HOSBIS Y CYMOEDD
Hospice of the Valleys
Registered Charity Number 517724

Three-year strategy

2022-25

Foreword

This document outlines the strategic plan for Hospice of the Valleys over the period 2022 to 2025. It sets out our approach to delivering services, responding to predicted changes in the external environment and the changes we want to achieve as an organisation.

Our strategy is rooted in analysis of current practice and trends in palliative care. It has a base around the current and future needs of the populations we serve as well as reflecting the influences of external local and national health and social care policies and priorities.

We have engaged with partners, staff and stakeholders in putting our strategy together and this engagement will continue during the life of the strategy and beyond. This will ensure that our services and plans remain flexible and responsive, and act as a guide to a meaningful process in adapting, developing and improving the services we offer in partnership with those we care for as well as those who commission our services.

We have achieved much over the last five years and I believe that it is appropriate to acknowledge some of the key achievements within this section of the strategy document.

Within our organisation we have:

- Maintained face to face contact and normal service delivery during the pandemic.
- Appointed an Advanced Nurse Practitioner and supported her through to become a nurse prescriber, and have developed another staff member to compete her Advanced Nurse Practitioner training.
- Developed a new Income Generation Team, developing new fundraising streams, a full events calendar, opened a new shop and increased our online sales.
- Secured new external funding to help develop and grow our dementia service (CARIAD).
- Delivered education programmes to social care staff across Blaenau Gwent, Caerphilly and Rhondda Cynon Taf.
- Worked in partnership with the local Health Board to deliver pilots for both a Dementia Respite Service and a local Hospital Admittance Avoidance Programme.
- Delivered bereavement support to the wider populations of both Blaenau Gwent and Merthyr Tydfil during the pandemic.
- Provided a responsive psycho-social service to our patients and families, and developed our bereavement service for children, young people and adults.
- Deepened our presence and relationships with staff and residents in all of the care and nursing homes in our area.
- Established an outpatient service in local Primary Care settings.
- Presented evidence and service outlines to the Palliative and End of Life Care Cross Party Group at the Senedd.
- Enabled the families we support to access an average of £1.8m per year in appropriate benefits and support.
- Created and maintained online peer support groups for hospice patients, families and bereaved relatives.

We have also received recognition and awards for our work:

2017

Our Specialist Palliative Care Team won the Research and Innovation Award at the Aneurin Bevan University Health Board Staff Recognition Awards

2018

Our Family Support Team was Highly Commended at the 2018 British Association of Social Workers Wales Award for their work providing bereavement support to the local community.

2021

Our Clinical Nurse Specialist Nicola Kearney won the International Journal of Palliative Care (IJPC) Palliative Care Nurse of the Year Award for her work supporting staff and residents in local care and nursing homes.

Our Family Support Team won both the Child and Adolescent Healthcare Award and Outstanding Contribution to Health and Social Care Award at the South Wales Argus Health and Care Awards.

2022

Our Complementary Therapist won the Complementary Therapy in Palliative Care Award at Integrative Health Convention and Complementary Therapy Awards, it was for his study evaluating patient generated guided imagery sessions conducted over the telephone during the pandemic.

Our Dementia Service (CARIAD) was Highly Commended in the Social Care Wales Accolades in the Supporting People Who Live With Dementia category.

We are proud to be embedded within our local communities, enabling residents to access our services in their own homes, in care homes, in the local community hospitals as well as linking with our outpatient service.

We recognise that we will be unable to deliver our new strategy alone so we must work in partnership with others to achieve our vision.

We will do this by sharing best practice, educating other healthcare professionals and joining together with other organisations to deliver more comprehensive and integrated services for the benefit of all our patients and their families.

Hospice of the Valleys remains part of the local community, we were started with the support of local residents and continued because of their ongoing engagement. We recognise that we all have a part to play in the delivery of our strategy and our goals and look forward to engaging further with local communities as the charity changes and develops.

What is **our strategy** trying to achieve?

Our strategy sets out to address the challenges we expect to face over the next three years. It looks at what we need to do as an organisation, to face these challenges and maintain our ethos, key services and be responsive to the needs of those we support. Our strategy needs to help to define this relationship and have a plan for sustainability, integration and partnership working.

