is carer to both her ageing parents and her young grandson, and has been suffering with stress, anxiety and low mood.

Rhys is 52 years old. He lives with his wife Sioned, daughter Lianne and grand-son Ben. Rhys is a long distance lorry driver and is away from home a couple of nights a week. He has smoked and at is overweight, due to a combination of poor diet and limited physical activity.

Gareth is 38 years old and the younger brother of Sioned. He is the finance director of an engineering company, and is married with two sons. Gareth is a keen cyclist and has been a social smoker. He tries to visit his older parents as much as he can, and stays in contact with Sioned.

Lianne is 19 years old and lives with her parents. She has a three year-old son, Ben, and is 24 weeks pregnant with her second child. Lianne hopes to become a childcare assistant. She is enrolled on a part-time course at her local college but is currently unable to attend due to pregnancy related sickness.

Ben is three years old. He was born prematurely and has lived with respiratory problems from birth. He has a mild developmental delay and has recently been diagnosed with a rare genetic condition. He lives with his mum and grandparents.

The journey so far

The picture below shows our transformation journey so far and looks forward into the next phase of this work to deliver the changes we know we have to make if we are to realise our longer-term vision. Throughout phases one and two of this journey we have undertaken check and challenge sessions with partners and stakeholders, so that they have been able to influence the development of this strategy and our new models of care.

We have already undertaken a considerable amount of work on some parts of this journey, such as the Transforming Mental Health programme which has started to implement a co-designed new model for mental health services following a period of public consultation in 2017. The changes to our women and children's services are also now entering the second phase of work in order to deliver our commitment to improving services and facilities for women and children. We have learned a great deal from the work already undertaken in these areas and have taken the opportunity presented through this strategy to bring all of this work together to consider the needs of our local people and impact on the whole system of health and care in mid and west Wales. In our approach to deliver the models of care set out in this strategy, we will make the best use of every opportunity to join up health, care and support for our population.

THE CASE FOR CHANGE

SAFE, SUSTAINABLE, ACCESSIBLE AND KIND

WOMEN'S AND CHILDREN'S PROGRAMME

TRANSFORMING MENTAL HEALTH PROGRAMME

PEOPLE ARE LIVING LONGER WITH LONG TERM CONDITIONS

FACILITIES AND ESTATES

DEMAND

WORKFORCE

FINANCIAL SUSTAINABILITY

ADVANCING MEDICINE AND TREATMENT AND TECHNOLOGY

PHASE 1: DISCOVER

DEVELOPING THE STRATEGIC CASE FOR CHANGE

WHAT WE HEARD FROM ENGAGEMENT

TIMELINESS

COMMUNICATION

WHERE TO RECEIVE HEALTHCARE

TRAVEL AND ACCESS

QUALITY OF CARE

CARE CLOSER TO HOME

MULTI-SKILLED WORKFORCE

RESOURCES

JOINED UP SERVICES

PHASE 2: DESIGN

AGREEING THE FUTURE CARE MODEL FOR HYWEL DDA

CLINICALLY-LED

WHAT WE HEARD FROM YOU

REALITY OF DELIVERING A NEW HOSPITAL

ALIGNMENT WITH MENTAL HEALTH

TRAVEL, TRANSPORT AND ACCESS

PREVENTION

AMBULANCE CAPACITY

ANOTHER ALTERNATIVE FOR PEMBROKSHIRE

TRANSITION PLAN

INFRASTRUCTURE

INTEGRATION ACROSS HEALTH, SOCIAL CARE AND THIRD SECTORS

WORKFORCE

REGIONAL CONSIDERATIONS

PRIMARY CARE

LOCATION OF THE NEW HOSPITAL

TECHNOLOGY ENABLED CARE

TEULU JONES WAS BORN

PHASE 3: DELIVER

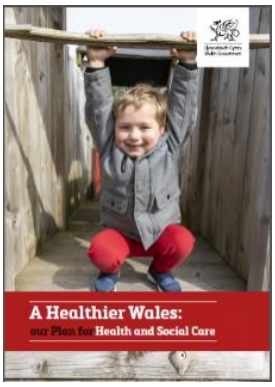
MAKING IT HAPPEN

Working together in partnership

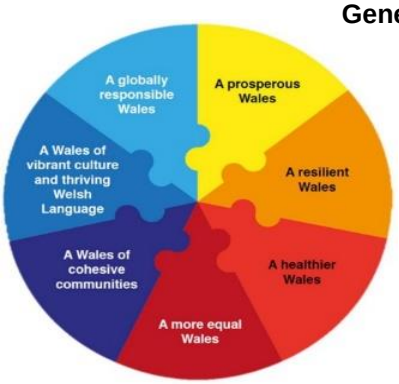
Our strategy is informed by a shared understanding with our partners of the change needed locally, regionally and nationally to develop health and care for the benefit of our communities. This strategy ensures that we deliver on our commitment to the expectations of key legislation and plans with our partners:

A Healthier Wales: Our Plan for Health and Social Care - Welsh Government June 2018

A national plan to bring health and social care services together, so they are designed and delivered around the needs and preferences of individuals, with a much greater emphasis on keeping people healthy and well.

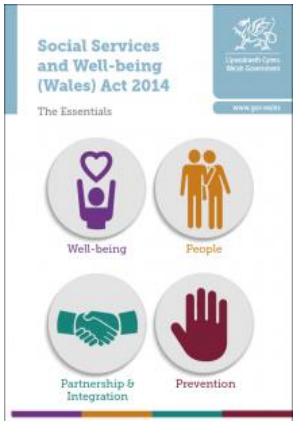


Well-being of Future Generations (Wales) Act 2015



National legislation to improve the social, economic, environmental and cultural well-being of Wales and to deliver sustainable services for future generations. There are seven well-being goals and five ways of working to demonstrate the principle of the Act has been applied.

The Social Services and Well-being (Wales) Act 2014



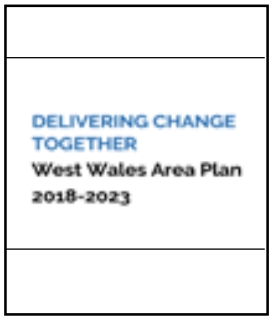
National legislation to promote well-being of those who need support, or carers who need care and support, with a duty to work collaboratively with local authority partners, through the establishment of a Regional Partnership Board (RPB).

Public Services Board (PSB) Well-being Plans

Partnerships of public agencies to support longer term population health and well-being through a number of well-being objectives and actions.

wwcp
Partneriaeth Gofal Gorllewin Cymru
West Wales Care Partnership

The West Wales Care Partnership is the Regional Partnership Board for the Hywel Dda area and drives integration, innovation and service change, bringing together partners from local government, the NHS, third and independent sectors with users and carers with the aim of transforming care and support services in the region.



West Wales Area Plan 2018 - 2023

A plan jointly produced by the health board, the three local authorities and other partners in the region. This collaborative approach will develop integrated and sustainable care and support to people in west Wales.

A Regional Collaboration for Health

ARCH

Collaboration between Abertawe Bro Morgannwg University Health Board, Hywel Dda University Health Board and Swansea University, spanning six local authorities - Ceredigion, Pembrokeshire, Carmarthenshire, Bridgend, Neath Port Talbot and Swansea. The two health boards are working closely together on the potential opportunities arising from the proposed changes and the regional approach we can take.

Mid Wales Joint Health and Social Care Committee

CBYC MWJC

A committee of four healthcare organisations that cover Mid Wales - Betsi Cadwaladr University Health Board, Hywel Dda University Health Board, Powys Health Board and the Welsh Ambulance Services Trust (WAST) to deliver a single integrated change programme that provides care as close to home as possible.

Joint Regional Planning and Delivery Committee

The Committee has a key role to drive forward at pace a range of projects that have been identified by both health boards as priorities for joint working, to deliver Ministerial objectives and alignment with ARCH.

Our existing partnership and regional arrangements reflect an expectation set out in legislation such as the **Well-being of Future Generations (Wales) Act**, **2015**, to work collaboratively with local authorities, the third sector, independent sector and other partners, as well as with our patients, carers and communities. There are several partnership arrangements in place across an area that covers a significant proportion of the landmass of Wales. Working with our wider regional partners, including through the Regional Partnership Board and Public Services Boards, will enable us to continue to seek opportunities for improving long term population health that collaboration can bring, as well as providing joined up and integrated services.

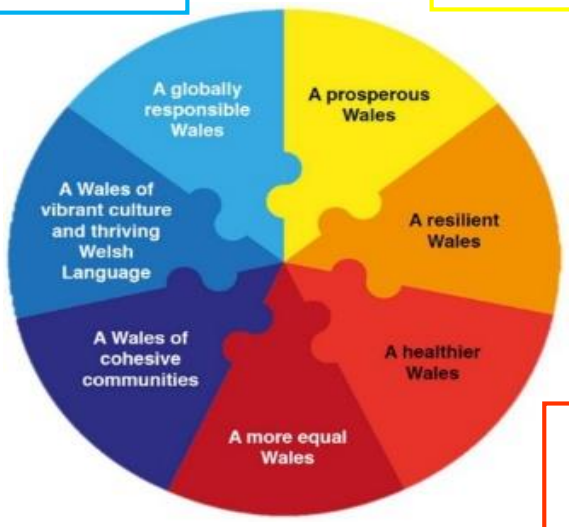
Our commitment to work in an integrated way across health and social care at regional and locality level will realise a long held ambition to deliver services that work better for people and are far less complicated and quicker to access. It also enables us to build our shared ambition to develop community resilience, prevent ill health, improve well-being, and promote independence and interconnectedness.

Delivering this strategy in partnership will realise our commitment to achieving the seven goals as set out in the **Well-being of Future Generations (Wales) Act, 2015** in the following ways:

A globally responsible Wales - Supporting global well-being by working with other countries and cultures to share best practice, and encouraging people from all over the world to come to work, and stay, in mid and west Wales

A prosperous Wales - Opportunities for volunteering, the development of new career pathways and employment that encourages people to live and work in mid and west Wales

A Wales of vibrant culture and thriving Welsh language - A social model for health that involves people in creating better lives, promotes community assets and promotes Welsh language.



A resilient Wales - Modernising our health facilities, and providing them in the most appropriate locations to support social, economic and ecological resilience.

A Wales of cohesive communities - A community model which develops resilient communities, with people supporting each other, and providing more care closer to home.

A healthier Wales - Working together to consider how we ensure our services are safe, sustainable, accessible and kind for ours and future generations.

A more equal Wales - More equitable care and opportunity that reduces variation, and better meets the needs of vulnerable groups.

Revolutionising health and care, through an integrated social model for health and well-being with greater emphasis on illness prevention; individuals making decisions and managing their own health and well-being; and care provided seamlessly and as locally as possible, will be our contribution to '**A Healthier Wales'**. Our joint bid for funding from the national Transformation Fund, developed through the Regional Partnership Board, demonstrates our shared vision and commitment to developing integrated models and seamless community provision. We have worked together to identify priority projects that will enable us to accelerate the change, based on four inter-related supporting priorities:

The proposal is part of a wider, ambitious programme for the transformation of health and care in west Wales and will complement a range of initiatives across the region.

Working together in partnership across our region also encompasses the arrangements we have in place with our neighbouring health boards, namely the Mid Wales Joint health and Social Care Committee; and ARCH (A Regional Collaboration for Health).

In 2015 a formal collaborative arrangement between the statutory health and care organisations covering the region namely Betsi Cadwaladr University Health Board, Hywel Dda University Health Board, Powys Teaching Health Board, the Welsh Ambulance Services NHS Trust, Ceredigion County Council, Gwynedd County Council and Powys County Council, was established. This was known as the Mid Wales Healthcare Collaborative and in March 2018 this collaborative arrangement transitioned into the Mid Wales Joint Health and Social Care Committee. This Committee has a strengthened role in the joint planning and implementation of health and care services across mid Wales and is supported by a Clinical Advisory Group.

