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End of Life Strategy 2016-2020

Foreword

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Southern Health Trust is committed to providing the highest quality care for patients, their families and carer's. Therefore, I am pleased to present our End of life Strategy which sets out how, as a Trust, we are planning to provide the best End of Life care.

For me this quote from NHS England 2015, "Every moment counts" summarises what we should hold as important when providing end of life care (NHS England 2015.)

"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

To achieve our strategy we have been guided by the national work presented in the Ambitions for Palliative and End of Life Care that outline six ambitions of care.

1. Seeing you as an individual
2. Ensuring that you get fair access to care
3. Maximise your comfort and wellbeing
4. Approach your care in a coordinated way
5. All staff are prepared to care
6. Work with the local community to promote care for the dying

As a community Trust we are committed to being involved in your local services working to enhance local community services and awareness of the needs of the dying person. Although our focus is on you and your experience our concern is broader. Our ambitions include your carers, families and those important to you. To achieve this I am committed to ensure our staff are supported to have the right skills, and training, are confident in their work and provide compassionate care to you when you need it.

Lynne Hunt
Chair

Local Context

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Southern Health is one of the largest Foundation Trusts in the UK, specialising in mental health, adult and child community health and learning disability services.

Covering Hampshire, we are one of the largest providers of these types of service in the UK. We employ more than 7,000 staff who work from over200 sites serving a population of around 1.3 million people.

Our services include:

- Mental health services - we provide treatment and support to adults and older people experiencing mental illness. We also provide treatment to adults and young people, in secure and specialised settings.
- Community services - our diverse range of community health services provide support and treatment to both adults and children. We deliver this care in community hospitals, health centres, GP surgeries and in our patients' homes. We also provide a stop smoking service (Quit4Life).
- Learning disabilities services - our community learning disability teams work in partnership with local councils to provide assessment and support for adults with learning disabilities. We also provide specialist inpatient services.

End of life care is one of the core services of Southern Health. Due to the breadth of our services we provide End of life care in a number of environments including your own home. It is therefore essential that we do everything we can to ensure and enable excellent quality of care for you and people important to you at the end of your life.

Our aim: to provide high quality, safe services which improve the health, wellbeing and independence of the people we serve.

The principles underpinning this vision include our commitment to quality at the heart of everything we do, plus our staff commitment to maintaining and enhancing their knowledge and skills, as well as to their codes of professional and organisational conduct. All end-of-life care will have the underpinning 6 Cs at its core (DH 2013 Compassion in Practice).

6 Cs and end-of-life care

Care

The care of the dying person must be personalised, reflect individual needs and preferences and have attention paid to assessing and addressing physical, emotional, psychological, social and spiritual needs of that individual, as well as that of his/her family and carers.

Communication

Regular, pro-active and responsive communication takes place between professionals, the person who is approaching the last days of their life, families and carers.

Compassionate

A compassionate approach elicits a patient's wishes, respecting the uniqueness of the individual, supporting the patient and family with kindness and empathy.

Commitment

A commitment to delivering high quality end-of-life care to patients and their families in a non- judgemental way. A commitment to service improvement via response to feedback from staff, patients and families

Courage

Patient at the centre of care with staff taking the time to act as advocates to ensure that patients' needs and wishes are supported. Staff to consider new ways of working to deliver personalised care to patients and families

Competence

All aspects of assessment, care and treatment must be carried out by staff who are competent to do so and who remain up to date in their knowledge and skills in end of life care.

National context

Each year, about 500,000 people in England die; for each person, there are many around them who are affected by caring, grief and loss. The National End of Life Strategy 2008 set a determined path to improve the quality and experience of care for all. Following withdrawal of the Liverpool Care Pathway for the dying patient (2014) the `One Chance to get it Right` document (2014) described five priorities of care that must be in place to care for patients in the last days of life.

1. The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the persons needs and wishes and these are regularly reviewed.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are explored, respected and met as far as possible.
5. An individual plan of care, which includes symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

More recently The Ambitions for Palliative and End of Life Care, a National Framework for local action 2015 – 2020 ,is a continuation of this work. It builds on the extensive national efforts made over the previous seven years and broadens its reach and challenge to the whole community. The Trust is committed to ensuring we make these ambitions a reality. Such success will not just occur, but requires leadership and commitment from all parts of the organisation. The Ambitions Framework recognises the important role of the communities, within end-of-life-care. The inclusion of concepts such as ‘each community is prepared to help’ is the desire to form new and improved partnerships between communities and professional services. This is why as a community Trust the introduction and provision of work included in the new ‘Ambitions Framework’ is so important in our everyday work.

