Llywodraeth Cymru
Welsh Government

Proactive Care for Adults with Complex Needs and Older People living with Frailty in the Community

National Integrated Care Guidance Framework

Index

Executive Summary 2

1.0 Introduction 3

2.0 Context and Definitions 4

3.0 Enablers of Proactive Care provision for Adults with Complex Needs ...6

4.0 Continuous Improvement: Suggested Outcomes and Measures 12

Appendix One 14

Appendix Two.....15

Executive Summary

Implementing Proactive Care is now acknowledged across policy and national programmes as a key priority for delivery in pursuit of improved outcomes for the population, reduced inequalities and enhanced system resilience as outlined in A Healthier Wales.

There is demonstrable evidence of proactive care approaches being implemented across our integrated community care systems in Wales. These approaches however are variable and inconsistent and would benefit from clarity of definition and standards of practice being made available across Wales.

This framework aims to provide this clarity specifically for the proactive management of adults living with complexity and older people living with frailty. Drawing from peer reviewed evidence base and the Integrated Quality Statement for Older People living with frailty it outlines the key enablers and components required for effective proactive management for 'rising risk' and 'high risk' cohorts.

It is anticipated that this guidance will be valuable for Regional Partnership Boards to inform implementation of best practice in order to optimise its impact on outcomes for people and the health and care system.

Delivering Proactive Care for Adults with Complex Needs (including Frailty); A Framework for Regional Delivery

Themes	Requirements / Enablers
Context and Definitions	Older people and people living with frailty: integrated quality statement | GOV.WALES A Healthier Wales Primary Care Model for Wales Prevention Based Health and Care Framework Building Capacity through Community Care: Further, Faster, Together More than just words National Framework for Social Prescribing Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES National_Community_Nursing_Specification_v1_Jan_23.pdf 50 Day Challenge Booklet:  2024 50 Day Integrated Care Winte

Proactive Care for Adults living with Complex Needs	National Digital and Data Infrastructure Flexible and capable workforce Clear accountability and shared decision-making
Core Principles and associated Standards of a Proactive Care approach for Adults with Complex Needs	Population and Case Identification Holistic assessment Future Care Planning Multi Professional Working; Continuity and Coordination

1.0 Introduction

This framework supports delivery of 'A Healthier Wales' [1]and its vision for an Integrated Community Care System (ICCS) that enables citizen focused place-based systems of care that meet a defined population need, improving their wellbeing outcomes and reducing health inequalities through data driven Population Health Management.

Population Health Management (PHM) is defined as:

"*an approach that improves population health by data-informed planning and delivery of proactive care to achieve maximum impact for the health and wellbeing of the population. Linked datasets are used to segment, stratify, and model the local "at risk" and "rising risk" cohorts that in turn are used to design, target and personalise interventions to deliver proactive care and proportionate universalism to reduce health inequalities*".

The framework is complimentary to the Primary Care Model for Wales and associated responsibilities at Cluster / Pan Cluster / Local Authority geographical level.

Proactive Care was introduced and remunerated as a priority objective to Health Boards and their Regional partners in October 2023 in response to the Ministerial Statement of Intent 'Building Capacity through Community Care; Further, Faster, Together'. Further investment and expectation for proactive care approaches was articulated in October 2024 as part of the 50 Day Challenge and specifically Interventions 4, 6, 7 and 10 (proactive care management, early identification of decline and the coordination of early intervention to manage crisis including falls). It is evident that progress is being made within this part of the system however there is variation in terms of approach, scope and monitoring impact.

As a minimum for Winter 2025 / 2026, Regional Partners are required to implement this guidance in relation to their identified 'top 0.5%' population at greatest risk of urgent

[1]

care. It is important however to stress that when managing the needs of populations with progressive conditions, a sole focus on 'high risk' populations is not advocated. Prevention and proactive management of 'rising risk' cohorts with moderate or low risk allows interventions to be implemented earlier and contributes to longer term outcomes for the person and the system and should also be considered when considering the scope of their 'top 0.5%'.

It is recognised that there is a need for some flexibility in the approach to take account of the different requirements across Regional Partnership Board areas.

This Framework aims to provide Health Boards and their Regional partners with guidance to support implementation of best practice in this area in order to gain consistency in approach and optimise its impact on outcomes for people and the health and care system.