Running alongside this collaborative arrangement are the following partnership groups:

- Statutory regional partnerships which came into effect in April 2016, as part of the introduction of the **Social Services and Well-being (Wales) Act 2014**, with the purpose of driving the regional delivery of social services in close collaboration with health. Across mid wales there are three Regional Partnership Boards which cover mid Wales – Powys, north Wales and west Wales.
- The **Well-being of Future Generations (Wales) Act 2015** established statutory Public Services Boards to assess the state of economic, social, environmental and cultural well-being in its area and set objectives that are designed to maximise the Public Services Board's contribution to the well-being goals. There are three Public Services Boards covering mid Wales – Ceredigion, Powys and Anglesey & Gwynedd.

The joint committee's vision assumes that all public services in partnership with others have a responsibility to work together to prevent ill health and that when health or social care is needed, services for patients should be high quality, as close to home as practicably possible, convenient, seamless and effective.

A Regional Collaboration for Health (ARCH) is a long term transformational collaboration that aims to improve the health, wealth and well-being of the south west Wales region. It is a unique partnership formed between Hywel Dda and Abertawe Bro Morgannwg University

Health Boards and Swansea University. The vision for ARCH is to develop an integrated, open, collaborative health and life science regional economy in south west Wales. ARCH has four powerful programmes: Service Transformation; Wellbeing; Workforce, Education and Skills and Research, Enterprise and Innovation.

The Service Transformation Programme aims to drive a whole system approach to implement new service models based on the needs of our population. This requires a different approach to how we currently deliver health and care services, and cuts across system and organisational boundaries. The well-being programme aims to develop a network of health and well-being centres and develop an integrated information platform for the region. The Research Enterprise and Innovation Programme aims to expand Institute of Life Sciences (ILS) facilities across the region and drive an ecosystem of vibrant life sciences. The Workforce, Education and Skills Workforce Programme aims to grow talent and improve workforce well-being.

Working together every step of the way

Our strategy is underpinned by our commitment to continuous engagement with our staff, patients, people in our communities and those delivering, or interested in, health, care and well-being. The recent Transforming Mental Health and Transforming Clinical Services consultations have demonstrated the importance and effectiveness of continuous engagement as an approach. The contribution of a wide range of people has been critical in helping us to shape future models of care through early conversations and designing these together. It will become even more important to build on this great start and continue an open dialogue and partnership approach as we go forward.

We have learned a great deal already and our commitment is to continue this approach by "working together every step of the way" when designing, developing, reviewing or changing services. The benefits of this approach mean that people work together to design services that better address what matters most to specific populations and communities. This approach will enable us to improve services and mean resources can be more efficiently focused. We will develop an ambitious, flexible and integrated approach to continuous engagement with our communities, including the Hywel Dda CHC and the Regional Partnership Board. This approach is consistent with **A Healthier Wales** – where all voices are listened to and mutual understanding and trust is built with the population and those who work in health and care services, and with our responsibilities set out in the five ways of working of the **Well-being of Future Generations (Wales) Act** to involve people in making decisions.

Hywel Dda CHC is a key partner as we translate this strategy into future service delivery, because they play an essential role in representing the patient voice in our area. We will work closely with the CHC to plan service change resulting from this strategy, ensuring we respond to the recommendations they made to us following our public consultation. The recommendations relate to changes to accident and emergency services, primary care, transport, community focus, workforce, future co-production and flexibility in implementation, specific recommendations for our three counties, cross border NHS care and mental health services. Our detailed plans will fully outline the work we will do to address these. The recommendations that the CHC made can be seen here.

What we heard from you

Our engagement during The Big Conversation listening and engagement exercise, and public consultations Our Big NHS Change and Transforming Mental Health, confirmed our commitment to prioritise the development of enhanced community models of care and support working with others to consider all aspects affecting a persons' health and care. This supports our belief that promoting good health and wellness is important to our population. We learned from you that receiving care and support when and where you need it is important and this should be as local as possible, although you understand that there are times when you will need to have to travel for care. We also heard that you are concerned about travelling and transport, and specifically how you will get to and access health services in future. This is mainly due to our geography and areas of remoteness, but also links to communication and how we use technology. We have listened to what we have heard and this strategy is our direct response to this.

We focused on the voice of those in groups with characteristics protected under the **Equality Act 2010** (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation) and the most vulnerable in our society throughout our engagement and consultation. We learned, through an ongoing assessment of the potential impact of future changes on people with these characteristics, that issues experienced by the whole population were heightened for certain protected groups.

We have listened to what we have heard and responded to it in our strategy. When we translate our strategy in to detailed plans, we will involve people every step of the way, with a particular focus on involving people from protected groups and support organisations, to explore ways of eliminating or mitigating any potential negative impacts.

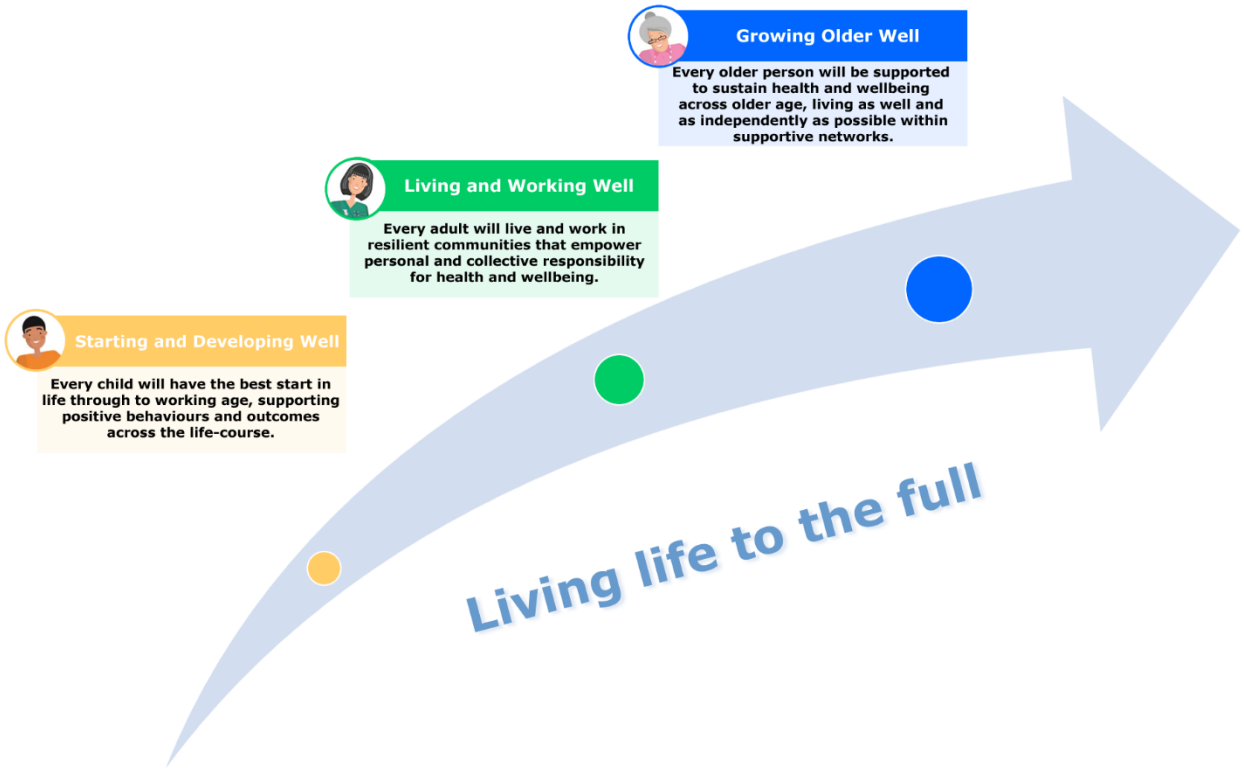
OUR COMMITMENT TO THE PEOPLE OF MID AND WEST WALES

Our vision and goals to improve health and well-being during the next 20 years

Our strategy is based on a vision for the future and a set of strategic goals.

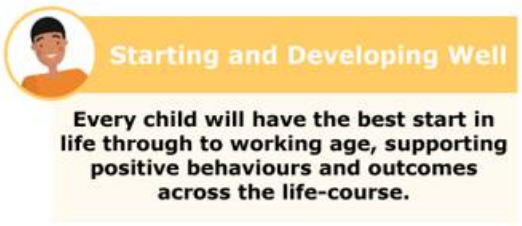
> Our shared **vision** is a mid and west Wales where individuals, communities and the environments they live, play and work in are adaptive, connected and mutually supportive. This means people are resilient and resourceful and enabled to live joyful, healthy and purposeful lives with a strong sense of belonging.

To make sure we focus on how the health and care system will look and feel for families in the future, we have focused on three interconnected phases across the life-course, each with an associated strategic goal:

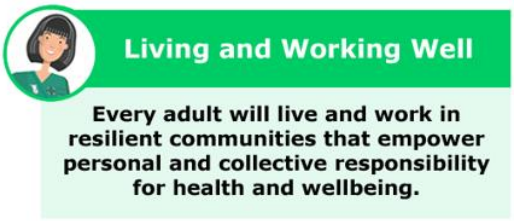


Our three strategic goals – starting and developing well, living and working well, and growing older well - are framed around three life phases and replace the previous eight health related strategic objectives. The three pro-active strategic goals emphasise a joint whole system approach to health and well-being with our partners and communities. While we recognise that these life phases overlap and that none is more important than the other, we also wish to support the provision of services and actions taken to improve health and well-being that may be focused on the delivery of specific goals. Whilst we can make a positive contribution to influence these strategic goals, we recognise that we cannot deliver them alone.

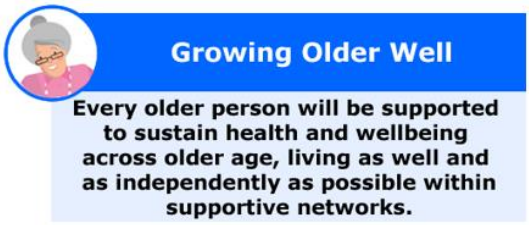
We have developed a series of long-term outcomes that describe our ambitions for each of the strategic goals. These early outcomes are informed by our 20-year vision and will be developed over time as we continuously engage with our communities to learn and understand what they care about and what matters most to them in relation to their health and well-being.



- I am happy and confident, feel safe and that I belong and have help if I need it
- I am listened to and understood enabling me to reach my full potential
- I have meaningful opportunities and feel empowered to influence decisions about my life



- I am supported and I contribute to creating the environment that enables me to look after myself, others and take responsibility for my independence
- My life counts, has purpose and I live a meaningful life with opportunity
- My community is connected, inclusive and supports life-long learning through the promotion of understanding and respect between generations



- I feel positive about my health and live an independent, healthy life where I feel valued
- I live my life to the full and have opportunities to participate and contribute to my community
- If I have specific needs they are understood and I am enabled to make choices

A health and well-being framework is in development to support our whole system journey towards our 20-year vision, including our strategic goals and long-term outcomes, and will be published in 2019.

What this means for our strategy

As we work to deliver our vision, we will be guided by the national principles in the **A Healthier Wales** plan when designing our local services. This means that we will:

Develop a wellness approach for our public and our staff, working across the whole system, to improve people's health. We will work together to focus on well-being, to **prevent** illness and to anticipate and predict poor health so that we can **intervene and help early on**.

Put **safety** and quality first, and ensure as a minimum that our services do no harm, so that people can live safely within their communities. The changes to our hospital services and the way care and treatment is delivered to our population will be carefully managed in a phased way, which prioritises **safety** and enables the delivery of agreed standards of quality leading to sustainability.

Support people to have **independent** lives, where they are enabled to manage their health and well-being, focused around their own homes and localities. This includes speeding up recovery after treatment and care, and supporting self-management of long-term conditions. We will work together with key partners and our staff to help build resilience and support people to live well within their own communities.

