Southampton City Five Year Health and Care Strategy 2020-2025

Progress update – October 2021

Southampton City Health and Care Strategy

2020-2025

Our vision

A healthy Southampton where *everyone* thrives

Our goals

Reducing **inequalities** and confronting **deprivation**

Working with people to build **resilient communities** and **live independently**

Improving **earlier help, care and support**

Tackling the city's **biggest killers**

Improving **mental and emotional** wellbeing

Improving **joined-up, whole-person care**

Our priorities

Start Well

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

Live Well

People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

Five key enabling priorities:

- Digital
- Workforce
- Estates
- Primary Care
- Urgent & Emergency Care

Southampton City Five Year Health and Care Strategy
2020-2025

Start Well
Progress update

Update: October 2021

Reminder of our five year vision for Start Well

Start Well

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

In five years time, we want children and young people in Southampton to:

- Live happy, healthy lives, with good levels of physical and mental wellbeing
- Be safe at home and in the community, with Southampton being a child-friendly, family focussed city.
- Have good levels of educational attainment, fulfil their potential and go on to successful opportunities in adulthood.
- Live in communities which are resilient, engaged and prepared for the future.

Start Well – Our original road map

Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

Year 1 2020/21

- Year of the Child
- Early Help locality model
- Local foster care offer expanded
- Two mental health support teams in schools established
- Phoenix specialist family service goes live
- Implementation of children's psychiatric liaison service

Year 2 2021/22

- Children's Hospital at Home service goes live
- Expansion of mental health support teams in schools and a whole school approach to mental health and wellbeing
- Employment and training opportunities expanded for young people
- Perinatal mental health services expanded for women and partners
- Development of local residential provision

Year 3 2022/23

- 0-25 year service offer in place
- Expansion of mental health support teams in schools
- Employment and training opportunities further expanded for young people

Our key ambitions

- Reduce the percentage of mothers **smoking** during pregnancy
- Reduce the rate of **teenage pregnancies**
- Increase the percentage of mother's **breastfeeding** 6-8 weeks post birth
- Reduce the rate of **looked after children**
- Increase the percentage of **care leavers in suitable accommodation**
- Increase the percentage uptake of healthy child mandated immunisations and health checks
- Increase the percentage of children achieving a good level of development at the end of **reception**
- Improve **School Attendance** and reduce Exclusions
- Increase the percentage of children reporting **positive mental health** at Year 7
- Reduce the rate of first time entrants to the **youth justice system**
- Reduce the percentage of 16-17 year olds not in **education, employment or training** (NEET)

What progress have we made in 2021/2022?

Improving mental and emotional wellbeing

- **Mental Health Support Teams in Schools –** Wave 4 trainees fully recruited and commenced university course this Spring (two teams to go live January 2022, covering 90% of the whole city's school and college populations). Wave 2 teams went live in Spring 2021. In Q1 21/22 the team supported 268 children and young people.
- **Children's Acute Psychiatric Liaison –** New service went live in July 2021.
- **No Limits Youth Worker support in UHS A&E –** continuing to provide valuable advice, support and signposting for young people; new pathway developed for young people ringing NHS 111.
- **NHS 111 -** Implementation of crisis support for all ages through our NHS 111 Mental Health Offer with Child and Adolescent Mental Health Service and adult mental health mental health nurses available 24/7 for immediate assessment and support
- **Supporting young people with complex social, emotional and mental health needs (SEMH) in special schools –** Majestic project going live in November 21 following successful bid to pilot model of support into the city's two SEMH schools and Pupil Referral Unit to reduce exclusions and youth offending.
- **Transition –** Ongoing work to improve transition from CAMHS into adult services. Work with adult mental health services is underway to improve pathways for those who meet criteria and exploration of how the new Enhanced Primary Care Mental Health Teams could support those who do not. Development of pathway into IAPT (psychological therapies) services from age 17 ½ . Transition care plans including crisis and risk management plan rolled out to primary care. Adult mental health services attending RE:MINDS parent groups.
- **Interagency Early Intervention** – agreement to expand the Building Resilience and Strengths Service, which is a joint children's health and social care team focussing on those children and young people with the most complex needs, to work in the new Early Help and Young People's locality teams supporting frontline staff with advice, assessment and joint case working. In addition to expansion of the community crisis offer (into weekends and evenings) and therapeutic offer for vulnerable young people including looked after children. Expansion planned for mobilisation from January 2022.