2.0 Context and Definitions

2.1 Proactive Care is a term which is increasingly being used to describe interventions that are focused to keep people well through a focus on prevention. It includes those activities and interventions which contribute to improving health and wellbeing by increasing self reliance, capacity and resilience of individuals and the people who support their care and across local communities.

While the specific 'Proactive Care' terminology is primarily found in healthcare related policy and strategy, the Social Care Institute for Excellence [2] also describes proactive approaches to health and wellbeing as integral to embedding prevention in social care and increasing independence and reducing or delaying the need for formal care and support services.

2.2 Adults with Complex Needs is a term used to represent the increasing population who are living with progressive physical and / or cognitive functional challenges attributed to the rising prevalence of multi morbidity and age-related clinical frailty. It is widely acknowledged that 'what matters' to this population is that they are supported to live meaningful and fulfilled lives in their own homes and communities. Achieving this outcome requires a recognition by the health and care system that:

- This population is predisposed to:
    - Condition exacerbation and associated functional decline and increasing acuity;
    - Increased likelihood of for urgent social care intervention;
    - Increased likelihood of health related urgent and emergency care provision;

[2] Prevention in social care - SCIE

    - Decline in physical function and overall functional decline (physical and cognitive) due to prolonged inactivity and avoidable increased health and social care resource
- Enables early identification of sudden changes in physical and / or cognitive function and early intervention to mitigate escalating needs and long-term care and support requirements.

An Integrated Quality Statement (IQS) for Older People living with Frailty was developed by an Expert Reference Group of health and social care stakeholders and published in January 2024 (Older people and people living with frailty: integrated quality statement | GOV.WALES).

The IQS outlines the quality attributes of a frailty attuned system that enables optimal outcomes for this population group. The IQS focuses specifically on Frailty as a clinical condition however the needs of this population group are such that the quality attributes and components of a frailty attuned system of care could reasonably apply to adults living with needs that are 'complex' relating to social, psychological and physical (e.g. disability, multi morbidity, sensory impairment) needs.

2.3 Proactive Care for Adults living with Complex Needs.

The IQS outlines the following relevant points:

- Long term conditions, multi morbidity and frailty are progressive in nature.
- The needs of the person become increasingly complex as the condition progresses with subsequent increase in the requirement of health and social care.
- Many adults living with complex needs depend on unpaid care and support provided to them by family, their neighbours and wider community. This type of care and support is known to result in heightened stress and anxiety for the unpaid carers and associated high likelihood of 'carer breakdown'.
- With awareness and optimal proactive management, we can intervene early when condition and needs escalate, slow down progression and ultimately improve outcomes for the individual and optimise use of finite health and care resources
- Similarly with optimal proactive management we can provide unpaid carers with timely support to reduce incidence of 'carer breakdown'
- Optimal management for this population depends on:
    - Early multi professional assessment of their heterogenetic needs, including carer assessment;
    - Implementation of interventions that mitigate adverse effects of the condition and outline plans that anticipate fluctuating and sudden changes in their needs;
    - Prompt recognition of sudden changes in social, psychological, and clinical needs that have resulted in a change in physical ability or mental

capacity such as a new confusion, a fall, or reduced ability to do things they are usually able to do or an increased risk of malnutrition.
    - At times of urgent or emerging escalated needs facilitate prompt access to 'intermediate models of care', including reablement, rehabilitation and Enhanced Community Care (link to principles) and Carer Respite.

Proactive care in the context of this framework is therefore defined as 'personalised and co-ordinated multi-professional support and interventions that deliver person-centred health and wellbeing outcomes' through:

1. Delaying the onset of deterioration where possible; (protecting wellbeing and independence and promoting independent living);

2. Reduce avoidable exacerbations of ill health, thereby reducing use of unplanned care, loss of ability (independence) and subsequent additional demand for long term care.

3. Further there is evidence that proactive management of planned care through pre surgical assessment can also contribute to the offer of alternative outcomes to surgical intervention that may be better to meet the expressed needs of the person and therefore enhance their quality of life. Where surgical intervention does represent the best outcome, this should include prehabilitation to maximise clinical outcomes.

3.0 Enablers of Proactive Care provision for Adults with Complex Needs

Implementing an optimal proactive care approach is dependent on partner organisations (Regional Partnerships) working together to achieve a Shared Goal for a defined population group.

Implementation of proactive care will vary locally, dependent on their defined population and on the existing service delivery models.