The Strategy is approved by the Hospice of the Valleys Board and is an integral part of our governance. It sets our ambition for the next three years; it aligns our ambition to the needs of our community. We will deliver it through a clear understanding of the Strategic Objectives we want to achieve, balanced with available resources. The Strategy guides our investment in people, time and funding.

Consultations with the local community, partners, staff and volunteers have allowed the strategy to focus on what we need to achieve over the coming years. We will ensure that the process of consultation is ongoing. We cannot achieve our aims in isolation. We have set the destination, but will work together to plan the route.

Challenges identified:

- A growing demand on palliative care services from an aging population living with more complex needs.
- Primary Care services remaining under pressure, with issues around recruitment and retention for both GP's and District Nurses.
- Over the next 10 years the incidence of cancer in the UK is projected to increase by 30% for men and 12% for women, and as the number of people living with and beyond cancer exponentially grows, by 2040 close to a quarter of people aged over 65 will be cancer survivors.
- By 2050 it is projected that one in three adults aged over 65 will die with a diagnosis of dementia.
- The cost-of-living crisis is expected to continue over the next 2 years and will have an effect on our communities, emotional, physical and psychological wellbeing as well as impacting on our ability to fundraise.
- Costs of delivering existing services are rising, but NHS funding has remained static.

We will respond to the challenges by:

- Ensuring clarity on our role as a service provider for patients and their families, staff and commissioners, so that we can use our scarce resources to support those with the greatest need.
- Improving outcomes for patients and carers by responding better to the priorities they have identified.
- Developing and adapting our services to reflect the changing local needs and a growth in demand.
- Delivering the strategy will enable us to develop a dialogue with funders and partners to ensure that our role is recognised and service developments are funded and integrated into a wider system approach.
- Diversifying our sources of income to ensure that not all income streams are affected by the cost-of-living crisis.

We will provide palliative care services that are:

- Responsive to patients and carers needs with services delivered at the right time in the right place to match their priorities.
- Compassionate and meaningful to those who need it most.

Our **local** communities

Hospice of the Valleys is based in an area that has statistically significantly lower healthy life expectancy than Wales as a whole, which is linked between socio-economic deprivation and poor health. While life expectancy overall is increasing, the gap in life expectancy between males living in the most and least deprived areas has not changed significantly.

Many of the health inequalities highlighted below have been present in the local population for more than one generation.

Our local population are facing the following specific challenges:

- 25% of the area is in the bottom 10% for Wales in terms of health outcomes and 26% for overall deprivation.
- 22% of residents report having activities limited due to poor health compared to the average for Wales, which is 15%.
- 82% of the population in Blaenau Gwent East are living in the two most deprived areas in Wales with above average mortality rates for persons aged under 75.
- Blaenau Gwent has the 2nd highest percentage of people who state they have a long-term health problem or illness in Wales.
- 10.39% of local residents' self-report having 'Bad' or 'Very Bad 'health compared to the average figure for Wales which is 7.83%.
- Cardiovascular disease and Cancer are the biggest causes of premature mortality in the local population.
- Men in Blaenau Gwent have one of lowest life expectancies in the UK.
- Unpaid Care Data from the 2011 survey shows that more than one third of unpaid carers in Blaenau Gwent aged over 65 provide 50 or more hours of care per week to people who are disabled or infirm.
- There are increasing numbers of people in their 80s caring for spouses / others who require support.
- The number of local residents accessing both Employment and Support Allowance and Incapacity Benefit and Personal Independent Payment is significantly higher than the average in Wales.

External influences

National and regional programmes and priorities below have had an influence on shaping the priority areas highlighted above.

The emphasis on patient centred care, partnership working and evidencing outcomes are themes running through all of these external documents.

- The new National Clinical Framework: a learning health and care system 2021
- The White Paper Rebalancing Care and Support. 2021
- The Aneurin Bevan University Health Board Annual Plan which includes Priority 5 which is focused on End-of-Life Care. 2021
- The National Framework for Bereavement Care.2022
- Blaenau Gwent Dementia Roadmap.2020
- Blaenau Gwent Corporate Plan 2020/22
- All Wales Dementia Pathway of Standards 2022

About Hospice of the Valleys

Hospice of the Valleys is a registered charity and a company limited by guarantee. It is governed by a Board of Trustees comprising of up to 10 trustees/directors who meet six times a year and who are also members of sub-committees to have oversight of the work of the charity. Day-to-day management is delegated to the Chief Executive with operational activity overseen by the Leadership Team.
The principal object of the charity, as defined in our vision is 'to enable people living with a life-limiting condition to live and die well, whilst supporting those who matter most to them'.