What progress have we made in 2021/2022?

Improving earlier help, care and support

- **Redesign of the integrated health and social care Early Help offer for children and their families**, strengthening the locality approach, simplifying structures and processes and strengthening social work input. This includes strengthening our offer of support through Children's Centres, Family Engagement Workers, Health Visiting and School Nursing. Reconfigured Early Help Services and a new Young People's locality service are due to go live from January 2022.
- **SEND** (Special Educational Needs and Disabilities)
    - Redesign of early help offer for SEND to provide more specialist support and advice to frontline Early Help workers. Ensuring SEND a key consideration in Early Help assessment and signposting to Parent Carer Assessment
    - Specialist parenting programmes for children with Autism Spectrum Disorder (Early Bird and Cygnet) to be rolled out from January 22 and further programme being explored for children with ADHD.
    - Autism in Schools pilot going live in four schools this term, based on learning from North Cumbria, to focus on developing whole school approaches and training, co-delivered with the Parent Carer Forum.
    - SEND Local Offer being further developed and Autism Allies programme, which will involve parents of children with SEND being trained up to support other parents, is going live this Autumn.

Working with people to build resilient (and inclusive and child friendly) communities

- **Child Friendly City –** vision to become a Child Friendly City starting in 2021 and working towards the goal of accreditation by 2024/25; plans in place for installing the city's first children's mayor by May 2022, establishing a Youth Council, devising a Children's Charter and implementing a pledge for care experienced children.
- **SEND Inclusion Charter** – launched September 2021

What progress have we made in 2021/2022?

Tackling the city's biggest killers

- **Children's Hospital at Home –** currently out to recruitment – phased start from November 2021. To support families manage minor child illnesses in the community through combination of telephone support and home visiting, and reducing pressure on ED department at UHS.
- **Long Covid Service –** implementation of long Covid service for children across Hampshire, Southampton and Isle of Wight.
- **Maternity –** continued targeted work to prevent smoking and excess weight in pregnancy.

Targeting support to the most vulnerable

- **Children's Residential Care –** strategy in place to implement three new children's homes in Southampton (two long term and one short term) which will reduce the number of children in out of area placements, enabling children to be better supported locally closer to their families/social networks (where this is appropriate). Plans in place to mobilise the first two homes during 2022/23.
- **Phoenix @ Pause Southampton –** supporting women who have had multiple infants taken into care to break the cycle – currently working with 21 women and now to be extended to work with a further 24 in 2022/23.
- **Young Carers –** strategy under development following Southampton City Council's Carers Scrutiny Inquiry. Additional resources being invested in working with No Limits to establish a Young Carers in Schools Programme, introduce a Young Carers identification (and discount) card, and further identify and explore needs.
- **Vulnerable Young People** - development of new locality based service bringing together social work, youth work and emotional and mental health support, closely aligned to the Youth Offending Service and the Building Resilience and Strengths Service – due to go live after January 2022

Performance against key measures

		Latest Period	Performance	Direction of travel	Trend
Start Well	Reduce the percentage of mothers smoking during pregnancy	Q4 2020/21	10.80%	↑ Worsening	
	Reduce the rate of teenage pregnancies	2018	17.4	↓ Improving	
	Increase the % uptake of healthy child programme mandated health checks - completed within 14 days	Q3 2019/20	83.1%	↓ Worsening	
	Increase the % uptake of healthy child programme mandated health checks - with a 6-8 week review	Q3 2019/20	76.7%	↓ Worsening	
	Increase the % uptake of healthy child programme mandated health checks - with a 12 month review	Q3 2019/20	17.9%	↓ Worsening	
	Increase the % uptake of healthy child programme mandated health checks - with a 2 - 2.5 year review	Q3 2019/20	50.8%	↑ Improving	
	Increase the percentage of children achieving a good level of development at the end of reception	2018/19	71.1%	↑ Improving	
	Improve access to Children and Young People's Mental Health Services (CYPMH)	Mar-21	180	↑ Improving	
	Reduce children emergency hospital admissions (0-17 years)	Mar-21	140	↑ Worsening	

What are the challenges for Start Well?