Three key enablers for the implementation of proactive care have been identified:

A. Digital and Data

Effective design and delivery of proactive care should be built on a strong digital infrastructure and connected data enabled by Population Health Management expertise. Standards expected should include:

- Agreement and implementation of an All Wales digital segmentation tool;
- A Shared Care Record that is accessible to the person and by all authorised health and care providers involved in providing the person with multi-professional support;

- Consistent reporting and evaluation of progress and impact against the shared goals and ambitions is enabled by nationally agreed and approved population, system and service level outcomes and measures framework owned by NHS and social care;
- An All Wales approach to Future Care Planning and processes that ensure Future Care Plans are accessible to the person and their nominated family / care givers / independent advocates and those health and care professionals directly involved in their planned and unplanned care episodes.

At the time of writing the framework, the Digital and Data standards outlined above are a national priority and 'in development'. In the meantime, Regional Partnership Boards are strongly encouraged to consider consistent Regional approaches to population segmentation / stratification and Future Care Planning.

B. Flexible workforce

Consistent reliable and robust workforce is central to delivery of proactive care. Standards expected should include:

- Segmentation and Stratification is modelled across demographic forecasts providing planners and commissioners of their 'place based system of care' to ensure the workforce and service infrastructure is developed 'at place', meets population need now and into the future.
- Workforce has sufficient levels of skill and capacity is available to provide proactive care over 7 days and 24 hours where this is required.
- The multi-professional team providing proactive care functions with sufficient capacity and skill mix, the right training and expertise, with the ability to draw on other professions or services as needed and respond to the needs of a local population;
- An integrated (joint) workforce plan for the delivery of proactive care and appropriate training for staff. Trusted Assessor models are considered where safe and appropriate to implement.

C. Clear accountability and shared decision-making

Regional Partnership Boards should ensure joint executive leadership across partner organisations. Standards should include:

- Regional Population Needs Assessment has been undertaken; [3]
- Regional Partnership agreement of shared ambition (strategy), goals and outcomes for a defined population derived from the Population Needs Assessment;
- Shared Decision Making agreements and associated governance processes in place;

[3] Social Services and Wellbeing (Wales) Act (2014) Social Services and Well-being (Wales) Act 2014: part 9 statutory guidance (partnership arrangements)

- Governance arrangements will include consideration of:
    - Joint executive leadership and monitoring of shared delivery plan (programme plan) and its implementation (NB the delivery plan where appropriate will ensure alignment of relevant national programmes eg NHS Executive's Six Goals for Urgent and Emergency Care, Strategic Programme for Primary Care);
    - Commissioning alignment;
    - Contracting;
    - Trusted assessor arrangements;
    - *Interim Future Care Planning arrangements;

*****NB national principles, standards, tools and templates for Future Care Planning in Wales are in the process of being considered and developed

3.0 Core Principles and associated Standards of a Proactive Care approach for Adults with Complex Needs

According to the evidence across peer reviewed literature and practice, there are 4 Core Principles associated with an effective proactive care approach that should be adopted by local PCPGs and their associated place based systems of care. The section below outlines those Core Principles and respective Standards that we would expect Regional Partnerships to implement to enable Proactive Care for Adults with Complex Needs.

In setting out the Standards we have acknowledged existing national constraints in relation to the key Enablers outlined above. These constraints have been recognised as risks to effective delivery and actions are in train nationally to mitigate these risks. Meanwhile, 'controls' for these risks have been considered in setting the Standards outlined below.

I Population and Case Identification

Regional Partnership Boards (RPBs) should be able to demonstrate the following:

- Shared Goal for identified Population Groups (e.g Older People > 75 years) based on their Population Needs Assessments;
- Agreed Population Outcomes they jointly aspire to achieve and agreed Outcome Indicators for that population (e.g wellbeing and independence);
- Benefits realisation for the Regional integrated health and care system for that population;
- System Level Outcomes that they jointly aspire to achieve and agreed Outcome Indicators for the System e.g demand management of long term care and the urgent and emergency care system
- Defined 'local' place based systems of care' e.g Clusters / Pan Clusters and who are responsible for delivering the Regional ambition and Shared Goal for that population with their Local Authority partners.