We see people, in their own home or care homes, in the hospitals and primary care settings within our catchment area and in our own premises.

Our services are delivered free to those with life-limiting illnesses. To do this we have an income generation team overseeing fundraising appeals, partnerships, events and managing 6 shops, which between them contribute towards our £2 million annual running costs. Just over 23% of our income comes from the NHS. All our actions are governed by the knowledge that we have a duty to manage our resources wisely and cost effectively.

We have limited resources and we want to use them as effectively as possible. We therefore need to ensure that we have a culture which embraces change and which values innovation and lateral thinking.

The services outlined below are available to patients, carers and family members and can be accessed via referrals from a healthcare professional or via self-referral.

Hospice of the Valleys provides:

- A Clinical Nurse Specialist service across all community settings.
- Access to a Palliative Care Medical Consultant.
- A Hospice at Home service offering over-night support to families.
- Social support for patients and for those who care for them.
- A nurse lead in-reach service in the local community hospital.
- Bereavement support anticipatory, and post-bereavement support as well as a children's bereavement service.
- Welfare rights advice for patients and to those who care for them.
- Specialist rehabilitative support from our Clinical Specialist Physiotherapist.
- Complementary therapy for patients and for those who care for them.
- A Dementia service (CARIAD) focused on supporting families living with a dementia diagnosis.
- A wellbeing volunteer service, linked to our CARIAD service.
- Spiritual support via our Hospice Chaplain and external organisations.

Our **Vision**

To enable people with a life-limiting condition to live and die well, whilst supporting those who matter most to them.

Our **Mission**

We commit to provide a professional and bespoke service at the highest standard which is free of charge.

In partnership with others we provide specialist support from diagnosis, through treatment and complexities; and when needed into end of life care and bereavement.

Our **Strategic** Aims

We have identified seven strategic aims which are built on those identified by the Cicely Saunders International Centre for Palliative Care.

We believe that focusing on these strategic aims puts the delivery of excellent patient-centred palliative care at the heart of everything we do. They will ensure that we continue to deliver holistic palliative care to the local communities we serve.

1. Provide holistic palliative care expertise in places where people are cared for: at home, in hospitals and in care homes.
2. Make joined up care a reality.
3. Empower patients and carers to have greater choice and control over the things that are important to them.
4. Provide our staff, other healthcare professionals and carers with high-quality training.
5. Use evidence-based decision making to embed a system of continuous learning and improvement.
6. Deliver a sustainable business model to ensure we are effective in meeting the demands on our services.
7. Engage in research into palliative care.

The **Aims** underpinning our Strategic **Goals**

1 Provide holistic palliative care expertise in places where people are cared for: at home, in hospitals and in care homes.

This objective is the core of the hospice's services. Continuing to improve, adapt and grow our patient-centred care is central to achieving our vision.

We will focus on:

a. Ensuring we have the clinical capacity to meet increasing patient referrals into all areas whilst maintaining the excellent quality of care.

b. Being accessible to all patients at the time they need us and in their preferred place of care.

c. Providing a named responsible senior clinician and care coordinator for each person who is experiencing symptoms or approaching the end of life.

d. Support families in receipt of appropriately funded packages of care in patients and carers normal residential setting.

e. Delivering one-to-one bereavement services (face to face, virtual and telephone), bereavement groups, walk and talk, and remembrance services, while exploring new services and recognising people's other care or work commitments.

f. Supporting palliative care professionals in all settings to provide symptom management, advice and expertise to patients, carers and care professionals.

We will know we have succeeded by measuring our impact through:

- Ensuring symptom control is measured, monitored and reported.
- Recording achievements around Preferred Place of Care, Preferred Place of Death with previous year's activities and other organisations.
- Compiling patient feedback and carer feedback.
- Ensuring that stakeholders are supported in creating an Advance Care Plan.
- Running an annual audit of care for our services.

2 Make joined up care a reality.

We do not deliver our services in isolation and need to work with colleagues across health and social care to ensure the best outcomes for patients and families. We can help to both navigate the current system and help work towards system improvements with our partners.

