Southampton City Health and Care Strategy

2020-2025

COVID Impact Assessment

Die Well Programme

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Recap: Die Well Programme

Key Ambitions

(taken directly from the strategy document)

- Increase the percentage of people in the last 3 years of life who are registered on a local end of life register
- Increase the percentage of people who have, or are offered, a personal health budget towards end of life (fast-track)
- Reduce the average number of patients per month who die in hospital whilst being delayed to be discharged
- Reduce the percentage of older people who die within 7 days of an emergency hospital admission
- Reduce the percentage of older people who die within 14 days of an emergency hospital admission

Original Plan

What we said we were going to do (taken from the strategy):

Reducing inequalities and confronting deprivation

- Support **more people to achieve their preferred place of care and death**.
- **Equitable provision** of end of life care and services available to all.
- **Develop staff** to support people who are less able to self-advocate their own care, such as people with a learning disability.
- Explore providing **end of life hospice care for children** and a hospice at home service.
- Improve **access to hospice services** including community support, day services and inpatient facilities if or when required.

Improving mental and emotional wellbeing

- **Support people to be clear about what to expect** as they approach and reach the end of their life.
- **Holistic needs assessments** will consider the person's wellbeing, psychological, spiritual and health and social care needs.
- **Carers** will be offered a holistic needs assessment to identify what practical and emotional support can be provided
- **Involving, supporting and caring for all people important to the dying person** is also recognised as a key foundation of good end of life care.
- Launch a new b**ereavement and psychological service.**
- Develop a process to **assess families post bereavement at day 21.**

Original Plan

What we said we were going to do (taken from the strategy):

Supporting people to build resilient communities and live independently

- Offer **Personal Health Budgets (PHBs)** for people in their last 12 weeks of life, to give people more choice and control around their end of life care.
- Develop a strategy to e**ngage and raise public and community awareness** and attitude of death and dying.
- **Volunteers** will be recruited, trained and developed to help support individuals, their families and communities.
- Support and encourage **local communities** to provide compassionate and practical help, pre and post bereavement.
- Engage and involve **local communities** and places of worship in the development and co-design of the local hospice.
- Encourage **schools** to support the development of an end of life programme for schools and colleges.

Improving earlier help, care and support

- **Early identification of people** thought to be within their last three years of life with a focus on older and frailer people and those with life limiting conditions, and those who may not, because of their condition, be able to communicate their end of life wishes in the future.
- All appropriate individuals in a **care home** will be on an end of life register and will have an advanced care plan discussion.
- Regular monitoring of people on the **end of life register** to provide timely intervention when required.
- Implement **proactive, personalised care planning** to support individuals to consider their end of life wishes early on in their illness or frailty.
- Improve **hospital discharge fast-track processes** to enable people at the end of their life to die in their place of choice.
- Improve **responsiveness within the community** to support individuals at the end of life and avoid unnecessary hospital admissions.
- Provide **support to individuals, their families/carers in times of crisis**.
- **24/7 help and support line and rapid, responsive support** for people in their own homes.
- People will have access to **timely pain control** and management of their symptoms.

Original Plan

What we said we were going to do (taken from the strategy):

Improving joined-up, whole-person care

- Develop and implement an effective **out of hospital end of life care coordination service** to allow more people to achieve their preferred place of care and death.
- Train and develop the **workforce within the home care and residential home services** to provide continuity of care.
- Use **Personalised Care and Support Plans, or Advance Care Planning**, to capture end of life care wishes.
- Develop a **workforce** which is confident and competent to discuss and capture end of life wishes.
- Proactive **working partnerships** between the NHS, social care, voluntary sector, charities and local communities.

Original Roadmap for Years 1 and 2

What we said we were going to do (taken from the strategy):

Year 1
2020/21

- **24/7 coordination centre** with access to rapid response 24 hour advice, support and home visits
- Development of **end of life champions**, linking with primary care and communities
- **Bereavement services** expanded
- Review the **provision of access to end of life services** for professionals and the families of children at or approaching end of life

Year 2
2021/22

- **Nurse-led unit in place at Mountbatten Hampshire Hospice**
- **Independent hospice provision** in place for Southampton
- **Everyone in a care home is identified on an end of life register with an advanced care plan in place**
- **End of life training** available to home care staff
- Work with **children's services and families** to design local end of life services for families and children

Where are we now?

Current Position: What has changed in response to COVID-19?

24/7 Coordination Centre

What has stopped?	What has continued?	What has changed?
	• Plans to develop and implement on track including management of NHS Solent PCSW service (contract now with Mountbatten Hampshire).	• 24/7 community hub instigated in response to COVID 19 – this was supported by H&IOW Community Foundation funding • Advice and support provided to stakeholders, including families for those specifically at EOL with COVID • Daily 3pm call • Strong and supportive relationships with GP's and SPCL have been developed in conjunction with Mountbatten and NHS Solent . • Collaborative approach resulting in no delays in the fast-track process, allowing people to be discharged responsibly and timely and prevented hospital admissions/kept people in their own homes, if this was their preferred place of care. • Mechanism for responsive access to EOL medication. • Community data uploaded twice daily to the national Capacity Tracker

Current Position: What has changed in response to COVID-19?