Upcoming challenges	Key actions
Increasing demand in referrals	▪ Strengthening Early Help and prevention ▪ Multiagency approaches to identifying and managing vulnerable families
Workforce	▪ Joint recruitment campaigns – whole city approach to making Southampton a good place to work ▪ Health and wellbeing of staff ▪ Collaborative working with providers in staff retention ▪ Continued exploration/evaluation/use of digital/different ways of working
Improving IT infrastructure	▪ Exploration of opportunities with new CareDirector system ▪ Exploration of CHIE – greater application in children's services
Capacity of the voluntary sector	▪ Work with the voluntary sector to understand pressures ▪ Support in identifying alternative funding streams

Southampton City Five Year Health and Care Strategy 2020-2025

Live Well
Progress update

Update: October 2021

Reminder of our five year vision for Live Well

Live Well

People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

In five years time, we want people in Southampton to:

- Live healthier, for longer
- Be happy in life and feel supported by their family, friends and local community
- Live independently and feel confident to take care of their own health and wellbeing
- Live in a city which is fully accessible.

Live Well – Our Original Road Map

People will achieve and maintain a sense of wellbeing by leading a healthy lifestyle supported by resilient communities

Year 1 2020/21

- **Lung Health Checks** fully implemented to increase the early detection and survivorship of lung cancer
- Patients will be able to receive a **definitive cancer diagnosis** within 28 days of referral
- **Cervical screening** implemented at more flexible timings
- Community **Cardiology and Respiratory** service developed
- Psychological therapy support available for people with cardiovascular or gastrointestinal conditions
- Development of an **Integrated Diabetes Service** that will be measured on improving outcomes for patients living with diabetes
- Introduce risk stratification to identify individuals with a **learning disability** who have the greatest need
- Expand portfolio of **housing options** for those with a learning disability/mental health need
- Implement "**The Lighthouse**" community based facility to support those experiencing a mental health crisis
- Pilot a complex nurse worker in **Homeless Healthcare** to work with people with complex needs, including mental health refocus in 2021/22 as return to more BAU following redirected work to support homeless population during covid
- Review best practice models for mental health services accessed by **rough sleepers**

Year 2 2021/22

- New Southampton **Alcohol** Strategy launched
- All patients have access to **on-line and video consultations** for their GP surgery
- Every person diagnosed with cancer will have access **to personalised care**, including a care plan and health and wellbeing information and support
- **Follow-up support** for people who are worried their cancer may have recurred will be in place
- New **heart failure** and breathlessness services developed
- People with a **mental health** condition will be able to access digitally-enabled therapy
- **Therapeutic care** from inpatient mental health services will be improved
- Produce a proposal for an effective mental health pathway for **rough sleepers** to access integrated holistic, long term care and support continues in development, service options emerging – work continue in 2021/2022

Year 3 2022/23

- Community **Cardiology and Respiratory** service fully in place
- Implement new mental health services for **rough sleepers**
- Every person diagnosed with cancer will have access **to personalised care**, including a care plan and health and wellbeing information and support
- **Follow-up support** for people who are worried their cancer may have recurred will be in place

Our key ambitions

- Increase **healthy life expectancy**
- Reduce the gap in life expectancy between the most and least deprived areas of the city
- Reduce **smoking** prevalence in adults
- Reduce the percentage of adults who are **physically inactive**
- Reduce **alcohol**-related mortality
- Eliminate all inappropriate **out of area mental health placements**
- Reduce the rate of **suicides**
- Increase the percentage of adults with a **learning disability living in settled accommodation**
- Increase the percentage of **cancers** being diagnosed at an earlier stage
- Reduce early deaths from **cardiovascular disease** and respiratory disease
- Increase the number of **social prescribing** referrals
- Increase the number of people being referred to the national **diabetes** prevention programme

What progress have we made in 2021/2022?