- Joint planning and commissioning of interventions and services that will contribute to achieving the Population and System Outcomes i.e Programme / Delivery Plan;
- Joint monitoring processes of their Population and System Level Outcome Indicators;

Clusters and their Local Authority partners should be able to demonstrate that:

- An identified population cohort is being managed proactively within the defined 'place based system of care' e.g 'high risk' (top 0.5%) or 'rising risk' cohort (NB this should align to the population cohorts and Shared Ambition for the population identified by the RPB);
- Joint commissioning and delivery plan (eg Pan Cluster Plan) outlining the relevant multi professional support and interventions being implemented over time;
- Processes in place that measure and monitor improvement at service / pathway level and their impact on the System (System Outcome Indicators);
- Used evidence to prioritise resource allocation to optimise improved outcomes for people and the health and care system;
- Used recognised tools to support case identification e.g the second version of the electronic frailty index (eFI)[4] will enable population segmentation and discrimination of frailty and risk of adverse outcomes.
- Clinical validation of segmented population using recognised tools such as the Rockwood Clinical Frailty Scale[5] and stratify the segmented population.
- Analysis of their System's unplanned care datasets and identification of those people and population cohorts whose fluctuating needs may benefit from proactive multi-professional support and early intervention to mitigate exacerbation of their needs.
- Reconciled population cohorts identified with wider determinants of health that contribute to earlier onset of frailty / disease progression eg socio economic, health inequality groups and where appropriate facilitate focused proactive care approaches for these populations.

Example population cohorts can be found in Appendix Two

II. Holistic assessment

Central to providing more proactive care is for community professionals to work with people and their unpaid carers to understand the full range of health, social and self-care needs, using a holistic assessment based on shared decision-making principles[6].

Clusters / Pan Clusters and Local Authority partners should be able to demonstrate:

[4] eFI
[5] Rockwood Frailty Scale
[6] https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making

- Appropriate use of evidence based holistic assessment tools e.g Comprehensive Geriatric Assessment[7] Proportionate and Integrated Assessment[8] CHC Framework[9];
- Assessments are accessible to all those involved in delivering care for the person (in the absence of Electronic Shared Record agreed arrangements for proportionate sharing of information);
- Assessments are reviewed at a frequency determined on the assessment or when person's condition dictates the need for review;

III. Future Care Planning

Following the holistic assessment, a Future Care Plan (FCP) is co-produced with the person and those who are important to them for example, family, friends and / or unpaid carers and where appropriate an independent advocate.

Regional Partnerships should demonstrate: (in the absence of All Wales Electronic Shared Record, FCP tools / template and repository):

- A Regional solution to embedding Future Care Planning and its associated principles (outlined in Appendix Two). Solution should include consideration of:
    - Regional FCP tools / template;
    - How / where Future Care Plans are held in that Region so that FCPs and associated documentation are accessible to all those involved in delivering planned / unplanned care for the person and in case of emergency intervention out of hours (including Welsh Ambulance NHS Services Trust)

IV. Multi Professional Working; Continuity and Coordination

This component is NOT advocating a new service. It acknowledges that Multi Professional Working[10] (MPW) (e.g community resource teams) exists across Wales and who collectively are responsible for providing 'wrap around' care for this population group. This component is included to acknowledge the responsibility MPW plays in the provision of proactive care monitoring and management as a core part of their function to support early identification of urgent or emerging needs of identified cohorts considered to be a 'rising risk' or 'high risk' status.

Continuity of care is a core component of effective proactive care. It could be defined as the ongoing relationship a person has with the MPW team or a member of that team to ensure that care is co-ordinated and that the person moves between different parts of the system seamlessly with a consistent approach to achieving their expressed wishes outlined in the FCP.

[7] Comprehensive Geriatric Assessment
[8] SSWBA
[9] CHC Framework
[10] MPW Framework here

Continuity of care enables personalised care, improves care quality, boosts a person's confidence in multi professional decision making, and fosters greater job satisfaction for health and care professionals. Overall accountability for people receiving proactive care needs to be clear. This may be any member of the Multi Professional Team responsible for overseeing the individual's wellbeing. Usually the **'Case Manager'** is the person who has the most regular or routine interaction with the individual and who assumes responsibility to lead the coordination and development of a Future Care Plan (FCP) and determining when the Plan should be reviewed.

At times of acute illness, the accountability for the clinical management of their needs in the community should always sit with the person's GP. Exceptions to this may include formal local agreements between the person's GP and medical personnel who form part of Enhanced Community Care[11] provision. Such formal agreements should be underpinned by Standard Operating Procedures which outlines clinical governance arrangements to satisfy legal, clinical and safety requirements.