COVID Triage

What has stopped?	What has continued?	What has changed?
		SPCL • Clinical assessment of 111 (0800-2200 7 days per week) that pick up and arrange appointments for patients that are potentially EOL. • Hot Visits - Face to face assessments in the community • EOL primary care support for suspected / positive patients at home including nursing and residential care homes • Daily access to SPCL advice • EOL virtual ward for COVID patients – RAG rated and supported according to clinical need • Treatment Escalation Plans • Collaborative approach to palliative and end of life care with NHS Solent and Mountbatten Hampshire • Verification of Expected Death (VOED) training • Emergency stock of anticipatory care meds

Current Position: What has changed in response to COVID-19?

Bereavement & Psychology Service

What has stopped?	What has continued?	What has changed?
	• Bereavement support has continued to be provided to patients and families known to Mountbatten Hampshire • Recruitment to the team – vacancy for a counsellor; successful appointment commenced 1st April 2020	• Service expanded ahead of planned time to provide support to the care home sector • Increased telephone consultations with patients and families • Extended bereavement support to families affected by COVID • Developed an information leaflet around managing resilience and managing stress (staff) • 24/7 telephone support for internal Mountbatten staff

Nurse-led beds at Mountbatten

What has stopped?	What has continued?	What has changed?
• Nurse led beds – shift to 2021/22, this is because training is now on hold for nurse prescribers due to COVID	• Recruitment of the Consultant nurse and Deputy Director of Nursing – successful appointment, role commences August 2020	• Restricted visiting in line with government guidance • Implementation of PPE and scrubs in line with government guidance

Current Position: What has changed in response to COVID-19?

Independent Hospice Provision

What has stopped?	What has continued?	What has changed?
• COVID 19 has resulted in the Mountbatten Fundraising being unable to implement their legacy and fund raising strategy.	• Rebrand to Mountbatten Hampshire	• Fund rising team working remotely • Profile in local community, greater awareness • Launched Mountbatten Hampshire COVID appeal • Implemented new Mountbatten website

Personalisation

What has stopped?	What has continued?	What has changed?
• Development of offer of PHB for patients eligible for fast-track	• Development of enablement and palliative rehabilitation, this focusses on what matters most to individuals	• Redeployed staff to manage staffing challenges in order to keep personalisation on the agenda • Uploaded an updated version of the Isle of Wight Advance Care Plan onto the Mountbatten website

Education and Training

What has stopped?	What has continued?	What has changed?
• Original end of life training programme	• Mandatory e-learning and social distanced face to face training	• Changes to the EOL training programme for residential and nursing homes • Method of delivery amended • This is scheduled to commence in October 2020 • Training sessions implemented for NHS Solent staff redeployed into end of life care • Virtual learning sessions set up for care homes around end of life care

Assessing the impact of COVID

Assessing the Impact

Possible metrics

- TBC

Exacerbation of existing needs and new needs

What impact will COVID have on people in terms of exacerbating existing needs and new needs?

- Likely to see an increase need for bereavement and psychology services
- People presenting late for diagnosis outside of COVID related illness – a whole cohort of patients have not flagged issues with their GP's
- Social isolation and loneliness

Summary

What's worked well and what concerns do we now have?

What has worked well during COVID and we should keep?	What are the concerns/unintended consequences we now need to address?
• Collaborative approach with Mountbatten, UHS, SPCL, SCCCG CHC and NHS Solent • Daily 3pm call to hold a virtual MDT • Staff flexibility and redeployment • New Fast-track approach	• Demand on psychology and bereavement services • Late diagnosis of diseases

Priorities and next steps

Short Term (next 4-6 weeks)

- Expansion of **bereavement offer** to residential and nursing homes
- Planning for the next period when measures are relaxed, e.g. reopening of day services, visiting arrangements

Medium Term (next 3-5 months)

- **Handover of PCSW service** from NHS Solent to Mountbatten Hampshire
- Commencement of **EOL education training programme** for the care and nursing home sector
- Development of **24/7 Care Coordination centre**
- Commencement of Consultant Nurse/Deputy Director of Nursing to start planning for **nurse-led beds**
- Expanding **bereavement service** provision including development of volunteers

Long Term (6-12 months)

- **Personalisation** – introduction of PHB's for patients eligible for CHC fast-track
- **Nurse led beds** at Mountbatten Hampshire
- **Social prescribing pilot** (this will link to the wider CCG initiative)
- Explore Mountbatten **discharge facilitator** to be based at UHS