Listen to the **voices** of our population**,** and provide the information and support to make decisions about the care and treatment they receive, based on what matters to them. We will use innovative approaches to continuously engage and work with patients carers, service users, staff and partners every step of the way. Listening to these voices will inform how we improve our whole system approach to health and care and co-design future service models.

Continuously engage to **personalise** and tailor our health and care services to the needs and preferences of both individuals and localities, with a focus on supporting people to manage their own care and outcomes. We will use technology and innovative transport solutions to provide more choice and better access to care where it is needed.

Work with partners and our staff across the whole system to develop integrated services, where social, primary and secondary care are not seen in isolation but work together to provide services which are **seamless** and improve the experience for the individual by providing less complex better coordinated care. We will focus on addressing the challenges we see in mid and west Wales around access, travel and transport by working together in partnership to deliver innovative solutions tailored for our geography.

Work with all partners to deliver more efficient and **higher value** health and care services which deliver better outcomes and a better experience for people. We will invest in our staff and explore innovative workforce solutions so that we can recruit, train and retain the best workforce for mid and west Wales.

Use research, knowledge and information, with our partners, to design **evidence driven** health and care services with people, which are based on what works, shared learning, and innovative solutions. We will develop and evaluate better tools and ways of working.

Work in partnership to **upscale** good practice around the delivery of the best possible health and care services that exist locally, regionally and nationally. We will work together to take opportunities offered through Welsh Government funding, such as the Transformation Fund.

Work in collaboration to find **transformative** ways of delivering safe, sustainable, accessible and kind services, so that we work differently to achieve our vision. We will maximise the use of technology as a key enabler for transformation and explore innovative approaches to workforce design.

OUR PEOPLE AND COMMUNITIES AT THE HEART

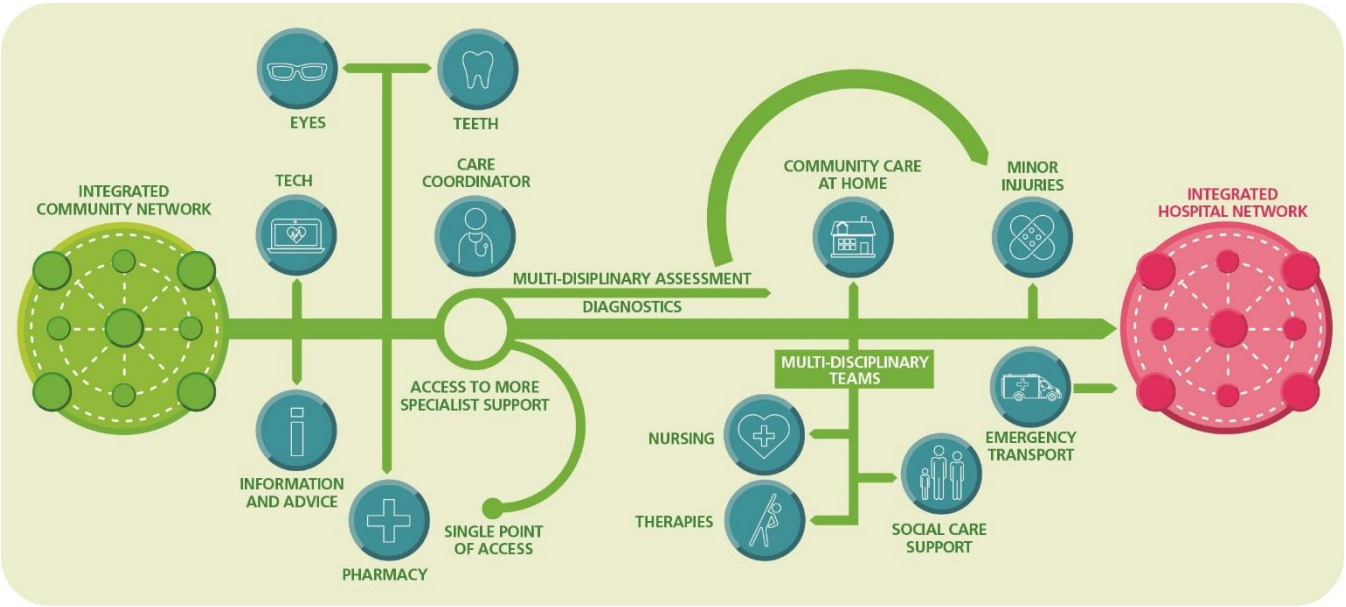
Our people and communities are at the heart of everything we do and so we need to work closely and collectively across all public services. This means everyone working together in an integrated way across the whole of the Hywel Dda area as well as with our neighbouring regions where more specialist care is provided for people who are seriously unwell. We recognise people's health and well-being is affected by far more than health and care services.

To improve people's health, we must work together with partners, including local people, to address every aspect of life that can impact on a person's health and well-being. This is sometimes referred to in the health and care sector as the 'whole system'. When we refer to the 'whole system' we mean hospital services, community services, primary care (such as GP surgeries), social care, people's homes, education, employment, leisure, food and the environment. A range of organisations across public, voluntary, independent and private sectors, in multiple settings, can impact on people's health, not just the NHS and social care services. We believe that care and support should fit around the person and what matters to them, and not around services.

Placing our people and communities at the heart of our whole-system and the changes that we need to make will help us focus on the needs of all of our local people.

We will need to transform our whole-system so that it works better for our people and communities. This means making positive changes to every aspect of the care and support we provide to people through an integrated approach that involves health and social care services, working alongside all other public-facing services which actively contribute to healthier communities.

Working across the whole system



The above diagram is an illustrative example of the whole-system approach to health and care in practice. The integrated community network supports the wider aspects of our health and well-being, supporting lower levels of need such as providing information and advice through to more professional care and support in a community setting, including care in our own homes. Specialist healthcare will be provided within an integrated network of hospitals that range from minor injuries and low-risk treatment and procedures, to more urgent and critical needs that require higher levels of specialist expert care locally and in regional centres.

Adopting a whole-system approach will enable our people and communities to care for themselves, prevent ill health, improve well-being, promote independence and interconnectedness, and access specialist care and support when required. We want to see a future whole-system approach that:

- delivers integrated care and support, enabled by digital technology with communication of information between health and social care partners across traditional community and hospital boundaries and allows people to access more information about their health and care

- views mental health and care equally with physical health and care, ensuring that those with mental health problems receive equitable access to the most effective and safest care available

- considers the full seven-days of the week, expanding access to the services that will have the most positive impacts

- creates a single point of access to health and care, linking all areas that contribute to the healthier lives of our people and communities

- increasingly considers our carbon footprint in everything we do, so we play our part in maintaining the environment for the health and well-being of future generations

Supporting informal carers

We recognise the extraordinary contribution of informal carers to the health and well-being of many of our residents and patients. Carers are a fundamental focus within the West Wales Area Plan which sets out the needs of our communities across west Wales and how we will work in partnership, through the Regional Partnership Board, to respond to these. We are facing unprecedented changes in health and social care and with an aging population the number of carers in the region is likely to increase. Within the west Wales population of 384,000, there are approximately 47,000 carers, with around 9,000 of these being identified either through their GP or social services, which demonstrates that many carers are being identified as a result of their own health or care needs. In addition, more than 400 young carers have been identified in our area. These are young people under 18 years who are caring for siblings and parents. Hywel Dda UHB co-ordinates the development of an annual carers delivery plan for the Regional Partnership Board which seeks to:

- address key requirements, gaps and improvements identified through the West Wales Population Assessment
- respond to ministerial priorities for supporting carers
- align with other Regional Partnership Board priorities and reflect the strategic objectives with the area plan
- complement and integrate a range of carers' initiatives across the region, including those funded through Welsh Government initiatives

Working in collaboration with the Regional Partnership Board, we are committed to raising awareness of the needs of carers and delivering support for carers in our communities in new and innovative ways, ensuring that the needs of carers are considered at every stage of their health and social care journey.

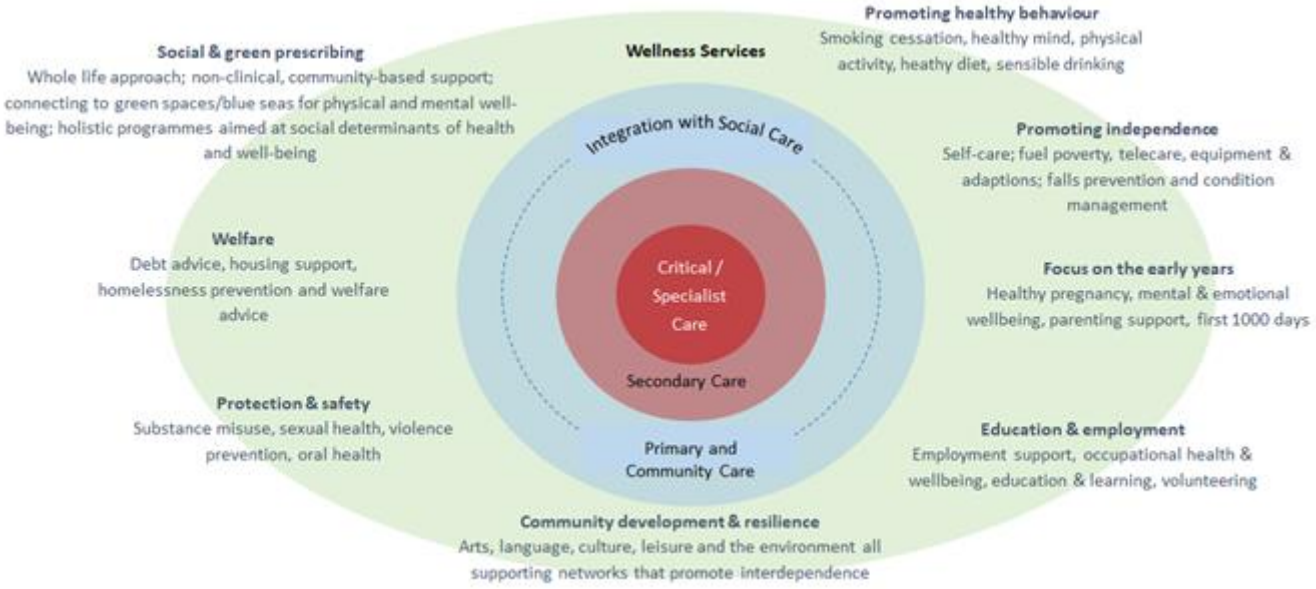
Our future community model

Improving health outcomes in mid and west Wales and creating a sustainable healthcare system for the future requires a shift from our current focus on hospital-based care and treatment to a focus on people and communities being empowered to do things for themselves. We will adopt a population-based health and well-being approach which is focused on promotion of happy and healthy living and prevention of ill-health.

The majority of health and care support is already delivered in the community and we have examples of excellent and often innovative services and initiatives which are having a positive impact on people's health and well-being in their communities. However, the overall community health and care landscape is often complex, variable, over-medicalised and fragile. This fragmented and illness-focused approach is holding us back from making the kind of impact we want, and need, for our population. By examining care models from across the UK and around the world, and listening to what people have told us is important to them in our engagement and consultation exercises, our vision is for a community care model which we believe will provide the best outcomes for our population, taking into account our geography.

We believe that health is co-created in communities, through family, friends and neighbours.

We know that the needs of communities will be different from each other, and we are committed to working with local people to develop tailored local solutions to what matters to them. Working in this way, with people who receive care and organisations involved in all aspects of a person's health and well-being is referred to by professionals as adopting a 'social model for health'. This is demonstrated in the diagram below:



Resilient communities

A social model for health recognises that where we live and our social circumstances have an impact on our health and well-being. A more connected community supports its members to participate, have a sense of belonging and to stay well, so we need to work with our partners and communities to generate the right conditions for this. There is a growing recognition, not only in the Hywel Dda area but across the UK and beyond, that an approach that builds upon

and enhances the strengths and resources that are already in place in our communities is respectful, empowering and effective. In order to achieve this, we will be guided by the strengths of each of our communities, often referred to as Asset Based Community Development (ABCD).

