Care shaped around you

SOUTHWARK & LAMBETH
INTEGRATED CARE

Southwark & Lambeth Integrated Care News

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Welcome to our fourth edition of the Southwark and Lambeth Integrated Care newsletter for citizens and staff working within our partner organisations. Southwark and Lambeth Integrated Care is the partnership that has brought the health and social care organisations and citizens of Southwark and Lambeth together, so local people can lead healthier and happier lives.

This edition focuses on how some of our projects are progressing and achieving real success for local people in areas such as: catheter care, transfer of care from hospital and prevention of falls.

My Catheter Passport

King's College Hospital, Guy's and St Thomas' Hospital and their community services have launched My Catheter Passport to improve care for people with catheters.

Catheter associated urinary tract infections remain a source of avoidable serious infections, despite the progress made in recent years to reduce the number of infections.

The Passport is a patient-owned document full of useful information and key contact details for people with catheters, to empower them to live as independently as possible with their catheters, and know what services are there to support them.

At our recent Catheter Summit, people with catheters told us: 'services seem a little disjointed', 'it would be nice if they could all work together' and that they 'can see the advantage of My Catheter Passport'.

It also allows the sharing of patient catheter care plans between people with catheters and health and social care professionals in hospital and the community, ensuring there is an up-to-date record that is easily accessible.

In July, the Catheter Passport was being rolled-out across Guy's and St Thomas' and King's College Hospital, including community services.

Adrian Hopper, Consultant Geriatrician at Guy's and St Thomas', said: "The Passport will really help improve communication between all the different health and social care professionals involved in catheter care. This has already been evident during testing."

Adrian went on to say: "It's fantastic that we had the opportunity to co-design the Passport with people with catheters and health and social care professionals."

This patient-owned document should be with them throughout their care and be used to keep a record of catheter changes or issues. It will be given to patients when they are discharged from hospital and those currently receiving care in the community.

Find out what's happening in integrated care

Training is Good to Go

Good to Go: Enhancing Patient Transfer is a new simulation-based training course for all health and social care professionals to improve care transfers of older people with complex needs leaving hospital. This is the first multi-professional training course which includes social workers, to be run at the Simulation and Interactive Learning (SaIL) Centre at Guy's and St. Thomas'.

The course enables staff from a range of professions to develop and enhance discharge planning skills.

Lesley Baillie, Professor of Clinical Nursing Practice at London South Bank University, explained: "We produced the course with local people and staff, to make sure it met the training needs of all health and social care professionals, the patients and families."

Lucy Powell-Nateghy, Occupational Therapist, trying to eat in an ageing suite

Staff engage in a full day of training based on real life experiences of local people. Professional actors play the roles of patients and relatives. This provides a safe learning environment in which staff can put their skills to practice, reflect on how they handle potentially stressful situations, and their role with patients and other team members.

The participants are also given the opportunity to wear ageing suites, to try to understand what it physically feels like to be 80 years old.

A variety of professionals have attended the course; from social workers to pharmacists, and consultant geriatricians to physiotherapists working in hospitals and the community.

Dr Beth Thomas, Clinical Simulation Educator at the SaIL Centre, said: "For me, the biggest value of the course is the multi-professional and multi-agency aspect – breaking down barriers between hospital and community care, and between health and social care."

Keith Clark, Social Worker at Southwark Council, who attended the first Good to Go course, said: "I found the course extremely beneficial and it successfully implemented training in a truly multidisciplinary way. This is also the first training course I have attended where I felt that a close to real life simulated environment has been successfully used to create a really immersive training experience."

Transfer of Care

People have said:

"Services weren't arranged promptly"

"There was poor co-ordination between services"

"I didn't receive the information I needed"

Amy Archer

Discharge Facilitator, Integrated Hospital Discharge Team, Anne Ward, St Thomas' Hospital

The Integrated Hospital Discharge Team (IHDT) on Anne Ward aims to make the hospital transfer of care process more efficient and to better involve older people and their families in descision making.

Amy plays a very unique role in the team. She identifies support the Voluntary and Community Sector (VCS) can provide to help avoid readmissions to hospital.

"I see myself as the extra care that people need to get back on their feet – like the cherry on top – from viewing care homes with people to buying clothes for them.

I've been seconded to Guy's and St Thomas' by the British Red Cross for six months, because the IHDT is keen to involve the VCS in the test on Anne Ward.

Because I'm not seen as being part of the clinical team on the ward, patients and their families are often more open with me, which helps us [the team] gain more of an understanding about the person, so we can provide more person-centred care.

It took a little while for the team to understand my role, but now I feel valued and don't feel like we're stepping on each other's toes. As well as building a link between the ward and VCS, I provide administrative support to the team.

It's fantastic when I know I can help completely change someone's life, but there is no one-fits-all model. The other week, a lady came onto the ward who had recently been diagnosed with cancer, had no friends and family in London and it was her first time in hospital.

I had a chat with her to find out if she wanted any support after she left hospital during this difficult time. I explained all of the help we could provide, but the thing she wanted the most was just someone to talk to. It's easy to take interaction for granted, but isolation is terrible.

At the British Red Cross we have a buddy service, so one of my colleagues will visit her for eight weeks after she was discharged and talk to her about her condition. We're not medically trained, but she just wanted the time to chat to someone about it as a 'normal' person.

When it goes right and you know you've really made a difference to someone's life, it feels brilliant."

Mavis' story: Strength and Balance

Mavis Adenekan speaks about her experience of attending the Strength and Balance classes and explains the positive impact they have had on her life.

Mavis, 74 years old, says: "I began having difficulties bending my knees – I had to hold on to chairs for support when I was standing up. Then last summer my knees gave up and I had to start using a stick.