Building on the information previously available to us to achieve the best end of life care we will include the 6'C's. Our strategy will outline how, over the next three years, we will achieve the 'Ambitions in end of life care' (2014). This includes the key eight foundations that are required to achieve this:

1. Personalised care planning - Everyone approaching the end of life should be offered the chance to create a personalised care plan, this is designed to offer to give you the opportunity to record your preferences and goals
2. Shared records - To ensure the plan can guide a person centred approach, it has to be available to that person, so that they can review, change and update it themselves. Subject to that person's consent, or, if they lack mental capacity, in their best interests, the plan should also be shared with all those who may be involved in their care.
3. Evidence and information - Involving, supporting and caring for those important to the dying person
4. Education and training - Every professional needs to be competent and up to date in the knowledge and practice that enable them. It is vital that every locality and every profession has a framework for their education, training and continuing professional development, to achieve and maintain this competence to play their part in good end of life care.
5. Involving, supporting and caring for those important to the dying person – ensuring we listen to feedback and build upon this to improve our services.
6. 24/7 access - Every person at the end of life should have access to 24/7 services as needed as a matter of course.
7. Co-design - the people that know the most about what services should look like are those that are using them, therefore all health and social care systems should involve people who have personal experience of death, dying and bereavement
8. Leadership – strong leadership that works with local partners and commissioners to provide care that is suited to the needs of the population.

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Ambition 1

Each person as an individual

'I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's'

Southern Health Ambition

We pledge that all of your personal needs and wishes will be explored through honest conversations about dying, death and bereavement at a time when you feel ready to have them; this will include you and the people that are important to you.

Our staff will deliver care that is person centred and will ensure that choices about your care are recorded, supporting you to retain as much control as you wish to have.

We will provide you and those important to you with information, advice and support to enable you to make timely decisions about your care.

Your care will be coordinated to incorporate your personal, health, social and social care needs.

We will achieve this through:

Strengthening our skills in honest and well informed conversations regarding dying, death and bereavement by developing a training and competency framework.

The development and implementation of an individualised care plan for everyone receiving end of life care in our services.

We will work with our local partners to ensure access to the best clinical assessment and care delivery in an environment that meets your needs and choice.

We will work with you and those important to you in preparation for bereavement, signposting to appropriate bereavement services.

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Ambition 2

Each person gets fair access to care

'I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.'

Southern Health Ambition

You and those important to you have the right to expect services at the end of life that are coordinated and provide you with all of the support you require.

Dying, death and bereavement affects everyone; we will ensure that you get the care that works for you personally.

We recognise there are vulnerable groups and individuals who may find it more challenging to access end of life services. Achieving equity, access and responsiveness will be at the centre of the day to day care we provide.

We are committed to understanding what outcomes are important to you in relation to your care, recognising that these are key in helping us make continuous improvements.

We will achieve this through:

Using all available data sources to better understand the reach of our services and identify any gaps in the provision of end of life care.

We will generate and use this data to inform us how we may need to improve care. We commit to using national, regional and local data to further guide and develop services that will improve care for you.

We will continue to strengthen relationships with our acute and local authority providers to maintain clear and open communication to facilitate an ease of transition of your care between services, where this is required. We will work with primary care and other providers to support you in your local area.

We will work with you and those important to you to develop a set of measurable, person centred outcomes so that we can continue to improve services in the future.

Ambition 3

Maximising comfort and

'My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.'

Southern Health Ambition

We know that many people approaching death may be fearful of being in pain or distress.

We will recognise and respond to your concerns, assess the cause and identify what might help you 7 days a week, 365 days of the year.

We know that access to early, good quality palliative care can improve outcomes. We will maintain and develop the existing Specialist Palliative Care service that we provide. Where this is not present, we will utilise the knowledge and skills of external Specialist Palliative Care services to ensure that all of your needs are supported.

We will achieve this through:

Implementation of the End of Life education and competency framework for all clinical staff, to ensure skilled assessment and symptom management.

We will work with and support you to achieve your personal goals whilst maximising your independence.

We will embed the use of Individualised Care Plan for the dying patient both in the inpatient and community setting.

We will equip our staff with the knowledge of how to access expert advice, medicines and equipment so they can respond rapidly to your changing needs.

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Ambition 4

Care is coordinated

'I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time day or night.'

Southern Health Ambition

We know that fragmented and disjointed care can be a source of anxiety and frustration. We are committed, as part of the Sustainability and Transformation plan for Hampshire, to develop and enable a more coordinated response that is proactive to your needs and uses a full range of community services throughout SHFT.

The Better Local Care initiative will be used to encompass the needs of dying children, young adults, those with learning disabilities, dementia, frailty and mental health diagnoses.

We commit to providing services to all communities that sustain excellent care outside of inpatient services. We will work closely with our local partners in social care and the voluntary sector to achieve this.