Assets are strengths, the collective resources which are found in people and communities, including their skills, knowledge, connections, lived experiences and social conditions. Used with purpose, assets help to protect and promote health and well-being and to prevent illness, even when people are faced with challenging life circumstances.

Examples of assets include:

People's skills and sense of purpose

People and the connections between them

Environmental resources

Learning

The asset approach is a set of values and principles and a way of thinking about the world. It:

- identifies and makes visible the health-enhancing assets in a community
- sees citizens and communities as the co-producers of health and well-being, rather than the recipients of services
- promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment
- values what works well in an area
- identifies what has the potential to improve health and well-being
- supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources
- empowers communities to control their futures and create tangible resources such as services, funds and buildings
- draws out what people care enough about to contribute to others in their community

Following these principles will help us to refocus existing health service and other public sector programmes as well as leading to new kinds of community-based working.

Traditionally, we are used to focusing on deficits (or weaknesses). We ask the question 'What is wrong with you?' which results in high levels of dependence on health, care and other services and a focus on illness rather than on wellness. An assets approach asks 'How can we prevent illness and protect health and well-being?' this helps empower people to manage their own health and well-being.

From 'What's Wrong'...		*...to 'What's Strong'*
Starts with deficiencies and needs	→	Starts with strengths and potentials
Treats the illness and symptoms	→	Promotes wellbeing and positive health
'Fixes' people	→	Empowers people to develop their potential
People are consumers of health services	→	People are co-producers of health outcomes
Implements programmes as the answer	→	Sees people as the answer
*'Does **to** people'...*		*...'**by** people'*

How we will organise ourselves to deliver the new model

Hywel Dda UHB serves the populations of Carmarthenshire, Ceredigion and Pembrokeshire (as well as provide care for some residents in neighbouring counties) and already works closely with the three local authorities and the third sector, at management and service delivery level. We are committed to work in an integrated way across health and social care at regional and locality level and we will further develop services that are seamless and focused (feel like one service to the user) on the needs of the individual.

The seven Integrated Localities will be:

- North Pembrokeshire
- South Pembrokeshire
- North Ceredigion
- South Ceredigion
- Amman/Gwendraeth
- Llanelli
- Tywi, Taf and Teifi Valley

Our aim is to mirror existing primary care cluster localities where good structures and relationships are already in place, developing them into seven integrated localities that integrate more than primary care services. In time, as the new model develops, it is possible that integrated locality boundaries may change.

The purpose of the integrated localities is not to draw lines on a map in order to divide up services, but to provide a mechanism for local leadership and delivery of services, with localities having real influence on how resources are used to meet the specific population health and well-being objectives for that area. This includes tackling inequalities by working in partnership with local people to co-design solutions and services.

The integrated localities will work and collaborate with all parts of the health and care system and the community to support the health and well-being of the local population.

Strengthening our integrated ways of working will enable our teams and resources to work better together through understanding and valuing roles and skills, and common shared outcomes through localised co-ordination and bringing together resources. Each integrated locality will, in time, have a devolved budget and take responsibility for the health and care outcomes of a defined population.

As our locality working develops, the seven integrated locality teams will work to deliver seamless services across primary, community and social care services, third sector organisations and wider partners. This, along with continuous and meaningful engagement with the local population will mean that care and support is co-designed, that things work better for people and services are simpler, quicker to access and just what people need.

The Regional Partnership Board will be further strengthened with expanded representation of political and officer leaders enabling it to accelerate the pace of integration and ensure that there is equity, a consistent standard of service and equal outcomes for people across the whole region. At the same time, it will pass as much decision making to the seven localities so that there is an appropriate local distinctiveness in each integrated locality, reflecting the diversity of each part of the region.

This will mean that the leadership of the NHS and social care will work together closer than ever and in the spirit of wanting to improve the services we provide, reducing duplication, working differently joining forces on shifting our services towards prevention and promoting wellness. We already have some integrated management posts and many of our staff are co-located with local authority colleagues but we will work at pace to embed this way of working so that it really makes a difference to the people who need services.

We will move immediately to work together to map out what this journey looks like, how we propose to work closely through the Regional Partnership Board and seven localities. Together our organisations will jointly set timescales for key progress points, phase our implementation plan, outline the challenges and mobilise our teams to work together to make this vision a reality. This integration has been a long held ambition by many and the current commitment from all partners to resolve challenging issues together and to travel this road together is different and lasting.

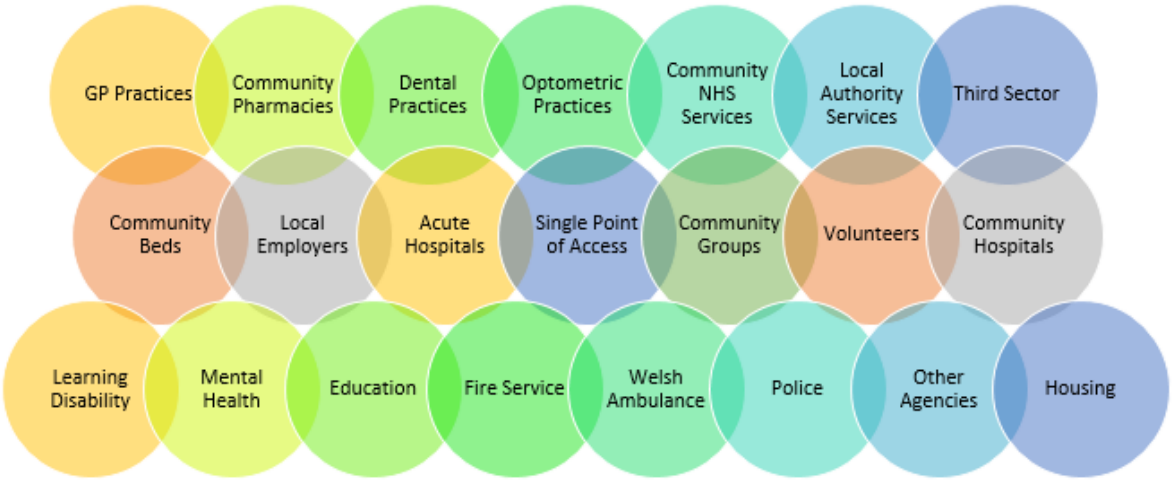
In addition to adult health and social care, including third and voluntary sectors, we will work to align mental health and learning disabilities service plans with the integrated team-based model to further strengthen joined up working.

We will continue to progress the alignment of existing Transforming Mental Health plans with the development of our plans for the community model, considering every opportunity to co-locate the community mental health centres with the health and well-being centres where appropriate. For learning disabilities, the ambition is to promote independence in community environments where possible. We are actively contributing to a multi-stakeholder learning disabilities transformation programme, looking at modernising our approach to the care and support of people with a learning disability, led by our local authority partners.

As part of ongoing reviews of children's community nursing, services are increasingly community based. This fits well within the overall community model and our strategic vision to move more care from hospital settings into the community and closer to home. The vision is to develop community-focused women's and children's services, with a strong wellness ethos based on a social rather than a medical model of health. This will ensure that wellness, illness prevention and early intervention lead to an increase in the provision of community-led care and result in an increase in midwife-led pregnancies and births.

Integrated community networks

Each integrated locality will provide information, advice, assistance and treatment through integrated community networks. These networks are complex and interwoven collections of information, groups, services and professionals which interact with our communities face to face, on the phone or through digital platforms. The integrated community networks cover the whole spectrum including physical health and well-being, mental health and learning disabilities. These networks will build strong relationships with their communities and will continuously engage with their populations.



Our aim is that these integrated community networks will provide the majority of health and care services, some of which have traditionally been provided in the acute hospital setting e.g. blood tests and x-rays, procedures, minor operations and outpatient appointments. Advice might be provided face to face or via video link or even e-mail in some cases. For example, a community optometrist who, with appropriate training and safety systems in place, will be able to make waiting list decisions for routine cataract surgery. This will have significant positive outcomes both for patients, who would not need to come to hospital for an assessment, and for the outpatient department, by releasing outpatient slots, which would become available to use for other conditions. The new model also provides opportunities for our staff and partners to work differently or in different settings, for example the community paramedic role, which sees Advanced Paramedic Practitioners working in support of general practitioners (GPs) and carrying out home visits, seeing and treating patients.

I work as a community based advanced paramedic practitioner, linked to a health and well-being centre, which is a key role for supporting community resilience. I can provide direct support to people without them needing to see a GP and it means that we can provide a lot more care in people's own communities. Along with training up more community first responders and expanding the roll out of public access defibrillators we have significantly improved access and timely care for rural communities.

Community beds and community hospitals

Recognising the concerns expressed in our consultation about changes to community hospitals, we are committed to working with local people to design the model that best meets local needs.

We know that being in an acute hospital can be detrimental to health and well-being, particularly for our more frail and elderly patients and so our model provides support and care outside hospital wherever possible. Ambulatory, or outpatient care, is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services, and allows the patient to return home on the same day. This care can include advanced medical technology, monitoring and procedures even when provided outside of hospitals. Ambulatory care will provide effective local alternatives to in-patient treatment, and our aim is to maximise this approach in our community hospitals.

In order to do this we will explore the potential for a range of different types of beds within the local community, whether in hospital, at home or another setting. This will include commissioned beds in nursing and residential homes and extra care supported living facilities as well as providing support and care to people in their own homes.

Health and well-being centres

When we consulted with you on our proposals for change, we talked about community hubs providing a range of support and services. However, feedback suggested this term was not easily understood and therefore we now use the term 'health and well-being' centre to describe these.

Each integrated community network is supported by one or more health and well-being centres, which in some areas will be a change to an existing community hospital. This will bring a number of people and services together in one place and also provide virtual links between the population and the community network.

Multidisciplinary teams and the wider networks will wrap around individuals and families. This team approach means that we can make the best use of the skills and knowledge of our staff and our aim is for people to have direct access to support or the service most able to meet their needs without first being assessed and referred by someone else. Through our engagement and consultation exercises we heard people wanted to have more timely access to GP services. This approach means patients will get quicker advice and treatment and our GPs will have more time available to support people with more severe or complex needs. There will be opportunities to co-locate mental health and learning disability services and facilities with the health and well-being centres as appropriate.

I've known for years that I should lose weight and get fit, but I never felt able to do it. It was only after my heart health was suffering and I started seeing my lifestyle coach that I gained the confidence to change. My '*Diet starts tomorrow*' thinking soon changed with the encouragement of the coach, and I have lost three stone over the last two years. I've also quit smoking. Social prescriptions of swimming and nutrition classes have changed my life for the better and I no longer have the worries I once I had about having to retire early due to ill-health.

The multidisciplinary and multi-agency approach in our health and well-being centres will be of particular benefit for our frail and elderly residents and those with complex needs. Our aim is to be pro-active in identifying and supporting these people to remain independent. The team approach to enhanced care at home, managed from health and well-being centres, means that any issues or problems are predicted, or identified early and addressed by the person with the appropriate skills. This will include linking with specialists, who will increasingly connect with services in the community providing guidance, advice and support.

We want our health and well-being centres to be integral parts of the community and there may be opportunities for local groups to use the facilities in our centres. Similarly, we will use community facilities such as community halls to deliver some of our services and activities, either face to face or virtually. For example, our award winning Virtual Pulmonary Rehab (VIPAR) Programme provides exercise and education classes in local village halls, via a video-conferencing link, enabling patients to access this important part of their rehabilitation without travelling long distances.