"It was a slippery slope from there, because I started to develop back problems from walking differently. I thought I was going to have to move out of my flat, because of all the stairs.

"Last year I was referred to the Strength and Balance classes by my GP. I've been attending since last September. When I first attended the class I took the walking stick with me, but the classes have now given me the confidence and strength I need – I don't use my stick anymore!"

Mavis, a former primary school teacher, went on to say: "Most importantly, the class instructor makes you aware that your movements naturally change as you get older, and that it doesn't mean you can't keep doing things for yourself.

"Everyone is getting older and going to need more support, but the exercises help to delay it and build muscle strength.

"The classes made me conscious that I had started shuffling, instead of walking properly.

"Now I know I must pick my feet up when I walk, so I don't fall over again. And if I do fall, they've taught me how to get myself up, so I don't have to lie there waiting for help.

"I laugh with my friend about 'when did we start shuffling and need help to stand up?'. I thought it was just part of the process of getting old, but it's in your mind. If others and you keep telling yourself that you are old and need support, you believe it.

"Recently I went walking in Yorkshire, at one point there was a tough descent and in the past I might have fallen down, but because I'm more confident and can process situations better, I managed to make it to the bottom. I knew I had to be careful, because I'm older, but I knew I could do it! If I hadn't gone to the classes I would have just sat in the car.

"I'm getting older, but I've found strength through the classes to prevent injuries."

What are the impacts of falling?

"I'm scared of going outside in case I fall"

This year there will be 5,173 falls in people aged 65+

It will cost the NHS in Lambeth and Southwark £6.4 million per year

Overall falls will cost the NHS more than £2.3 billion per year

What are the benefits of falls classes?

"I'm much stronger and more balanced"

Falls classes reduce the risk of falling by up to 60%

People have a 41% improvement in quality of life

Potential healthcare cost reduction of £3.8 million

We want you to get involved

@slicareorg

www.slicare.org

info@slicare.org

Save the date

Our next Citizens' Forum will be on 22 October, from 6.30pm-9pm, at Cambridge House, 1 Addington Square, Camberwell, SE5 0HF.

To book your place, you can:

- Email: info@slicare.org
- Phone: 020 7188 7188 x55290
- Website: citizensforumoctober.eventbrite.co.uk

THE @home SERVICE

Bringing hospital care to your home

WHAT IS @home?

Many people prefer to be cared for at home rather than in hospital

To make this possible, we have the @home service

Which provides care for acutely unwell people in their own home to avoid them coming to hospital or to help them return home sooner

WHO IS IN THE TEAM?

Occupational Therapists
Social Workers
Nurses
Nurse matrons
Pharmacists
GPs
Rehabilitation Support Workers
Physiotherapists
Hospital Consultants
Support team

1,644
people were supported by the @home service in the last 6 months

872
people were supported to return home from hospital sooner

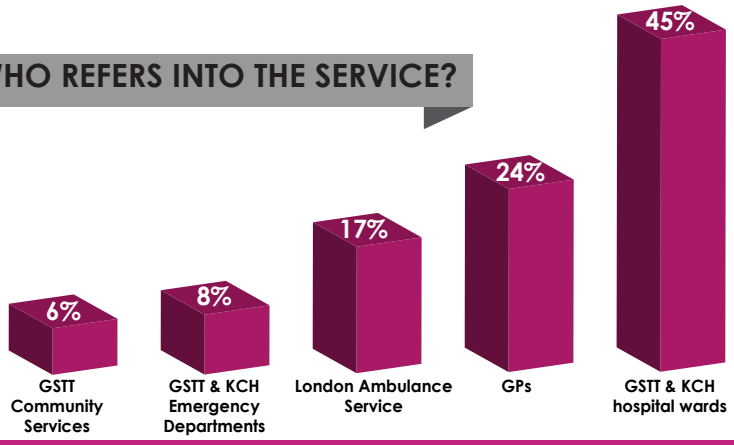
795
people did not need to go to hospital due to @home

On average people were supported by @home for **6 days**

WHAT ARE SOME EXAMPLES OF THE CONDITIONS @home SUPPORT?

COPD
Cellulitis
Asthma
Infected foot ulcers
Dehydration
Gastroenteritis
Heart Failure
Diabetes
Post Surgery
Urinary Tract Infection (UTI)

WHO REFERS INTO THE SERVICE?



Reducing hospital stays through integration

The Integrated Hospital Discharge Teams aim to help make the hospital discharge processes more effective, avoid duplication and minimise delays, so people can return to their homes as soon as they are medically fit.

The teams have helped reduce the length of time patients are staying in hospital on two wards at St Thomas' and King's College hospitals.

They have also reduced the time it takes to complete a health needs assessment with patients. These assessments identify whether patients are eligible for continuing healthcare and/or NHS-funded nursing care when they leave hospital.

The teams are working to improve communication with patients and carers; and improve collaborative working between health and social care professionals when they are planning to transfer care to a person's home. They are currently being tested on two older people's wards; on Anne Ward at St Thomas' Hospital and Donne Ward at King's College Hospital.

In July, the Integrated Hospital Discharge Team on Donne Ward has seen the average length of stay reduced by four days (when compared to 2014 data on the same ward).

Sue Bowler, Director of Integrated Care and Partnerships at King's College Hospital, said: "This is a significant reduction in the amount of time people stay in hospital for, which is fantastic for our patients."

On Anne Ward, the team have significantly reduced the time needed to complete a health needs assessment, in one case it was completed in just two days. Previous audits show the average time it took to complete an assessment has been 22 days.

Teresa Meldrum, Clinical Specialist Occupational Therapist at Guy's and St Thomas', said: "A better understanding of each other's roles in the discharge process has resulted in improved communication between the team members and helped to break down the barriers between health and social care."