The person should be aware at all times when their FCP is due for review and how they are able to arrange an earlier review if they believe their circumstances have changed such that an earlier review is believed appropriate.

Care coordination for adults living with complex needs should be facilitated through a single point of contact in the community providing integrated Information, Advice and Assistance (IAA). Effective coordination helps individuals navigate across the health and care system when they are concerned or when needs are escalating or urgent providing access to the most appropriate IAA that meets their presenting needs. Principles and Standards for integrated IAA for this population are outlined HERE.

Care coordination should also be complimented by virtual proactive monitoring as an integral part of the approach through Technology Enabled Care (TEC)[12].

Regions (and / or Clusters at Pan Cluster / Local Authority level) should be able to demonstrate the following:

- Proactive care management processes are in place for a defined caseload across their 'placed based system of care' by existing multi professional teams providing care for this population group;
- 'Case management' processes ensure personalisation, a comprehensive approach to assessing, planning and seamless (including coordination and continuity of care) holistic care management of needs

[11] ECC
[12] TEC enabled integrated health and social care provision; What Success Should look like' IN Development

- ‘Care coordination’ arrangements enable the organisation and proportionate sharing of information across health and social care providers to ensure continuity and safety of care. These arrangements are considered as key component of integrated IAA provision for planned reviews and intervention, management of urgent / escalating needs in the community and supporting hospital discharge coordination;
- Local Authorities and Health Boards working towards a single integrated system of coordination across health and social care at Pan Cluster / Local Authority locality level to support efficient and effective sign posting to community based ‘step up’ and ‘step down’ care;
- Local Authorities and Health Boards working together to integrate technology enabled care (telecare and telehealth) with proactive health and social care approach at Pan Cluster / Local Authority level. There is recognition that consideration is required in terms of the potential efficiencies afforded by delivering at Regional level. (TEC Framework for Integrated Community Care System for Older People living with complex needs);

4.0 Continuous Improvement: Suggested Outcomes and Measures

	Outcome we Expect	Outcome Indicators	Measure
Population	Population is supported to remain as well and independent as possible in their own home and community	Healthy Days at Home (HDAH) / Independence at Home Proxy: ‘Independence at home’ Emergency admissions to hospital	HDAH QoL Indicators % of emergency admissions with LOS > 21 days LOS in care home
System	Improved System Resilience	Long term care demand is managed effectively Urgent demand in community is managed effectively Demand for support on discharge is managed effectively	Count of people receiving Social Care / joint arrangement / CHC per 100k population Count of people waiting for Social Care / joint arrangement / CHC per 100k population Count of emergency admissions > 75 years POCD delays Readmission rates % of people referred to ECC and Reablement from Community (as safe alternative to hospital admission)

Improvement (Process) Measures

Case Identification	Count of people identified in a specific cohort eg top 0.5%
Holistic Assessment and Future Care Planning	% of cohort who have been offered assessment and future care planning (should be 100%) % of cohort who have had medication reviews undertaken
Multi Professional Working; Continuity and Coordination	District Nursing Count of People Seen and Visits District Nursing weekend working ECC Referral numbers, source of referral and outcome Reablement Referral numbers Readmission rates

Appendix One

Example Population Cohorts

- Vulnerable residents who are known to social care such as care home residents or those with high frequency / high volume care and support at home (as a proxy indicator of severe / very severely frail individuals);
- People living with complex and fluctuating needs due to progressive long term condition e.g cardiac and / or respiratory illness, dementia, Parkinsons and are prone to exacerbation;
- People living with 4 or more chronic conditions and whose needs are complex due to multimorbidity / polypharmacy;
- Primary Care (GMS) register segmentation with multiprofessional assessment and stratification of risk;
- People frequently using primary care, service or unplanned care readmissions into acute care within 30 days of discharge;
- House bound older people who require a Registered Nurse / District Nurse to visit. People connected to Technology Enabled Care (TEC) and the frequency that they trigger their alarms

Systems may also consider populations with high frequency interactions across health and social care and who may benefit from proactive care. These interactions are likely to include:

- Annual single condition reviews in primary care
- Unscheduled care interactions with primary care and community services;
- Discharges from hospital
- Enhanced Community Care caseloads
- Urgent community response services (WAST, TEC Alarm Receiving Centres)
- Unpaid carer assessments
- Request for an increase in long term care as existing care and support package no longer meets their needs
- Frequent presentations to Local Authority Information, Advice, Assistance arrangements requesting support
- Frequent presentations to Emergency Departments

Appendix Two

Future Care Planning (FCP) in Wales

Definition

Future Care Planning (FCP) is an opportunity for an individual to work with health and social care professionals to consider what matters to them in terms of their wellbeing and explore their wishes for any future care or support that the person may need, in the context of their condition, circumstances and options.