Health and Well-being Centres
Local health and well-being centres are part of an integrated community network that will include:

Unscheduled care in the community

At present, we know that people sometimes attend the emergency department when their needs could have been better met by a community-based service, but these services do not currently exist in many local communities. Minor injuries and ailments are best assessed and treated by community pharmacies, GP surgeries, optometrists and minor injuries units. We also recognise the key role an advanced paramedic practitioner (APP) can play in the rapid stabilisation at the scene in an emergency, therefore saving lives protecting airway, breathing and circulation; we intend to work with WAST to provide enhanced access to APP's to communities who are further away from an acute hospital such as in coastal communities. The further development of these services will be key to realising our vision.

People have told us that they would be willing to use different services or to see professionals other than their GP but they needed to understand more about them. With this in mind, we will continue to raise awareness and encourage use of these services and what they can offer to enable people to access the service that best meets their needs, quickly and close to home.

Care navigator roles will also help to direct people to the most appropriate course of action or service. Care navigators offer assistance to patients and carers in identifying and accessing the systems and support that are available to them within health and social care and beyond. They support people to make positive choices to promote good health and emotional well-being and can often provide a non-medical referral option that can support existing medical treatments for patients. Examples of assistance offered include referrals to social groups such as walking groups, arts groups and lunch clubs or the offer of assistance to obtain advice for issues such as housing, benefits or debt management.

Many of our community services which provide excellent care in the community, do not currently provide 24 hour, seven days a week cover. This can mean that the only option, particularly for frail or older people, is to be admitted to an acute hospital which can have a

detrimental effect on them. This is not as safe or kind as we would want. We will assess our services and consider the full seven-days of the week, expanding access to services that will have the most positive impacts. There will also be 24/7 mental health service provided at community mental health centres which will be co-located with the health and well-being centres where appropriate.

Ensuring timely discharge from hospital

When admission to an acute hospital is required we will work with partners to support people to return home as soon as they no longer need acute hospital-based care. This responds to what we heard in our public consultation, when people told us they wanted to be cared for closer to home as soon as they no longer needed hospital-based care. Our community teams will work closely with their hospital-based colleagues to actively manage the person's return back to their home, with support as required. We will adopt a 'discharge to assess' model as we know that assessing people outside of an acute hospital environment gives a much better indication of how they manage than in an unfamiliar environment such as a hospital. The enhanced care at home approach will be used to support certain patients.

> I slipped and fell in the supermarket six months ago, breaking my hip. It was very painful, but the ambulance arrived quickly, and the paramedics were excellent; they reduced the pain and explained what was happening next. They took me to the A&E where I was seen immediately by a consultant without having to wait. After my operation a lovely physio assistant helped me get on my feet quickly. I stayed for two nights until it was safe for me to be discharged to my local hospital to be closer to my family. Planning for my discharge home started as soon as I was admitted from A&E. They kept me, my wife and daughter involved throughout to be sure the right care and support was in place not just for me but also for them, as my carers.

Demonstrating the new model in action

We understand that we need to build public confidence in moving to a new social model for health (see page 24 for a description of a social model for health). We have responded to what we heard in the consultation and will therefore move forward plans for early implementer sites that can demonstrate the new model in action quickly. The early implementers will be in Pembroke Dock, Fishguard, Cardigan, Llandysul, Lampeter, and Llanelli and will include the planning and development of health and well-being centres and integrated community networks. We will work with local communities to understand what matters to them and co-design services for the centres and wider integrated community networks. Of course, this doesn't mean that work will not progress in other areas across the three counties, including development of health and well-being centres in Cross Hands, Cylch Caron (Tregaron) and Aberaeron, for which planning is already underway.

What does the new community-based model of care mean for our hospitals?

Focusing on prevention, early intervention, self-care, providing care and support closer to home and actively managing those most at risk means that we will become less reliant on hospital-based care. Once the community model is well-established, we believe that acute hospital-based care will only be needed for those with the most severe clinical needs, planned operations and specialist diagnostic tests. Hospital based care will be an important but small component of the range of care provided. We expect our staff will increasingly use their skills to work across community and hospital settings, which will improve understanding between clinical teams and facilitate seamless care.

Some of the things we will do first

We heard from our engagement and consultation that people in Pembrokeshire had particular concerns about the impact of their more remote and coastal geography on changes to hospital services and the location of a new urgent and planned care hospital. This will be addressed through the strategy by concentrating first on the co-design of an enhanced acute 24/7 community response in Pembrokeshire, which follows the principles outlined in our community model above. In order to progress this, five Steering Groups will be developed in Pembrokeshire with our population, to co-produce a robust model which will meet local needs:

In the *South West Pembrokeshire Community* we will focus on a plan for the development of South Pembrokeshire health and well-being centre (South Pembrokeshire Hospital). A key focus in this area will be on rehabilitation services within the community building on the existing services co-located in South Pembrokeshire Hospital. This group will rapidly identify the need for community beds as part of the long term model. Scoping work for this project will begin in February 2019.

In the *North Pembrokeshire Coastal Community* we will consider a development plan for the Fishguard community which links effectively across this wide rural area. A key focus will be on the longer term wellness and prevention opportunities of working across statutory and third sectors and on reducing social isolation for the older age community. Scoping work for this project will begin in December 2018.

In the *Milford Haven and Neyland Community* we will consider a development plan for the Neyland community in 3-5 years and a networked approach with other surgeries in the area. A key area of focus could include elements of long term chronic condition management. Scoping work for this project will begin in March 2019.

In the *South East Pembrokeshire Community* we will focus on a plan for the development of Tenby health and well-being centre (Tenby Hospital) and how this links with services across this large rural area. A key focus in this area will be on same day and urgent care access for the local and temporary population, with particular reference to meeting the needs of the older age community. Scoping work for this project will begin in January 2019.

In the *Haverfordwest Central Community* we will consider the central network needed to support wider county clinical teams that respond urgently to the step-up and step-down care of our population. Scoping work for this project will begin in February 2019.

In addition to this focus on early co-design in Pembrokeshire, we will also:

Set up an operational working group and work with staff and local people on the future model and development of Amman Valley Hospital.

Develop the Community Resource Team (CRT) in North Ceredigion to provide a comparable model to that in the south, which has been very successful in preventing unnecessary admissions and supporting timely discharge.

Develop and offer a range of community based preventative services in Carmarthenshire, including CUSP (Carmarthenshire's United Support Project).

Work in partnership to transform health and care through funding for four priority areas which align to our strategy:

- Improving lives through technology
- Supporting change together
- Strengthening our integrated localities
- Connecting people…kind communities

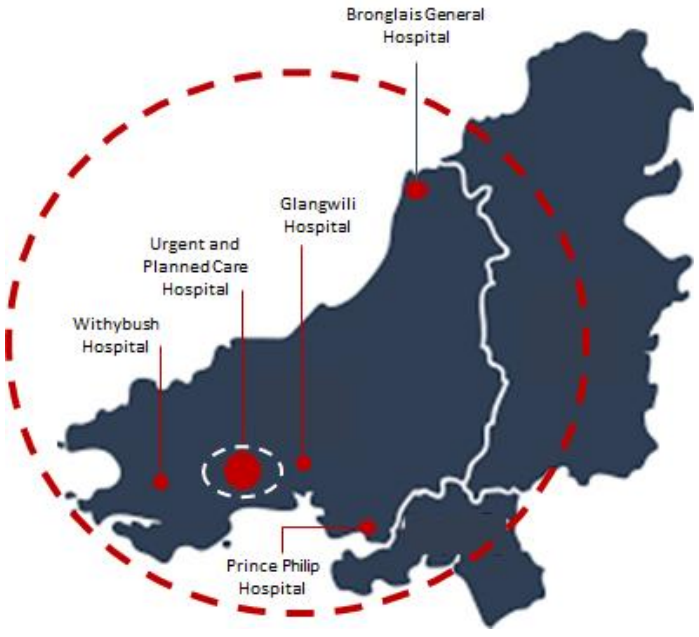
Increase the number of dental practices who are participating in the dental contract reform process (baseline level 10% of all contracts).

Roll out the Choose Pharmacy platform. This is part of a national campaign to promote and inform what community pharmacy can offer.

Develop a Glaucoma Optometric Diagnostic and Treatment Centre (ODTC). This will improve waiting times for follow up and ongoing monitoring.

Our future hospitals model

Our hospitals are embedded in our communities and will continue to be a key part of our wider health and care system delivering a broad range of services for the people living in mid and west Wales. They will play an important role in providing clinical excellence in specialist support when it is needed, whether that be to undertake highly-skilled surgery or treating people who are more severely unwell. This can include care that is planned, such as an individual's need for a hip replacement, or in times when care is more critical in nature and an urgent response is required. They will also be designed to facilitate high quality education and research for students, trainees and established staff. The sites and facilities



will promote well-being of the workforce, reduce reliance on paper, and use the latest carbon efficient, infection control design knowledge.

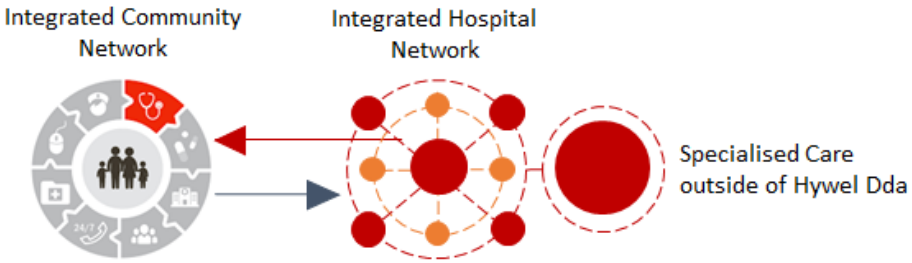
Our future hospitals model will have a new hospital located in the south of the region, which will be our main site within a network of hospitals that includes:

- Bronglais General Hospital in Aberystwyth
- Glangwili Hospital in Carmarthen
- Prince Philip Hospital in Llanelli
- Withybush Hospital in Haverfordwest

Our hospitals will be vibrant centres supporting the health and well-being of the communities they serve. Building a new hospital will take several years to realise. Due to service fragility, there may have to be pathway changes or difficult decisions made to maintain the safety and sustainability of services during the transition years. These may deviate from our long-term aspirations for our health and care services, but would be required to maintain patient safety until we can deliver the ambitions described in this strategy. This will be alongside the strengthening of our community model by moving towards specialist care teams providing expert management of long-term conditions in the community.

This will mean new ways of working as we direct resources towards preventing ill health, whilst promoting wellness, independence and interconnectedness. Specialist expertise will continue to be essential, but we will look to broaden the range of generalist skills so that our specialist teams work across our hospitals, and more closely with community and social care services to increase access to care in the community rather than in a hospital setting.

New ways of working across the whole system

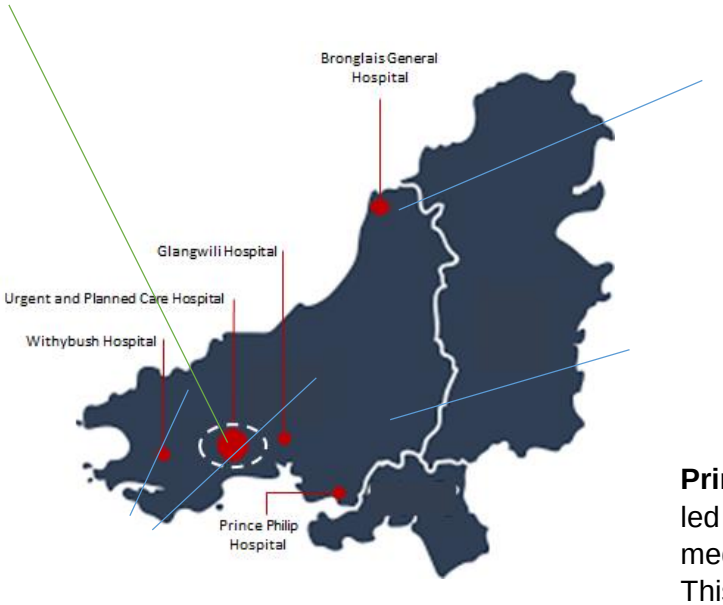


Our hospitals network will form part of our wider whole-system approach, working much more closely in the community at one end, while forming stronger links to highly specialised services at the other. This will involve close working arrangements with our neighbouring heath boards in Swansea and Cardiff along with other organisations such as those providing emergency and non-emergency transport services. Collectively we will need to develop information communication technology, which will include effective wireless and mobile solutions across the whole-system. An important example of this is tele-heath technology, which will provide new and innovative methods and pathways in patient assessment and diagnosis, and home monitoring and follow-up, which closely links patients with hospitals and community services.

