Care shaped around you

SOUTHWARK & LAMBETH
INTEGRATED CARE

Southwark & Lambeth Integrated Care News

February 2016 | Issue 5

Welcome to the fifth edition of Southwark and Lambeth Integrated Care News for citizens and staff working within our partner organisations. Over the last four years Southwark and Lambeth Integrated Care (SLIC) has brought staff together from across health and social care, alongside citizens, to redesign and transform the care for people predominantly aged 65 and over and with multiple long-term conditions.

This edition focuses on the successes and learning of SLIC, and looks forward to the next phase of integrated care in Southwark and Lambeth.

Reducing social isolation

Care navigation is now being piloted in Southwark GP Federations, with the aim of supporting GP practices to reduce social isolation and manage the social needs of their older patients.

Care navigators from Age UK are identifying appropriate support networks and community groups to help older people remain as independent and well supported as possible.

Rachel Henry, SAIL Care Navigation Team Leader at Age UK Lewisham and Southwark, explains how they helped Mary, 67: "Mary was referred to us by her GP, as she had been frequently visiting the GP practice for about a year. She would often be waiting outside the practice for it to open in the morning. The receptionists would have a chat with her and make her a cup of tea."

A member of the SAIL team met Mary at home and found out that Mary's mother had died a year ago and she had felt very lonely since then.

They also talked about what Mary would like to do to get out of the house more and make new friends. As she was interested in trying out an arts and crafts group, she and the care navigator went along to a centre together the next day.

"Mary really enjoyed it and wants to go back regularly as she can see herself making friends there. She has not been dropping into the surgery since she started to go to the centre," said Rachel. "Her GP has said attending the centre has made a big difference to her quality of life."

Find out what's happening in integrated care

Q&A with Cathy Ingram

Head of Local Rehabilitation and Integrated Care, Guy's and St Thomas' Community

What have you been involved in as part of SLIC?

I've been involved in SLIC from the very beginning and across a variety of projects, from simplified discharge to Enhanced Rapid Response. On top of all that, I'm a member of the SLIC Operations Board.

I'm now also involved in discussions about how we continue the great work we have done, after SLIC comes to an end, and we move into the next phase of the partnership.

What have been your favourite SLIC successes?

I have a few favourites, but the Falls Community Exercise project has been a really innovative piece of work. And given the relatively small amount of funding it has made a real impact. Most gratifyingly, the people who attended the classes have more confidence, improved wellbeing and most haven't fallen since. I hope it continues long after SLIC.

Only 2 out of 200 people have fallen since attending

I think partnership working may have been the biggest impact of SLIC. We would have struggled to work together without SLIC. We've now been able to develop much more long-term thinking – this isn't complete, but the foundations are definitely there.

What have you learnt from being part of the SLIC partnership?

I've learnt a lot over the last four years. I've learnt that as a change programme it's important that you give things a go and see what happens - this can be difficult, as you're testing within a live system. Most significantly, I've learnt the importance of patient feedback in giving you the full picture, and it can be more powerful than clinical outcome measures in some instances.

What have been the main challenges for you?

One of the main challenges has been demonstrating change and value of small projects during testing. They may not be the solution to whole-system problems, but help provide the answers.

Another challenge has been keeping people around the table, as everyone has competing priorities within their own organisations.

What from SLIC do you want to continue?

I hope the Falls Community Exercise Service is commissioned, so it can continue to develop at the rate it is now.

In terms of integrated care as a whole, it is vital we continue to work together as a partnership. If we don't we will lose momentum and integration could go off our radar.

What are the challenges for the next phase of the partnership to tackle?

We must keep the partnership together, at all levels, but it is particularly important at an operational level.

Financial pressures are a huge risk to all the partners, but we recognise that we can only overcome these hurdles by working together in a structured partnership.

We also need frontline staff and local people to really understand and believe in the importance of integrated care and just how far we have come so far.

SLIC and the next phase of integrated care

The SLIC programme comes to an end in March 2016 to make way for the second phase of the strategic partnership – one that radically reimagines the way care is delivered for the people of Southwark and Lambeth. This next phase will build upon the foundations and the lessons learnt through SLIC.

Partners are now in the process of producing a formal End of SLIC Report, and have commissioned an independent team from King's Health Partners, Academic Health Science Centre, to assist with this. The report will build on the evaluation reports been done to date, SLIC data and the views of people within the partnership since 2012.

Our collective learning of what works and does not work is already being embraced by the strategic partnership, and we will continue to share lessons learned and reflect on successes over the past four years as Southwark and Lambeth moves into the next stage of integrated care.

Virtual Clinics

GPs, community pharmacists and hospital-based consultant geriatricians are now coming together to review the care of older people at new Virtual Clinics.

The aim is to improve our ability to identify the frailest people within the community, so we can meet their healthcare needs in the right place and at the right time.

This local initiative has only been running since December 2015, but so far they have been able to assess several patient care plans and identify patients who need additional support.

The geriatricians are also providing education to primary care teams in managing frail older people with complex conditions.