Tackling the city's biggest killers

- Cancer services fully restored following pandemic. Referrals for patients with suspected cancer at pre-pandemic levels for most cancer types, and length of time to treatment has reduced. Hampshire and Isle of Wight has the third highest ICS performance across England for the faster diagnosis standard, with July performance of 83.3% (standard is 75%).
- Cancer screening programmes have been restored following the pandemic.
- Work with primary care to ensure maximum use is made of Faecal Immunochemical Testing (FIT), helping to detect colorectal cancer as quickly as possible, resulting in a 62% in use of FIT tests from August 2020 to August 2021.
- Targeted Lung Health Check programme to detect lung cancer in 55–74 year olds at an earlier stage went live in Autumn 2020. Over 4,000 lung health checks completed to date.
- New Integrated Diabetes Service model developed; business case approved in July 2021. The service will provide specialist support to primary care to help patients living with diabetes manage their condition more effectively, and improve patient outcomes.
- Home-based screening service for albumin to creatine ratio (ACR) went live in May 2021, enabling early diagnosis of kidney disease, reducing kidney failure.

What progress have we made in 2021/2022?

Promoting behaviour change and healthier lifestyles

- Expansion of alcohol telephone support line, both to test the approach at scale and in response to increased higher risk alcohol consumption during Covid.
- New, additional Tier 2 adult weight management services starting and more being commissioned, from new national funding for 2021/22.
- Smoking - new training in place to help health and care providers support patients and clients to stop smoking; Stoptober campaign underway.
- Implementing child obesity cabinet action plan, including work on both food and physical activity, which will benefit adults too.
- Continuing to develop City of Culture and child-friendly city work to optimise reduction in health inequalities

Targeting support to vulnerable people

- **Homeless people and Rough Sleepers –** Proactive work has resulted in many clients coming into services who are now already fully vaccinated with second dose. 213 rough sleepers offered the vaccination.
- **Sex Workers –** needs assessment undertaken. £50,000 has been secured to deliver a support service in 2022/2023.
- **Domestic Abuse –** Detailed needs assessment has been completed and informed a draft Safe Accommodation Strategy which is currently out for consultation. The recommissioning of Domestic and Sexual Abuse services remains on schedule to secure new services from April 2022.
- **Housing Related Support Services** – The recommissioning of Housing Related Support Services remains on schedule to secure new services from July 2022 and includes Housing First as a component for adults, young people and vulnerable women with more complex needs.

What progress have we made in 2021/2022?

People with learning disabilities

- **Independent Living –** increasing sustainable housing options that promote independence. This involves people moving from residential care into supported living. 14 new supported housing facilities are under development/developed. Seven people have been supported to move to more independent forms of living over last four months.
- **Active Lives –** work has commenced with clients, carers and the market on developing a new model of support which promotes opportunities for access to employment, skills development, travel, community activities, advice and information and digital support.
- **Tackling Health Inequalities** – Ongoing work to increase uptake of Annual Health Check which increased to 68% by March 21 despite impact of COVID and promote COVID vaccination uptake.

Adult Mental health

- **Increased access to psychological therapies –** achievement of NHS England target despite the impact of COVID
- **Mental Health Network and Service User Network -** Service has commenced and is working towards key outcomes to support Southampton becoming a Mental Health Friendly City
- **Supporting Rough Sleepers –** development of support for Rough Sleepers with Mental health problems and Rough Sleepers with Substance Misuse problems, following successful funding bids
- **Enhanced primary care MH service -** dedicated Southampton City Mental Health Partnership Board in place with collaboration between CCG, PCNs, NHS Providers and Voluntary, Community and Social Enterprise (VSCE), driving development of new Enhanced Primary care Mental Health roles in each PCN. 3.5 FTE new Primary MH workers in post and will be 4.5 FTE by year end
- **Crisis support –** additional Light House for the East of the city
- **Ongoing implementation of Suicide Prevention strategy**