An overview of our future integrated hospital network is presented on the following pages as an indication of the changes across our integrated hospitals network:

Urgent and planned care hospital

Our new hospital will act as our main site for our network of hospitals, covering both urgent and planned care provision for the whole of the Hywel Dda area. We will move to a more centralised model for all specialist children and adult services, which will include a specialist mental health facility and learning disabilities. It will function as our Trauma Unit and main Emergency Department. We will have more consultants in permanent posts being available more of the time, specialising in urgent and emergency care, and planned care activity for rapid treatment of highly-specialised elective (planned) operations. Consultant-led services will be available 24 hours a day, seven days a week and we will provide rapid access and high-quality emergency and specialist assessment and treatment, discharging people as soon as possible so they can receive the appropriate rehabilitation closer to home. We will design the hospital site to ensure that planned care is delivered in a timely manner. There will be rapid treatment of elective operations, in a separate building on the site, therefore avoiding the disruption or delay that can occur from high volumes of emergency cases through protecting available beds.



Bronglais General Hospital will build its reputation as an excellent rural provider of acute and planned care. It will therefore continue to provide urgent, emergency and planned care services, with more specialist cases transferred to our new urgent and planned care hospital as part of our wider hospitals network (as well as other regional sites for more critical care).

Glangwili and Withybush hospitals will both provide a GP-led minor-injuries unit with full diagnostic support. The hospitals will include therapy and nurse-led step-up and step-down care, midwife-led units, along with chemotherapy and palliative care with the ambition to provide dialysis units at both sites. Additionally, we will develop more locally-based treatment and care including a range of outpatient clinics so that care can be provided closer to home.

Prince Philip Hospital will provide GP-led minor-injuries as well as acute adult medical care with diagnostic support. This will include consultant-led overnight inpatient beds for patients to be cared for locally and will also act as a stabilisation and transfer hub for certain specialised conditions as part of our network with colleagues in our new urgent and planned care hospital, as well as other regional sites for more critical care. Additionally, we want to build on existing services that can thrive as centres of excellence, for example those relating to breast surgery.

What you will see in our hospitals

We have been working with our clinicians to start to define the services people should expect to see within our network of hospitals, although this is not exhaustive and will need to be further developed as we start to co-design all the different pathways of care through our whole-system.

Urgent and Planned Care Hospital

- trauma unit and A&E department
- 24/7 access to specialties including:
  - general surgery
  - general medicine
  - specialty surgery (including trauma and orthopaedics, ear, nose and throat (ENT), ophthalmology, urology and other specialty advice including vascular, breast etc.)
  - specialty medicine (including cardiology, gastroenterology, respiratory, diabetes and endocrine, elderly care, and other specialty advice including neurology, renal, rheumatology, dermatology, oncology, palliative care etc.)
  - anaesthetics and intensive care
  - paediatrics and neonates
  - obstetrics and gynaecology
  - psychiatry (co-located assessment and treatment units)
- critical care (levels one, two and three)
- full 24/7 diagnostic support that cannot be undertaken locally
- planned major day case and inpatient operations and treatment covering range of specialities outlined above including major cancer surgery
- cardiac catheter and pacing laboratory
- multi-professional health education facility
- research and innovation facilities, including Institute for Life Sciences (ILS)

I was recently involved in a serious car accident with my friend Mark, on our way to visit my parents in Newcastle Emlyn. Unfortunately, Mark had serious injuries but was thankfully taken by helicopter to Cardiff for specialist neurosurgical input. I was taken by ambulance to the new urgent and planned care hospital,kept in overnight and discharged the next day with minor injuries. Mark suffered a head injury but did not require any surgery. After he was stabilised in Cardiff he was transferred back to Bronglais Hospital initially until he no longer needed medical support and is now currently receiving some physio in Aberystwyth for his injuries. He is also receiving support at home, along with follow-up clinics through Skype with a neurosurgery specialist.

Having had one difficult pregnancy and going into premature labour with Ben I was very anxious when I found out I was pregnant again. I now have regular monitoring both with my mid-wife at my health and well-being centre, and a consultant who sees me at the new hospital where I have regular scans. I am booked to have my baby at the new hospital where they have state of the art facilities and full neonatal support should my baby need it.

Bronglais General Hospital

- 24/7 access to A&E department and minor injuries
- general medicine, general surgery, surgical and medical specialties, paediatrics, mental health and diagnostics
- midwife-led-unit and low risk consultant-led obstetrics
- day case operations including endoscopy and a range of surgical procedures would continue at Bronglais Hospital
- outpatient services, oncology and palliative care

Prince Philip Hospital

- 24/7 GP-led minor injuries unit providing care for injuries and illnesses
- consultant-led care for medical emergencies through the acute medical assessment unit
- speciality beds for patients supported by consultants and their teams
- critical care capability
- low risk day surgery and endoscopy
- chemotherapy
- diagnostics support
- rehabilitation

Glangwili Hospital and Withybush Hospital

Our repurposed hospitals will form part of an Integrated Community Network that include:

- all the care and support offered in our health and well-being centres
- 24/7 GP-led minor injuries unit providing care for injuries and illnesses
- beds for patients with less critical needs or rehabilitation (nurse or therapy led) which will be step up / step down
- specialist ambulatory hot clinics for long term conditions, frailty, dementia, pain
- outpatient specialist advice, including remote access to specialist opinion via telemedicine
- community paediatrics
- 24/7 access to diagnostic support
- midwife led unit
- chemotherapy and palliative care
- ambition to maintain renal dialysis
- ring fenced day case elective facilities including endoscopy

Ben had a bump on his head when we were on the beach in Tenby recently. I took him up to Withybush where he was assessed by a nurse and then the GP. He did need some glue to close the cut on his head, but fortunately didn't need to stay in. We didn't need to wait very long at all to be seen and for Ben to have his treatment. The hospital has been built with sensory impairment and hidden disabilities like autism in mind, with clear signage and calming spaces. Ben is delayed in his development, but he copes brilliantly with his surroundings when I take him to his appointments and the staff are very understanding and kind.

Emergency transport

In the design of our network of hospitals we will address concerns expressed during our engagement and consultation around the provision of a timely response for residents in rural

communities who may have further to travel to hospital as a result of changes to the hospital services. Examples of some medical conditions which are time sensitive include cardiac arrest, ST elevation myocardial infarction (STEMI), stroke, and sepsis.

Within the new model of care there will also be emergency conditions that would not be definitively managed in our hospitals. Some conditions such as ST elevation MI, burns, head injuries or chest injuries would continue to be treated at tertiary centre sites namely Morriston Hospital, Swansea, or University Hospital Wales, Cardiff. The new model needs to be cognisant of these medical conditions when designing a transport model that remains fit for purpose.

Within the new model the Wales Air Ambulance and the Emergency Medical Retrieval and Transfer Service (EMRTS), with their road and air vehicles, will have an important role to play providing critical care for patients requiring life-saving treatment. It will be vital moving forward to further develop and enhance this part of the service specifically working with national partners to promote 24 hour, seven day a week service provision.

Regional working with Abertawe Bro Morgannwg (ABM) University Health Board

We are committed to continuing our strong working partnership with our neighbouring ABM health board, in order to design sustainable health and care on a regional footprint which is integrated around the patient, enhances well-being, resilience and independence, and enables a shift toward prevention, self-care and care at (or closer to) home.

Legislation such as the **Well-being of Future Generations (Wales) Act 2015** has enabled closer working between the health boards and a strong collaborative approach to improving long-term population health.

We already plan and deliver services together on a regional basis, to manage the flow of patients in both directions across the borders of ABM and Hywel Dda UHB. The strength of this working relationship is demonstrated through the existing regional arrangements of the Joint Regional Planning and Delivery Committee (JRPDC) and A Regional Collaboration for Health (ARCH). Both health boards are fully committed to jointly delivering on the priorities of the JRPDC and ARCH, which are as follows:

Joint Regional Planning Delivery Committee	**A Regional Collaboration for Health**
Endoscopy Catheter laboratories Orthopaedics Ophthalmology Vascular	• Service transformation - pathology - hyper acute stroke services - neurology - cardiology - interventional radiology - digitisation • Skills and education – growing talent and workforce well-being • Well-being – expanding network of health and well-being centres and development of an integrated well-being information platform • Research, enterprise and innovation – expansion of Institute of Life Sciences (ILS) facilities across the region

In addition to these existing priorities, clinicians from both boards have met at two workshops and signalled their joint commitment, in principle, to explore further opportunities for joint working around:

- emergency care
- frailty care
- women and children's services

MAKING IT HAPPEN

This strategy sets the overall direction for health and care in mid and west Wales, which will guide the service change needed during the coming years. We have committed to working together with our staff, patients, people in our communities and those delivering or interested in health, care and well-being to design detailed plans to deliver this together through continuous engagement. Hywel Dda CHC asked us to continue to engage and consult when necessary on service changes when we have designed the detail of how new services will run.

Phase 3 of our programme of transformation has four objectives, to:

- align the key deliverables of the transformation programme with this long-term strategy
- facilitate the successful implementation of the initiatives within each change programme
- ensure an integrated way of working between all of the change and enabling programmes
- define the roles and responsibilities of each programme

We know that to deliver the change required we need to work at scale and pace during the coming months and years ahead. What we have learned already from our engagement and consultation tells us there are some important areas we need to concentrate on.

In order to make this happen, we will be working through a programme approach to move our strategy into reality through a set of enabling and change projects. The scale of this strategy covers the whole-system so we will need strong programme management and governance to ensure accountability and transparency throughout. We will also need to carefully plan the transition to the new way of working, while making sure that we address the short term challenges we face around fragile services and workforce. This may mean that we have to make decisions which in the short term divert us from our longer term strategy, in order to sustain safe services, but any changes would be temporary in the interests of patient safety until we can realise our ambitions. We will continue to talk to our staff and local people as we move forward with any service change.

This strategy will be translated into detailed plans during the coming years through our planning process. These plans will set out how we will work together with our partners to deliver the required changes to set out:

- key development and actions that the board will take
- why these actions are important and how they link to the strategic direction
- what these developments and actions will achieve
- when the benefits will be realised and the key risks to delivering these changes

We will plan in three-year cycles, with the level of detail being different for each:

- Year 1 plans – will clearly describe actions, milestones and resourcing for the coming year
- Year 2 plans – will indicate priorities, actions and risks for the second year, and include performance projections and will identify major challenges and opportunities
- Year 3 plans – will show how we propose to make continued progress towards our strategic vision

Transforming our future: a portfolio of programmes

We will adopt a portfolio programme management approach to transform the future of health and care. This means that we will have a set of different projects brought together under one programme to ensure that all of the connections are made between all of the work that we need to do to deliver this strategy. This moves our Transforming Clinical Services programme into phase three, the Deliver Phase, which is about starting to make the changes that we need to make to make our strategy a reality.

We know that to deliver the change required we need to work at scale and pace during the coming months and years ahead. What we have learned already from our engagement and consultation tells us there are some important areas we need to concentrate on. We are committed as a board to address issues that will enable us to deliver this strategy. There are steps already underway to progress this work but we will be developing detailed plans around these areas, informed by continuous engagement, as we translate this strategy into reality.

The programme to deliver this strategy will have a strong governance structure that provides leadership and oversight at all stages along the way.