We will focus on:

a. Ensuring all health and care partners have access to appropriate information and skills to provide the best care.

b. Target palliative care resources towards patients in high-risk groups to increase not only the benefit to those patients, but also the cost-effectiveness of resource allocation.

c. Providing pre and post bereavement support for children, families and carers either through our own teams or signposting people to other appropriate specialists.

d. Developing stronger links with primary-care, secondary and tertiary care and local authorities.

e. Maintaining active participation in the Gwent Palliative & End of Life Care Board.

We will know we have succeeded by measuring our impact through:

- New partnership agreements.
- New initiatives with the local authority.
- Work with the Regional Partnership Board and the Provider Network.
- Participation with the Neighbourhood Community Networks.
- Staff membership on steering groups and clinical pathways.
- New fully funded service provision.

3 Empower patients and carers to have greater choice and control over the things that are important to them.

People who live with life-threatening or life-limiting illness, their caregivers, and the bereaved are often segmented social groups, forced to experience lifestyles that are commonly socially hidden and disenfranchised from the wider society we will ensure that patients and carers are at the heart of decisions and choices about their support.

We will focus on:

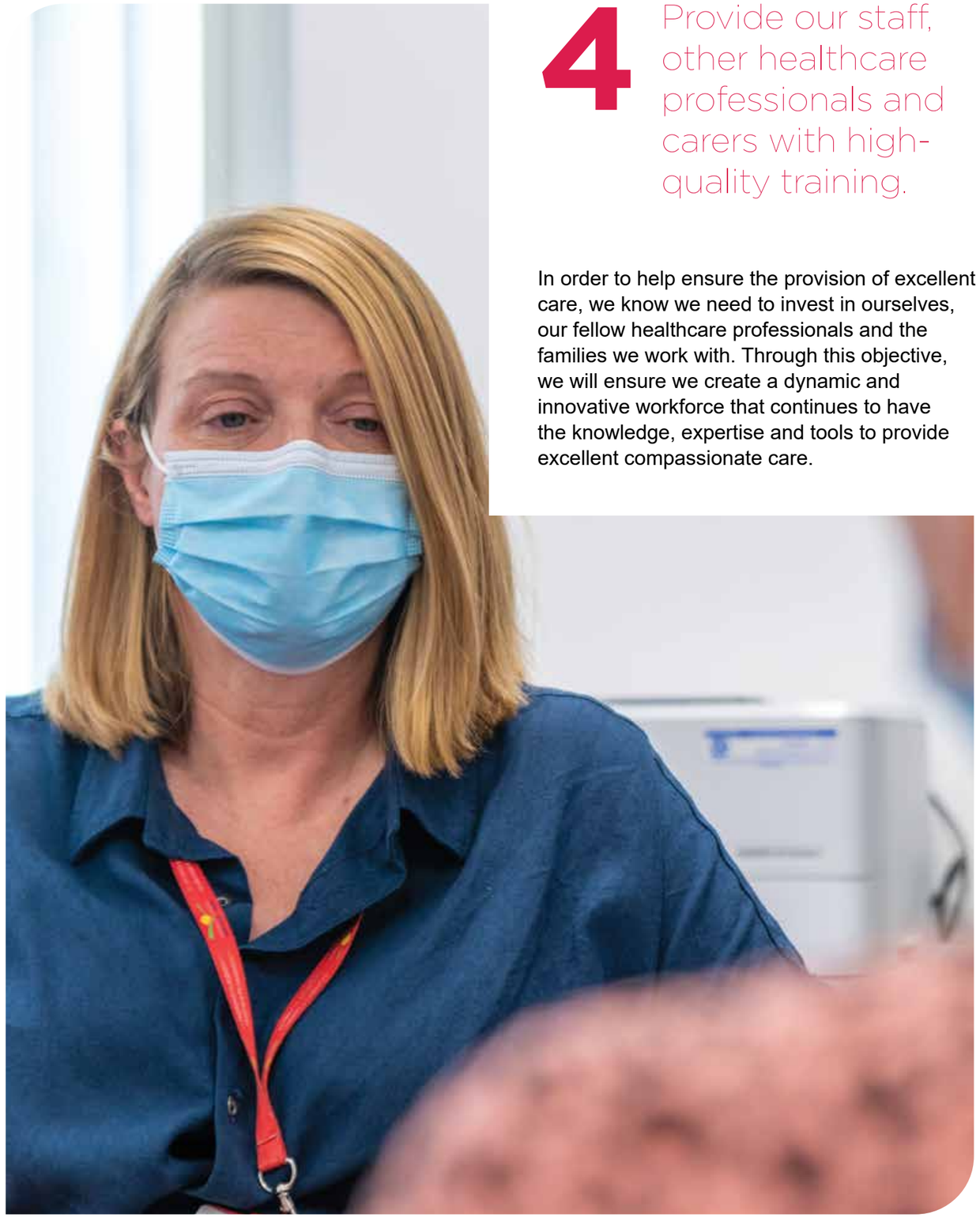
a. Ensuring that patients request and receive professional palliative care at the time of their choosing rather than having to ‘wait’ until they are referred or having to negotiate referral.