We will achieve this through:

Working with our partners to further develop and utilise shared records, with informed consent from you.

Developing and consistently using patient held information including 'my voice', 'patient passports' and advanced care plans.

Clear leadership and executive support for excellent End of Life care.

Adopting a key worker approach to the management of end of life care in all clinical teams which is clear and accessible for you, your family and carers.

Clear signposting to locally and nationally relevant services available to you.

Ambition 5

All staff are prepared to

'Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.'

Southern Health Ambition

This strategy is underpinned by our Trust's values and objectives and all of the professional codes of conduct under which our staff work.

Adhering to values based recruitment at all levels of staff will ensure that we have a competent and compassionate workforce that feels well supported to deliver excellent end of life care.

We remain open to new ways of learning and interacting with the people we support. We are committed to providing our staff with the correct education and skills to help them to best meet your needs.

We will listen to your voice and ensure that any themes or trends identified are reported through governance and reporting structures to enable shared learning across the organisation

Undertaking regular audits, to establish adherence to best practice and making changes to practice where these are required.

We will achieve this through:

The implementation of the education and competency framework for end of life care.

Recruiting End of Life champions across the Trust, with clearly defined roles and responsibilities.

Providing opportunities for clinical supervision and peer support in all clinical teams to allow for reflection and learning.

Promotion of and supporting staff in the use of the electronic Wessex Palliative Care handbook

An audit timetable for end of life care will be developed which enables us to review the quality of care that we provide to you.

Formalising the ward to board meeting structure to ensure that there is a clear process for communication and shared learning for End of Life Care.

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Ambition 6

Each Community is prepared to

'I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and

Southern Health Ambition

As part of your end of life care we believe that it is important to identify and work with the voluntary sector in local areas to help support you and those important to you.

We are committed to increasing public awareness of the difficulties faced by those that are dying.

We aim to promote in our communities more openness in end of life issues.

We will achieve this through:

Developing signposting systems e.g.; website, localised service directories and easy read leaflets to enable families, neighbours and communities to help.

A high quality End of Life resource on the Southern Health website which is current and accessible to all.

Use all available opportunities to share patient stories with a wider audience.

Partnership working with national and local organisations who provide support.

Enablers

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To achieve the ambitions it is recognised the Trust needs to work on some key enablers outlined in the table below:

Enablers	How
Education and Training	• Access to high quality education and learning resources • Self-assessment of competence to allow for gaps in learning to be addressed • Recognition by staff of support services available and how and when to access these • Education and training for patients and carers to optimise self-care • Inclusion in local and national health and well-being programmes • Knowledge sharing with specialist and social care providers
Partnership working	• Recognition that our patients and service users are the most valuable partner we have • Work alongside those who access our services to identify where improvements could be made • Strengthen relationships with our commissioners, local hospices and social care, to allow for direct access to local end of life providers and the potential to influence services. • Multi-professional representation at local provider groups and the end of life steering group • Forge relationships with voluntary organisations and to provide pastoral care where needed
Documentation and shared records	• Develop and implement an individualised care plan that is available for all that need it, when they need it • Horizon scan for new ways of recording and communicating care needs
IT	• Make better use of data and technology to shape, deliver and communicate care • Use electronic patient records and technology to support current and future service delivery • Ensure timely access to diagnostic and imaging data
Each community is prepared to help	• Work with voluntary sector partners in each community to provide support/information to patients, families and carers within the community. • Produce a high quality Trust End of Life website page which is current and accessible to all, including patient stories and learning. • Produce supportive literature appropriate for each community.

Accountabilities and Responsibilities

Delivery of the strategy is overseen by the Medical Director and Director of Nursing.

The steering group report to the Caring Forum, which reports to Trust Board via the Quality and Safety Committee.

The End of Life Care Strategy Group sub-groups take responsibility for implementation of the Strategy objectives, for setting out a the methods of implementation and measuring progress.

The End of Life Care Strategy Group will report bi-annually to Caring forum and Quality and Safety Committee.

The End of Life Care Strategy Group takes responsibility for risk-reporting.

The clinical divisions are responsible for embedding the strategy at local level. And for delivering the strategic goals at an operational level, with support from the End of Life care Strategy Group.

Communication

This strategy will be circulated to all members of the Trust Board, Divisional Directors, Heads of Services, Area Managers and Service Leads for dissemination to all clinical staff. And to all members of key teams- such as community care teams. A copy will also be circulated to key partner organisations and stakeholders.

This Strategy will be available to view and download on the Trust website. It will be accessible to patients, carers and staff.

Measuring Success and evaluation

Progress towards delivering the strategy objectives are measured through the End of Life Care Strategy group and progress updates provided in reporting section.