Our programme plan, which will sit alongside this strategy, will define the scope of the transformation portfolio programme, how the work in each programme will be organised and the associated arrangements for leadership and delivery. Given the scale of this programme we will need to be flexible in its delivery, and as we move forward, we may need to amend or add projects.

Our change programmes

We will work with our local and regional partners to deliver the following programmes:

- Prevention and early intervention at scale
  A focus on population health – creating our movement for change

- Integrated community services
  Working in an integrated way to deliver services across a whole system

- Transforming our hospitals
  Helping those who need the most specialist health and care support through a network of hospitals across mid and west Wales

- Operational delivery, performance and turnaround
  Enabling effective change management, delivering performance and maximising productivity and efficiency gains to support the sustainable delivery of the new care model

- Partnerships and commissioning
  Building key partnerships with local authorities, university partners, third sector, and other organisations to deliver and commission services and support

Our enabling programmes

Key infrastructure and approaches to working (known as enablers) will be put in place to support the successful delivery of our strategy:

- engagement and communications
- leading and working differently
    - workforce and organisational development
    - regional and partnership working
    - education, training, research and development

- transport and access
- finance and procurement
- capital and estates
- digitally enabled mid and west Wales
- quality and service improvement

Engagement and communications

Continuous engagement

Our commitment is to “work together every step of the way” with our staff, patients, carers, people who live and work in our communities and people or organisations delivering or interested in health, care and well-being.

The benefits of this approach mean we work together to design services that better meet the individual and community needs. This approach improves services and means that resources can be more efficiently focused.

We are developing a framework for continuous engagement, which will outline:

- our vision
- the underpinning principles and benefits
- why we are taking this approach
- how we will know it is working

The framework will provide the basis for any continuous engagement Hywel Dda UHB will need to undertake.

Recognising the richness and diversity in experiences amongst our population, our approach to continuous engagement must be flexible and accessible for people with protected characteristics and whose first language is not Welsh or English. We will sometimes need to listen and have conversations with particular communities about specific services or around what is important to them. We will need to make it easier for people to have these conversations with us.

When considering changes that have an impact on communities, we will base this engagement on our seven integrated localities. This will support working across not only health and social care but also with other organisations involved in the wider determinants of health and well-being, including the third sector.

For changes involving the re-design of service pathways, our engagement will be prioritised according to the timeline of work as detailed plans for services are developed. We will also continue to engage on the impact of potential changes that relate to action being taken now to work in more efficient and productive ways.

We will also have conversations with the whole population, asking what 'wellness' and 'well-being' means to them and what support services and networks they would like to see developed in their community to enable and promote health and well-being.

We will continue to build on what we have learnt and are committed to delivering an ambitious, flexible and integrated approach to continuous engagement. To achieve this we will work with the Regional Partnership Board and Public Services Boards to update existing engagement mechanisms. This will enable us to achieve the strategic vision whilst also being flexible enough to adapt to needs at a local level.

To deliver our strategic aims we will need to communicate with our whole population on an ongoing basis. Our work to engage with the population and to listen and learn from patient experiences, along with providing general opportunities for the public to respond to us and have a dialogue, will inform what we do. We have a statutory duty to communicate with our public, for example when there is a major incident to 'warn and inform' but it is also the right thing to do and critical if we are to be accountable and therefore, trusted.

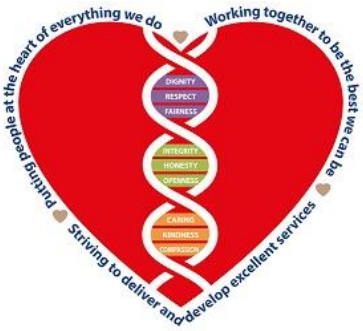
Communication activity will be essential to some of the detailed plans coming out of this strategy. For example in ensuring our populations have the right information to make choices about how they access health and care support and in both celebrating current employees so they feel valued and in attracting a future workforce. We will continue to talk with people, including staff, through a number of means, depending on the audience we are trying to reach. This includes non-digital campaigns, using printed materials and face-to-face events; working with the media; and using digital platforms such as websites and social media. We need to be creative and flexible to learn from the changing needs of our audiences and advances in communication techniques to continually evolve.

Leading and working differently

Workforce and organisational development

Our **values** are:

- Putting people at the heart of everything we do
- Working together to be the best we can be
- Striving to deliver and develop excellent services



To deliver this strategy, we need to make changes to the way in which we deliver our services, which means we need a flexible and adaptable workforce that is competent, confident and engaged. We strive to be an employer of choice and the health and well-being of our staff is paramount.

By understanding future requirements we can develop workforce pipeline, concentrating on our local population and providing them with new and exciting career opportunities in our rural healthcare model. This is our opportunity to achieve a sustainable future.

We recognise that around 80% of the staff we will have in the future are already working for us, and we have been working with them to develop and implement our workforce transformation programme, to support the delivery and sustainability of our future service model. We will continue to work with and engage our staff in shaping their future, throughout this programme.

While the transforming clinical services strategy has been developing, we have escalated our workforce transformation programme, which has seen changes in the way we currently work, the increasing development of new roles and expansion of roles. This work will continue throughout the programme and includes,

- new ways of working – maximising use of our information systems, and streamlining processes.
- developing and implementing new registered health care professional roles including advanced and extended scope paramedic, nurse, therapy and health science practitioners
- developing further physician associate roles
- introducing new types of health care support worker roles
- developing new professional roles and ways of working that do not currently exist
- delivering a workforce pipeline through the development of career opportunities targeted at our local population to future proof our workforce through our 'Grow Your Own' programme.

For our workforce transformation agenda, this means that we will:

- deliver this transformation in partnership with our staff
- prioritise our workplan to maximise effectiveness and enable our staff to be able to care for those with the greatest health need first
- avoid duplication, and ensure that staff are working to the top of their license for the majority of their time (this means practicing to the full extent of a staff member's education and training, instead of spending time doing something that could be effectively done by someone else)
- maximise the benefits of our workforce intelligence systems to streamline our working practices, and utilise robust intelligence to make our decisions, and monitor our performance
- look at the opportunities the wider public and third sector brings and where appropriate, deliver multi-disciplinary and multi-agency workforce

I work as an emergency department consultant across Hywel Dda - the majority of my work is based within the recently built urgent care hospital, which also has a planned care hospital on the same site. I also work at other sites as part of my regional role. This role allows me to ensure that my skills are constantly improved and updated by working in different situations and with colleagues with a different skill set to my own. It also allows the sharing of best practice across all sites with colleagues within the emergency department…we see ourselves as a regional consultants rather than being affiliated to one hospital site.

Our greatest asset is the people we employ to provide our services and care for our patients. Alongside this are our partners who work with us as volunteers, work experience and staff who work within partner organisations. It is essential that we continue to support our existing and future staff as the organisation transforms. We are committed to continue this through our communications with staff and their representatives and we will develop and embed our retention and attraction strategy to ensure staff are reassured of our commitment to them, are fully informed, involved and influence future service models.

The key to our future is the delivery of our Education Strategy to ensure our workforce is supported and developed to undertake their current roles effectively and are ready to embrace new roles for the future in an organisation which is continually learning and improving. We also

understand the need to attract new staff to our organisation, and support our local population in health and well-being outside of our hospitals. The strategy concentrates on three areas:

Staff	• Providing requiste skills and competences and supporting career development
Our Community	• Including our partners, the wider public services and, where appropriate, the people of Hywel Dda who provide care on our behalf
Our Workforce of the Future	• Including our education partners; supporting our local population in understanding the opportunities we provide for a career in health

We have close working relationships with our local Further Education and University providers, and have been introducing new education and training programmes at all levels, to meet the needs of the changing workforce. For some areas the education programmes take many years to complete, so understanding the needs of our future services to ensure we are commissioning the appropriate education is vital.

In all of our workforce transformation plans, we are committed to providing opportunities for the workforce to study and to deliver services in the Welsh Language, and there is a range of support for staff who wish to learn Welsh, or improve their existing Welsh Language skills.

An Organisational Development programme which supports and improves our leadership capacity and capability is in place to ensure an effective transition towards the new service models. This includes programmes currently in development which will be delivered in partnership between the health board, our three local authority partners, and where also appropriate third sector partners.

Building on our staff survey results for 2018, our TOP (Transforming Organisational Performance) strategy work will commence in 2019 with a discovery phase where we will conduct an organisation-wide inquiry about our existing culture in relation to best practices and that which we desire to co-create for Hywel Dda UHB to ensure that we become a top performing organisation. This phase will inform our design template for the organisation so that we can grow our culture for the future to underpin our strategy.

I'm so proud to be a health care support worker for Hywel Dda University Health Board. I had my appraisal recently and told my manager of my dream to become a paediatric nurse. She was very supportive and told me that even though I don't have the qualifications I need to go to university and I can't afford to give up my job to study, I can access the Hywel Dda 'Grow Your Own' scheme. They have mapped out a development pathway for me to achieve my dream while remaining employed.

I have enrolled on the level two apprenticeship programme which will then be followed by the level three and four programmes. Eventually this will develop into an assistant practitioner role, and then I'll have an opportunity to go university on a part time basis. I would qualify as a registered nurse in around six years time. My friend Nia has completed this programme recently, and has taken up a position as a registered nurse in a surgical ward a few months ago. It's a long road ahead and a lot of commitment but it's worth it to achieve my dream.

We are working with WAST to support the delivery of our enhanced community model, providing rapid lifesaving treatment in an emergency, and also providing urgent assessments in people's homes reducing the need for transfer to hospital. This may include increasing the number of advanced paramedic practitioners or paramedics to support primary and community based services, further integration of WAST clinicians with GP clusters: working as part of the multidisciplinary team within the minor injury units, or further development of WAST's rotational model (the rotation of advanced paramedics through the Clinical Contact Centre, WAST and Out of Hours or other Primary Care settings) which could encompass working with respective emergency departments.

Further WAST workforce opportunities may exist in relation to developing multi-disciplinary response teams which allow for health care to be provided within the home e.g. a joint clinical response from a paramedic and a therapist responding to non-injury fallers within the community.

Education, training, research and development

We will continually invest in our research capabilities and work closely with our university and education partners, to nurture a culture of research, innovation and development. Through a range of innovative models, tested across health and social care in Wales, we will transform our local health and care services. This will enable us to provide better outcomes for patients now and in the future and also have a positive impact on our staff and the facilities they use.

I need to keep up my healthy lifestyle or my health will still be at risk. I now wear a device that constantly measures my heart rate, blood pressure and breathing. My lifestyle coach has explained to me how it works: data are processed through algorithms that are streamed to my care team, building up a complete picture of my health that means that even a subtle change is immediately picked up and acted upon. It means that my care is personalised to me. I don't need to tell my GP of any changes when I see her; she has all the information she needs at her fingertips in my electronic notes. My coach has taught me how to interpret the information myself, which helps me feel in control of my health. My data are also collected for research purposes, and the university updates me on how my information is informing new medical

We plan to develop a new multi-professional health education centre at the new urgent and planned care site, which will provide excellent facilities for training students, trainees. It will take advantage of the latest technology including simulation, and will enable sessions to be joined by attendees remotely using the latest video conferencing equipment. All clinical facilities will be commissioned with education in mind, ensuring that students and trainees can be easily accommodated in the clinical environment.

In addition to facilities at the Llanelli Wellbeing and Life Sciences Village, we aim to develop our research and innovation capability further and intend to develop research and innovation facilities on the urgent and planned care site, including an Institute for Life Sciences (ILS), supporting the creation of a research culture and giving all the staff the opportunity to add to the body health and social care research.