b. Providing patients and carers with an assigned contact point to liaise with about their care and preferences.

c. Developing further our person-centred approach, (around the NHS backed ‘What matters to you?’ initiative) delivering great care according to the needs and requirements of our patients.

We will know we have succeeded by measuring our impact through:

- Patient feedback from our hospice survey.
- Updated internal documentation to record the ‘What matters to you’ conversations.



4 Provide our staff, other healthcare professionals and carers with high-quality training.

In order to help ensure the provision of excellent care, we know we need to invest in ourselves, our fellow healthcare professionals and the families we work with. Through this objective, we will ensure we create a dynamic and innovative workforce that continues to have the knowledge, expertise and tools to provide excellent compassionate care.

We will focus on:

a. Extending our education provision to carers and families, and the wider general public, with a mix of paid and free workshops at the hospice and online.

b. Pilot new methods of teaching using technology to reach more people, with the same resources

c. Ensuring that all staff have the right competencies, at the right level, in the right role.

d. Creating a specific education strategy to underpin sustainable improvements in the quality of end-of-life care.

e. Continuing to participate in clinical placements.

f. Develop our volunteering initiatives, which will include well-designed and managed volunteering programmes, the roll-out of mandatory training for certain groups of volunteers and development opportunities that are good for both them and the hospice overall.

g. Developing a people strategy to define our organisational culture, structure and decision making, including staff rewards and benefits, training and development.

We will know we have succeeded by measuring our impact through:

- The creation and delivery of an education and a people strategy.
- Monitoring and reporting on attendance numbers at training courses and increased training requests received.
- Staff receiving 1:1, supervision and IPR’s in a timely and appropriate manner.
- A staff survey, to measure potential increase in the number of staff who are happy with their personal development opportunities.

5 Use evidence-based decision making to embed a system of continuous learning and improvement.

We need to continue to be a dynamic organisation, learning from best practice, expanding our knowledge and recognising the impact our services have.

We will focus on:

a. Ensuring that clinical decisions are made using a strong evidence base.

b. Utilising technology and systems to maximise efficiency, improve integration with external healthcare systems, and provide better management of our data and reporting across all areas of our work

c. Capturing person-centred feedback to help health professionals to identify unmet patient and carer/family needs and concerns, and allow them to act to deliver more effective and cost-effective care.

d. Using the OACC (Outcomes Assessment Complexities Collaborative) suite of measures to ensure that we monitor, learn and benchmark.

e. Developing a mechanism for recording and analysing carer support.

We will know we have succeeded by measuring our impact through:

- Use of patient reported outcomes to drive clinical discussions, meetings and reports.
- Evidence of initial training and assessment of competence in practice.
- Use of data to benchmark hospice activity with other services and providers.
- Use of Welsh Health Map data to ensure that we are meeting expected local need.

6 Deliver a sustainable business model to ensure we are effective in meeting the demands on our services.

We rely on the generosity of our local population to fund our activity, but the current geographical limits on this activity provides constraints. We therefore need to look at new ways of generating income, and using resources more effectively. We aim to provide stability and a bright future for our services.