Performance against key measures

		Latest Period	Performance	Direction of travel	Trend
Live Well	Reduce alcohol-related emergency hospital admissions	Mar-21	1	Improving	
	Eliminate all inappropriate out of area mental health occupied bed days	Jun-21	5	Improving	
	Improve Access to Psychological Treatment – Access – people entering treatment	Q1 2020/21	5.80%	Improving	
	Increase the percentage of cancers being diagnosed at an earlier stage	2016-18	54%	Improving	
	Cancer – 93% of patients to be seen within 2 weeks	Jul-21	95.01%	Worsening	
	Increase the number of people being referred to the national diabetes prevention programme	Jun-21	107	Improving	
	Reduce working age adults emergency hospital admissions (18-64 years)	Mar-21	1,252	Worsening	
	Increase the proportion of people with a Learning Disability receiving an Annual Health Check	Q3 2020/21	27%	Improving	
	Increase the percentage of people with Severe Mental Illness receiving a full annual physical health check	Q1 2021/22	16.4%	Worsening	
	Increase the number of Primary Care Virtual Appointments (telephone and online)	Feb-21	45,723	Improving	
	Housing - settled accommodation for adults with Learning Disabilities				
	Employment - Increasing access to employment support				
	Housing for the Homeless				
	Physical Activity				
	Cardiology and Respiratory Disease				

New Metrics for future development

What are the challenges for Live Well?

Upcoming challenges	Key actions
Recovery from COVID period	▪ Continue with communications/ other campaigns to encourage people to attend appointments. ▪ Continue to prioritise elective activity/reducing waiting lists ▪ Continue to prioritise elective activity/reducing waiting lists
Prioritising **Public Health** during period of change	▪ Improved monitoring of impact of Public Health investment ▪ Optimise NHS Long Term Plan emphasis on prevention and data quality, and new funding. Smoking cessation high impact intervention. ▪ Optimise role of public sector as anchor organisations ▪ Build on covid community engagement
Workforce	▪ ICS wide HR workforce development ▪ Continue to promote health and wellbeing of staff ▪ Continued exploration/evaluation/use of digital/different ways of working
Increased demand on mental health services	▪ Strengthening Early Help and prevention ▪ Additional crisis investment – Lighthouse on East of city ▪ Additional investment to reduce waiting lists
Housing stock for independent living – people with learning disabilities	▪ Proactive work with developers to identify opportunities for new developments
Community and voluntary sector market	▪ Proactive work with market – co-production of new models of support ▪ Transition arrangements which support development of the market

Southampton City Five Year Health and Care Strategy
2020-2025

Age Well
Progress Update

Update: October 2021

Reminder of our five year vision for Age Well

Age Well

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

In five years time, we want people in Southampton to:

- Be able to maintain their health, wellbeing and independence into old age, stay living in their own homes and feel part of their local communities.
- Be supported to recover from illness in their own home wherever possible and only go to or stay in hospital when needs can't be met in the community.
- Be supported by collaborative and integrated working between health, social care and housing support.
- Be able to access the right support, at the right time, in the right place, as close to home as possible.
- Feel in control of their health and wellbeing, be part of any decision about their care and have the information and support they need to understand and make choices.

Age Well – Our original road map

People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

Year 1 2020/21

- Integrated community teams, 'One Team', across Southampton – beginning to operate
- Enhanced healthcare teams supporting all residential and nursing homes across the city
- Community navigators (social prescribers) in place across Primary Care
- Exercise classes in place for people at risk of falling
- More dementia friendly spaces in place
- Extra Care housing scheme at Potters Court opens
- Risk stratification rolled out to tackle inequalities and case manage people with the greatest needs
- Multiagency services at the hospital front door – with a 'Home First' principle

Year 2 2021/22

- Care technology support becoming the norm in enabling people to maintain their independence
- Health and care professionals using single care plans enabled through technology
- Single intermediate care team operating across hospital, community & primary care

Year 3 2022/23

- Integrated community transport service in place
- More intergenerational opportunities and older people volunteering
- Further increase in Extra Care homes available
- Health and care professionals across all sectors, including care homes and home care providers making active use of single care plans to share information and use technology to seek rapid advice from each other
- Enhanced healthcare teams providing support to extra care housing

Our key ambitions

- Increase the number of older people with a personalised care and support plan
- Reduce the number of older people being referred for adult social care
- Reduce the rate of emergency hospital admissions, including readmissions
- Reduce the rate of older people having discharge delays from hospital (delayed transfers of care)
- Increase the percentage of older people receiving reablement care after hospital discharge
- Reduce permanent inappropriate admissions into residential care
- Increase the number of carers having a carer assessment and receiving appropriate support
- Increase access for older people with a common mental illness to psychological therapies
- Increase the number of volunteers supported to find a volunteering opportunity
- Reduce the percentage of older people reporting that they feel lonely

What progress have we made in 2021/2022?