As we develop our plans to deliver the new social model for health we will work closely with our University Partners and Health Education and Improvement Wales (HEIW). There is much to learn from research studies already undertaken and it is essential that we work in partnership to measure the impact of new services and initiatives that we put in place. An example of this is our work with the Wales School for Social Care Research (Swansea University), the Centre for Ageing and Dementia Research (funded by Health and Care

Research Wales) hosted by the Centre for Innovative Ageing at Swansea University, Centre for Health and Ageing at University of Wales Trinity St David and the Centre for Excellence in Rural Health Research at Aberystwyth University. Swansea University (Medical School and College of Human and Health Science) is committed to supporting the development of the integrated locality way of working described in this strategy. This work will focus on weaving teaching and research into clinical practice; approaches to ageing and dementia; innovative approaches to housing and living for older people; and social care dimensions and sustaining population health - from childhood onwards.

Transport and access

We are working with our regional and national partners such as the regional transport group, local authorities and the Welsh Government to consider improvements to the region's transport infrastructure to deliver this strategy, including the development of a Regional Transport Plan. Considerations will include road infrastructure and also the importance of the rail network, and its potential in supporting patients, family, carers and staff travel to our future facilities, and reduce traffic on the roads. This will include promoting the completion of the Joint Transport Plan (JTP) for South West Wales, 2015-20 and ensuring that the new hospital developments are considered as part of any new plan developed for the time period post 2020.

Working in partnership will ensure that the aims, objectives and programme of improvements identified in any future JTP will be of mutual benefit, will help strengthen the case for transport and highway improvements and crucially, support and enhance our prospects of securing funding for the required enhancements in future years.

We will continue to campaign for the provision of 24/7 Emergency Medical Retrieval and Transfer Service (EMRTS) and Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS). This, along with continuation of 24/7 responsive Wales and West Acute Transport for Children (WATCh) services and the commissioning of community access solutions that build and scale up existing successful models, is vital to providing extra assurance that critically ill patients will rapidly get to the right place. We continue to work closely with WAST to commission ambulance services that better support the delivery of services within the community, and engage with local equality groups to ensure consideration is given to the particular access needs of people with protected characteristics and those most vulnerable in our population.

I was getting my hair done when I tripped over my feet and fell. My husband was quite upset that I fell but thankfully the staff in the hairdressers were really helpful and phoned 999 straight away…I said I was fine but they wanted to be sure. The call went to the clinical contact centre and a 999 call taker took the call off the nice hairdresser. I was passed the phone and following a quick chat with me to find out what had happened they transferred the call to the clinical desk. It was only a little fall but I had a few l cuts and grazes on my hands, arms and legs from where I hit the pavement. The clinical desk thought it was best that I was checked over so a nice community paramedic called John came out and treated my cuts and grazes – he was with us in just over 10 minutes so not too long to wait. John the community paramedic advised that if I was struggling with my mobility following the fall, the Community Response Team (CRT) would be able to come to see me in my home and treat any issues I may have then. He said that he and the CRT were based in the same health and well-being centre so he would tell them that I might call and highlight what had happened along with the injuries I sustained. Although I felt a bit silly from falling and I didn't want to worry my husband, everything was treated quickly and efficiently and allowed us to go back to our daily routine.

Finance and procurement

Building on current affordability modelling, we will continue to refine and check that affordability assessments are correct as we move to detailed planning and co-design of the service changes signalled in this strategy, with fully detailed plans costed in depth. Finance has a key role in the delivery of the strategy with the development of a strategic financial plan to support both revenue sustainability and capital investment in new and re-purposed facilities. We need to bring together acute (hospital) redesign, community and social care expansion, and a greater role for health promotion and disease prevention together. We also have to consider the impacts of workforce, digital, estates and transport enabling changes on the cost of delivering care and support.

As part of the process of defining the 10 year Strategic financial plan we will have a strong focus on engagement with the public, patients, staff and other stakeholders. Whilst the reasons behind the need to transform services are not predominantly financial, it is important that we remain accountable for how we use our resources in delivering services so that we can transparently assure our population that our health care provision is innovative and of excellent quality, and also delivering the best outcomes possible for the money invested.

Detailed financial planning cannot be done in advance of developing detailed service change and enabling plans for each of the areas identified. These elements of work will move forward at pace and inform the 10 year financial strategy.

Capital and estates

This strategy sets out our clinical strategy including a new hospital and community model, with a new Planned and Urgent Care hospital on a single site; Bronglais General Hospital; Prince Philip Hospital and repurposed hospitals in Glangwili and Withybush, alongside health and well-being centres. We are now in a position to begin discussions with the Welsh Government on the scale of works and the essential governance required to deliver a capital programme including investment into buildings or assets such as technologies. We will need to consider the following areas as part of the development of a business case to support these developments:

Resources and funding – the money needed for the building and where this will come from

Land acquisition – our aspirations for the site, the timing of purchase and how we select a location

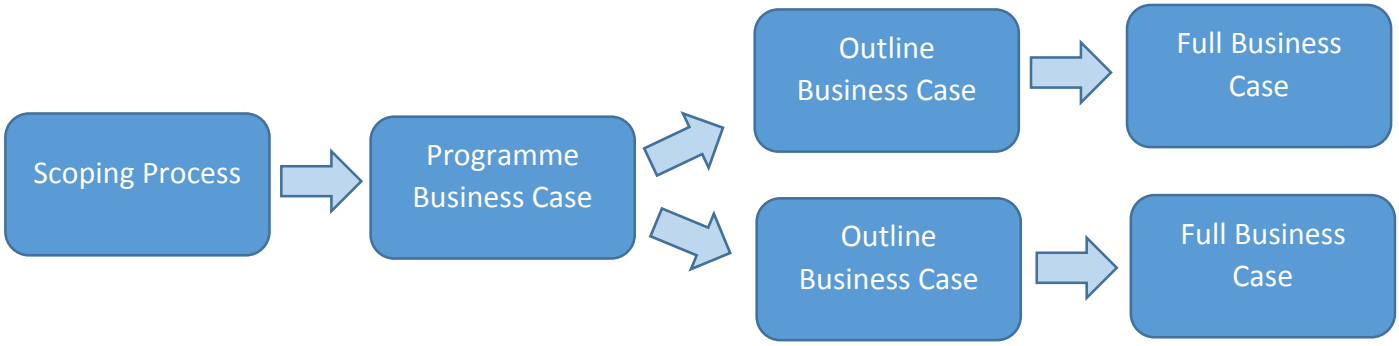
Staffing structures – the team needed to draft and deliver the business case

Sequencing – what order the developments will happen in

Broad timelines – the amount of time it is expected to take to deliver the scheme

We will work with our partners across the region to identify the most suitable locations and other opportunities to share our assets as part of our commitment to integrated working.

The key steps in the business case route are:



The scoping and overarching programme business case will cover all capital projects, but each of these projects will have their own Outline and Full Business Cases. Purchasing of the land for any new buildings is subject to agreement with the Welsh Government and a separate appraisal and feasibility study will be undertaken specifically related to the location of the proposed new Planned and Urgent Care Hospital. We are committed to starting this study at pace.

The capital programme will be subject to a defined resourcing plan and clearly defined governance arrangements.

Whilst we have not yet confirmed the detailed timescales for each element until we have completed the scoping process, a high level indicative timeline is detailed below:

The business case will set out clearly any opportunities for estates integration, which may include working with WAST to develop Social Deployment Points within the new build urgent and planned care hospital and other healthcare sites as appropriate. These points are spaces for ambulance staff to stand down during shifts when not dealing with calls, allowing operational staff to be based in areas where it is expected the next call will originate from. This ensures the staff and resources are positioned closer to the area they will be covering for emergency calls rather than travelling much longer distances back to the nearest ambulance station. There may also be opportunities to base Non-Emergency Patient Transport (NEPTs) vehicles at some of the new hospital sites.

Further estate integration and joint working opportunities may also exist with the other emergency services, such as the police and fire services which we will pursue as part of the business case development. We will also remain cognisant of the requirement to continue

providing Clinical Logistical Support services (including the delivery of specimens, blood, vital medicines and a wide variety of other non-patient items) in routine, urgent and emergency (blue light) conditions for primary and unscheduled care in hospitals, clinics, surgeries, GP practices, pharmacies etc. We will work closely with Wales Health Courier Service (HCS), and internal porter services (inclusive of private providers) to ensure that transfer to the new model is as seamless as possible.

Digitally enabled mid and west Wales

Digital working and solutions will underpin every aspect of health and care.

We want everyone to have access to the digital information, tools and services needed to help maintain and improve their own health and well-being. We want health and social care information to be captured electronically, integrated and shared securely. We want digital technology and data to be used appropriately and innovatively to help plan and improve services and ultimately improve outcomes for all.

We will work closely with Welsh Government to adopt the national priorities, which includes implementation of the Welsh Community Care Information System (WCCIS), and the creation of an online digital platform to enable individuals to make choices on their treatment and find appropriate services. Working with our regional partners is key to shape the future of health and care through a digital mindset based on our infrastructure and the introduction of new technology.

Through the digital ambition set out in this strategy we want to deliver the strategic benefits illustrated in the following table, which are listed alongside generalised outcomes:

Hywel Dda Strategic Benefits	Examples of types of outcomes and benefits
Patient safety increased	Increased timeliness and availability of relevant clinical information decreased transcription errors and decreases risk to patients' safety
Positive patient outcomes increased	Easy access increases speed and of diagnosis, care, treatment plan and onward referral
Patient confidence increased	The availability and targeting of accurate and relevant information at the point of contact
Legal compliance maintained	Requirement to comply with policy, legislation and standards
Healthcare system efficiency increased	Processes are faster, or wasteful processes can be decreased or eliminated
Overall healthcare system costs decreased	Information management and technology improvements eliminate wasteful processes and reduce expenditure

Quality and Service Improvement

The detailed service pathways to be co-designed will be developed through the lens of quality improvement. We have committed to adopt a whole system approach to quality improvement and this is set out in our Quality Improvement Strategic Framework.

Our goals within the framework include:

- no avoidable deaths
- protect patients from avoidable harm from care

- reduce duplication and eliminate waste
- reduce unwarranted variation and increase reliability
- focus on what matters to patients, service users, their families and carers, and our staff

In practice this will include carrying out actions such as improving communications within and between teams and service providers to ensure that care and treatment plan objectives are clear and comprehensive.

We will put have mechanisms in place to evaluate risks associated with care so that clinical pathways and services are implemented in a consistent and equitable way, along with ensuring incident reporting and investigation processes are fit for purpose.

We strive to create a culture at all levels of the organisation where challenging the way we do things is actively promoted and proposals for new ways of working encouraged and provide staff with appropriate guidance and training.

In order to improve quality within any new service pathways patient engagement in shared decision making about their care is paramount.

HOW YOU CAN GET INVOLVED

To transform and achieve the vision for a healthier mid and west Wales, a critical component is to continuously engage with the people who live and work in our area, so we design together how this will look. This will deliver outcomes that matter to people, and services to meet people's needs and expectations. We will know we have met our strategic goals – those around starting and developing well, living and working well, and growing older well – by listening to your views and experiences. We will also empower and inspire people – our public and staff alike - to determine for themselves what success looks like and to join us in a conversation about what really matters when we seek to improve health and well-being.

Our approach is to engage within our seven integrated localities at an unprecedented scale, by providing a dedicated person in each area to support and enable continuous engagement around health, social care and well-being. This resource will also support integrated locality teams with communication, achieving inclusion, and ensuring requirements around preferred language choice are met.

We will utilise many engagement opportunities and methods as we strive to be leaders in continuous engagement. These will range from informal conversations and engagement in communities to developing representative focus groups and panels or citizens assemblies. These could be based in locality areas or be specific to certain services, including primary care. This means we talk to people with lived experiences, including those who traditionally experience barriers and exclusion, adding a depth to our conversations and avoiding engagement and consultation fatigue.

Our involvement and engagement scheme - Siarad Iechyd / Talking Health - will help develop our integrated locality models and design new service pathways. Member of this scheme are empowered to have their say on how local health services are planned and the scope of this to include wider determinents of health and well-being. **You can get involved in this conversation by joining Siarad Iechyd/Talking Health – contact details can be found on the health board's main website - www.hywelddahb.wales.nhs.uk**