FCP is relevant to every stage of life, including for those who may have diminished capacity at the time of information gathering, and for whom a best interests approach should be followed. The output from FCP conversations may include a plan or other document reflecting the person's preferences about the nature, type and location of such services and may include discussions in relation to a person's medical treatment and views on how their end of life care might look. When the discussions and decisions are recorded they should be shared with care givers, families and professionals involved in their care. Such output does not contain legally binding decisions, but rather helps guide decisions about treatment and care in the context of realistic appraisal of what is possible in the relevant circumstances. It can contribute to achieving a 'no decision about me, without me' approach in all eventualities including when circumstances change, or when the person, or those close to them, express the need for a review.

Proposed Principles for FCP in Wales

The design principles for A Healthier Wales and the quality dimensions outlined in Duty of Quality Statutory Guidance (WG, 2023) were considered in the determination of high level principles for FCP in Wales and are as follows:

Relatable and Safe

- Our approach is compliant with professional and statutory (regulatory) requirements and is viewed as a valuable 'thing to do' by citizens;
- It encourages and supports people share 'what matters' in terms of their wellbeing and to be actively involved in timely discussions and decisions relating to current and future treatment and care.
- Decisions about current and future treatment and care considers the available treatment or care options which are considered best placed to meet their expressed goals and wishes
- Compliance with Mental Capacity Act 2005 and its associated Code of Practice"

Accessible

- Citizens will understand that FCP is an important undertaking to ensure that a record outlining 'what matters' to them is available and shared with their loved ones, unpaid carers and health & care

professionals in order that they are provided with the information, advice and assistance that they require to fulfil their goals and wishes.

- FCP should be easily understood and planning templates easy to use.
- FCP template should adopt 'once for Wales' approach
- Planning templates includes information pertaining to general wellbeing, clinical, legal, and financial matters
- There is a clear record of contingency plan, risk arrangements and treatment escalation, where these are relevant

Available

- Support for FCP should be offered by health and care professionals to all citizens (NB 'competent adults') at every appropriate opportunity and the;
- Plan reviewed with the citizen at each contact by a professional involved in their care or when requested by the citizen themselves
- Plan is held in a place that is fully accessible at all times to the person, their family / unpaid carer, health and care professionals and care workers.

Timely

- Thinking ahead about 'what matters to me' is relevant at any age or stage of life. Undertaking FCP however may be particularly beneficial at a point when health and wellbeing is changing or has changed due to physical and / or mental health problems or is likely to deteriorate following a diagnosis.
- Care plans must be reviewed regularly including if the person's health condition or social situation changes or as they wish to do so.
- Review dates are agreed on initial discussion and planning stage and should be at least annual.
- Individuals who may benefit from FCP include those:
  - living with one or multiple long term health condition living with disabilities and/or fluctuating and complex health and care needs (including frailty and children and young people with life limiting conditions) approaching the end of their life

Proposed Ambition

Aligned to A Healthier Wales and the Social Services and Wellbeing (Wales) Act, **'we'** (health and care providers, professionals, practitioners, commissioners and planners) will develop a Once for Wales approach that secures the rights, entitlements and control of everyday life for citizens. We will do this through the adoption of a 'what matters / value based approach' to wellbeing and the anticipation of progressive health and care needs through offering citizens support to undertake Future Care Planning.

By date 'TBC…': ***'I'*** *((*the population in Wales) will understand why Future Care Planning is important for me to be able to fulfil 'what matters to me' and achieve my wellbeing goals and wishes throughout life and at the end of my life.

I will know how to access support to co – produce or review my Plan with the health and care professionals that know me best so that I can share my wishes, feelings, believes and values. I will also know who I can share my Plan with to make sure that future decisions about my wellbeing, care and treatment are considered in line with those wishes outlined in the Plan.