- **Enhancement of the support to care homes –**
  - Embedded the lessons learnt for enhanced support to care homes in the city – including digital approaches and clinical support
    - Work with providers to promote staff vaccination, in light of mandatory staff vaccination timeline
  - Work with relevant partners, in particular PCNs, to promote the sustainability of the enhanced support to care homes
- **One Team development –**
  - Public Health registrar drafted a One Team resource document to inform the next stage of this development – building on evaluation, partner views, best practice in HIOW and wider.
  - Test one team approach in other areas – discussions underway with other areas of the city to promote the next steps of testing
    - Including colocation of community services
  - Engagement across the wider community and voluntary sector to explore how to develop their collaboration within the one team approach
- **Straight forward access and Reactive care –**
  - Reviewed demand for D2A bedded provision in line with government policy, home first principle and Covid modelling.
  - Work with the care market to support sustainability following the significant impact on local businesses, particularly the smaller providers
  - Next stage of Single Point of Access provision for the city agreed and implementation underway – hospital discharge and urgent community response.

What progress have we made in 2021/2022?

- **Proactive care**
  - More dementia friendly spaces in place – this area of work having been delayed by Covid wave 2
  - Promotion physical activity through a targeted plan with community and voluntary sector partners in conjunction with public health.
    - Including a refresh of the falls prevention plan and dashboard
  - Testing of a dial a ride access to vaccinations and other health related appointments in place
- **Supporting people to stay well into older age**
  - Disability Facilities Grant proposals endorsed and new approach under development with the support of a project manager.
  - Potters court extra care open and filling in accordance with adjusted plan
  - Fully integrate a focus on older persons into the socio-economic response to COVID-19 – note this has been delayed as a result of Covid wave 2
- **Supporting Carers**
  - Carers Scrutiny enquiry completed and report drafted
  - Carers strategies being formed following the enquiry – with a coproduction approach to the implementation of its key principles.
    - Two strategies, the first for children and young people and the second for adults.

Performance against key measures

		Latest Period	Performance	Direction of travel	Trend
Age Well	Increase the number of older people with a personalised care and support plan				
	Reduce the number of emergency hospital admissions (65+ years)	Mar-21	911	↑ Worsening	
	Reduce the number of emergency hospital readmissions (65+ years)	Mar-21	211	↑ Worsening	
	Reduce permanent inappropriate admissions into residential care	Mar-21	35	↑ Worsening	
	Increase the number of registered Carers in the City	Q3 2020/21	126	↑ Improving	
	Increase the number of Carer Assessments and Reviews (rolling 12 months)	Q3 2020/21	231	↑ Improving	
	Increase the proportion of carers receiving appropriate support, including Direct Payments	Q3 2020/21	102	↑ Improving	
	Reduce the number of people aged 65 and over with long lengths of stay in hospital (21 days or more)	Jul-21	71	↑ Worsening	
	Increase the dementia diagnosis rate	Mar-21	61.2%	↑ Improving	

What are the key challenges for Age Well?

Upcoming challenges	Key actions
Move to virtual/remote offers – ensuring older people who may have less access to digital means continue to have access	▪ Range of offers considered – ▪ Phone, IT and where Covid safe, face to face ▪ Proactive approach for the most vulnerable people in receipt of services ▪ Promotion of the community hub, to provider volunteer support with key areas e.g. food and medication delivery
Economic impact on individuals	▪ Advice and guidance offer available in an accessible manner to this group.
Access to health provision	▪ Review of GP coding ▪ Consideration of risk to this client group during restoration planning
Older persons physical activity and well being.	▪ Development of a targeted plan to promote physical activity in Covid safe ways for this group

Southampton City Five Year Health and Care Strategy
2020-2025

Die Well
Progress Update

Update: October 2021

Reminder of our five year vision for Die Well

Die Well

People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

What do we want to be different in five years' time?:

- More people will be supported to stay at home when they experience a decline in their health within their last years of life.
- There will be equality in provision of end of life care across all socioeconomic backgrounds.
- More people will achieve their preferred place of care and death.
- Early identification and end of life discussions will be the norm; more people will be describing their end of life wishes and preferences.
- There will be local, compassionate communities who are confident to talk about and support friends and neighbours who may be experiencing death and dying.
- Proactive, personalised care planning to help people to consider their end of life wishes and options for a Personal Health Budget will be the norm
- More palliative care patients will have continuity of care and support across all health and care settings.
- Bereavement care will improve the involvement, support and care for all those important to the dying person.