We will focus on:

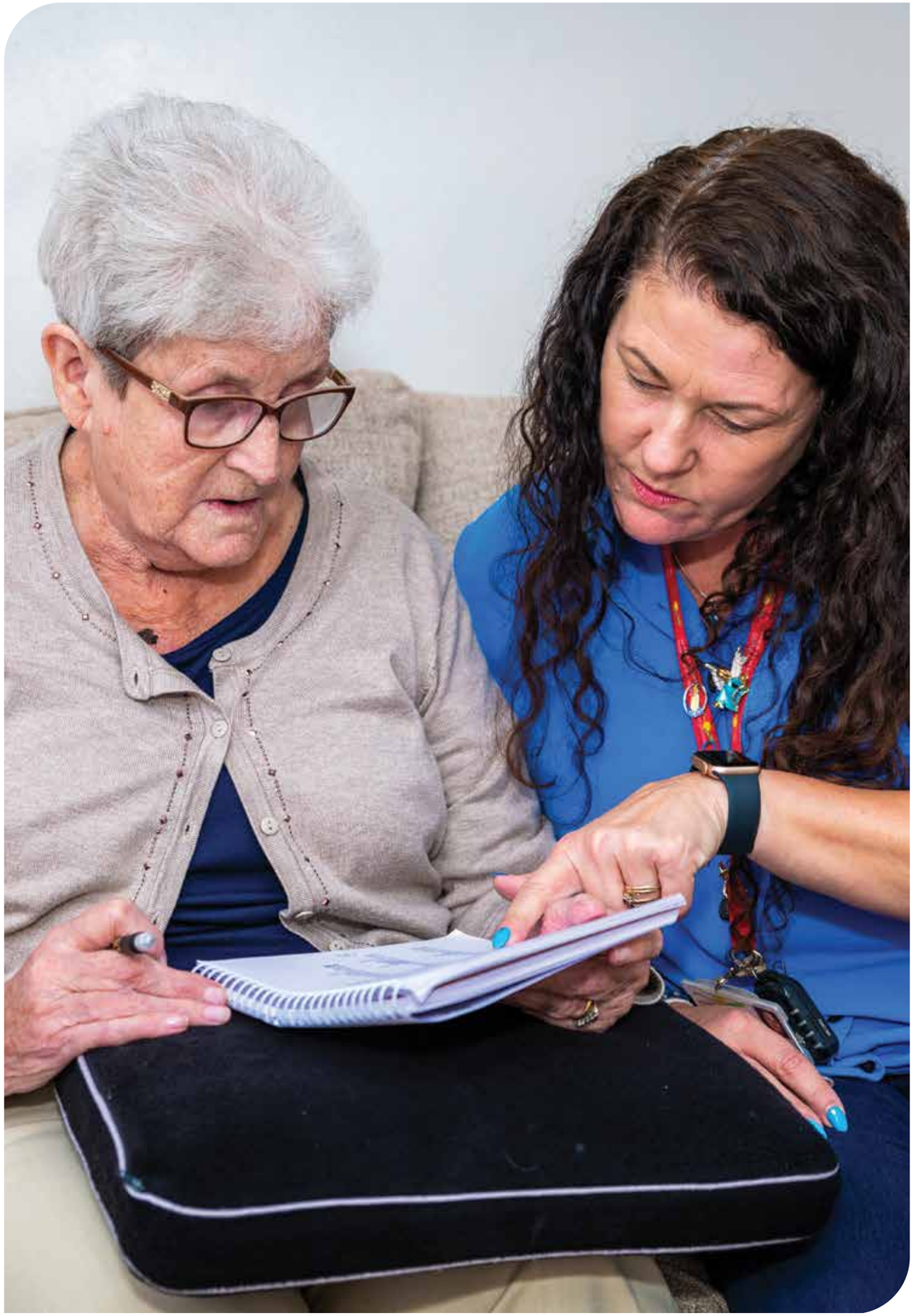
a. Working with hospices and the Welsh government to improve statutory funding for hospice services

b. Diversifying our income streams by identifying, investigating and establishing new sustainable business enterprises and expanding our online presence.

c. Increasing head of departments' understanding of costs and introducing cost improvement targets across the departments.

We will know we have succeeded by measuring our impact through:

- Meeting annual budget targets.
- Increasing funding from new sources.
- Keeping within the agreed expenditure envelope during the life of the strategy.
- Financial forecast updates to our Finance and Income Generation Committees.



7 Engage in research into palliative care.

We wish to both follow best practice as well as contribute to the knowledge around the delivery of palliative and end-of-life care.

We will focus on:

a. Put research at the heart of patient-focused high-quality care at Hospice of the Valleys.
b. Actively seek research opportunities.
c. Encouraging staff to participate and lead in research, seeking opportunities to publish outcomes of service delivery and innovations.

We will know we have succeeded by measuring our impact through:

- Logging participation in studies and citations.
- Published research papers and contributions.
- Internal research proposal progression.

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