Die Well Road Map and Ambitions

Year 1 2021/22	▪ **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 2022/23	▪ **Nurse-led unit** in place at Countess Mountbatten 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**
Year 3 2023/24	▪ Development of an **end of life schools programme**
Year 4 2024/25	▪ **Children's end of life care** services in place ▪ Bank of end of life children's home care /sitting service

Ambitions – by 2025 we will

- ↑ the % of people in the last 3 years of life who are on an End of Life register
- ↑ the % of people who have, or are offered, a personal health budget towards end of life
- ↓ the average number of patients per month who die in hospital whilst waiting for discharge
- ↓ the % of older people who die within 7 and 14 days of an emergency hospital admission

What progress have we made in 2021/2022?

- **Coordination of care**
  - 24/7 telephone helpline implemented for patients, their families and professionals providing a central point of contact for patients, families and professionals
  - access to rapid response 24 hour advice and support
  - Sustained the new models of partnership working introduced to respond to COVID-19
- **End of Life Home Care**
  - Embedding of Palliative Care Support Worker Team within the Mountbatten at Home Care Team MBH).
  - Mountbatten at Home Care team, joining up the support and care with MBH CNS', District Nurses and Primary Care
- **Bereavement Care**
  - Offer of bereavement care extended beyond patients & families known to Mountbatten
  - Bereavement support funded to support all residential care home staff that have been impacted significantly as a result of the pandemic

What progress have we made in 2021/2022?

- **Education**
  - Virtual End of Life training available to all external providers on a variety of End Of Life Topics
  - End of Life forums to support care home end of life champions
  - Six Steps education programme in residential and nursing homes continues and rolled out to home care providers.
  - Increased level of Advance Care Plans through work with health care partners
- **Day Care**
  - Virtual day care group offering exercise, bereavement support, support for people with fatigue and breathlessness
  - Review of day care offer, promoting a more flexible approach that expands engagement with the wider community
- **ICS**
  - Work across the ICS to progress the key deliverables agreed by Hampshire and Isle of Wight:

    - End of Life interoperability
    - Training
    - Early identification
    - Care after death

Mapping against the six ambitions

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

- Southampton is working towards fulfilling these ambitions, in the next 6 months this will include –
  - Supporting the system
    - Inreach role working with UHS to promote discharge
    - Review of community team approach and capacity to promote a sustainable urgent community response
  - Hospice@Home
    - Workforce reviewed and provision of Home Care at End of life now available across Southampton and parts of West Hampshire (south localities)
  - Nurse Led Beds
    - Nurse lead beds to be in place by the end of the year 2021.
    - Advanced Nurse Practitioners in place.
  - Bereavement Services
    - Has been in place for some time, fully staffed team; with a plan to roll out to Care Homes post pandemic
    - Starting children's groups.
    - Planning virtual groups and recommencing face to face when guidance allows.
  - ICS – continue collaboration with ICS to progress key deliverables – in particular interoperability of care records.

Performance against key measures

		Latest Period	Performance	Direction of travel	Trend
Die Well	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 identified as fast-track, who died in hospital whilst being delayed to be discharged	The process for hospital discharges has changed since the COVID-19 outbreak			
	Reduce the number of older people who die within 7 days of an emergency hospital admission	Mar-21	13	↓ Improving	
	Reduce the number of older people who die within 14 days of an emergency hospital admission	Mar-21	16	↓ Improving	

What are the challenges for Die Well, how are we mitigating them?

Upcoming challenges	Key actions
Ensuring End of Life plans are met	▪ Mountbatten 24 hour service being further developed to provide home visits, enhancing the current 24 hour helpline ▪ End of Life register developed in conjunction with key stakeholders
Identifying people as requiring End of Life care	▪ Weekly call with NHS Solent, Mountbatten Hampshire, CCG & UHS reinstated to discuss EOL pathway ▪ Continued discussions regarding complex cases ▪ Review of capacity within the Mountbatten Community team