Dr Mark Chamley, Interim Chair of South East Lambeth Local Care Network, said: "It is great for local people that we have the experience of hospital geriatricians at a local level. It's also fantastic for our GPs to learn more about how to care for some of our most vulnerable patients."

Sharing patient records

Our partner NHS organisations have joined forces to improve care by sharing electronic patient records through a new secure system.

The Local Care Record will allow healthcare professionals at Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts and local GP practices to view each other's patient records quickly and securely at the touch of a button.

As a result, patient care will be improved as clinicians will be able to see information such as test results, medication and previous treatments to help them make clinical decisions.

Adrian McLachlan, Chair of Lambeth Clinical Commissioning Group and GP Partner at the Hetherington Group Practice, said: "The Local Care Record is something my GP colleagues and I have been really excited about and it is already adding clinical value.

"We've already started to use it in our practice and it is helping us improve safety and the quality of care we provide to our local patients in Lambeth and Southwark, as we have a clearer picture of the people we are caring for and their different health needs."

IHDT test - How did it go?

Aim: Improve the discharge process on hospital wards, as there are often delays in assessments being completed and a lack of coordination between staff, which impacts on patient experience.

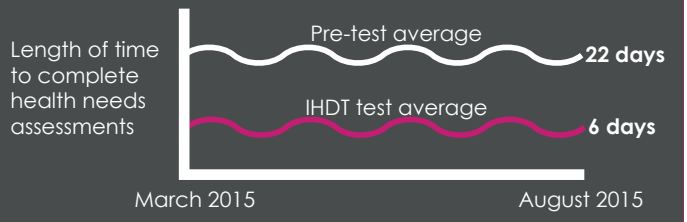
Method:

- Developed two ward-based Integrated Hospital Discharge Teams (IHDT), including a social worker, discharge coordinator, therapist, nurse, doctor and administrative assistant.
- The teams reviewed patients on the ward on a daily basis.
- Each patient was allocated a member of staff to contact during their time in hospital – Key Worker.
- The teams completed assessments and paperwork together.

Successes:

- A reduction in the time it took to complete health needs assessments at Guy's and St Thomas', with the minimum time spent just two days. This was due to the teams working closely together with an improved process and the inclusion of social workers.
- Patients and families responded positively to the Key Worker.
- At King's College Hospital there was an improved collaborative way of working between professionals meant there was better ownership on activities related to transfer of care.

Dr Peter Sommerville, Medical Registrar at GSTT: "Our social worker was absolutely invaluable, especially when we were making plans for discharge. Also being part of a ward-based team meant we were more coordinated and improved the way we completed health needs assessments."



Next steps: Both NHS Foundation Trusts are working closely with social care colleagues and are looking at ways to use the learning from the test to develop a model that can be rolled out across more wards within the hospitals.

Grant scheme improving community spirit

Local people from Vassall and Coldharbour wards in Brixton are benefitting from an injection of community spirit after 13 local individuals and groups were awarded grants from the Health and Wellbeing Fund.

The recipients will use the awards to work together on projects that tackle isolation amongst older people, encourage interaction and promote wellbeing in the wards, two of the most deprived in Lambeth.

The projects range from cooking and tai-chi, to drumming and English lessons. The projects will attempt to support evidence that local people who have good social connections are healthier and better able to deal with any health problems they may encounter compared to those who are isolated or lonely.

The voluntary and community sector is a valuable asset that needs to be supported to be sustainable and integrated into the system to help achieve our ambitions of prevention, community resilience and integrated care. The Health and Wellbeing Fund is a project between Lambeth Council and Lambeth Clinical Commissioning Group.

Engage for success

Building relationships and focusing on better engagement with community and primary care has been key to bringing about change within the Older People's Programme (OPP), according to a report produced by The King's Fund.

The three-year independent evaluation concluded that strong leadership and partnerships created between the organisations involved in implementing the programme had the biggest impact, and will be essential as local health and care systems continue to transform.

The report recognises the progress the programme made in laying foundations for integrated care locally, concluding that "the work of the OPP has permanently changed the delivery of care to older people in Southwark and Lambeth."

Particular successes included the programme to develop primary care leaders, which helped to place primary care 'in the driving seat' for embedding projects based in general practice, and 'much improved' engagement with citizens. However, the evaluation also made clear that the OPP was not without its challenges and that there are lessons to be learned. It made a number of recommendations, including clarifying the membership of the Citizens' Board and its future role, and maintaining the commitment to supporting emerging leaders in primary care.

In its conclusion, the report stated that "SLIC partners should be encouraged about what has been achieved – particularly the strengthened relationships at various levels," and stressed that in future "shared ownership of integrated care by the partner organisations and stronger staff and citizen engagement will be key."

The full report is available on the SLIC website.

Passport shortlisted for engagement award

My Catheter Passport was recently shortlisted for the Guy's and St Thomas' Involvement to Impact Awards. The awards recognised the valuable input of local people into the design and implementation of the patient held document.

Dr Di Aitken, GP at Vassall Medical Centre, said: "Given the purpose of the passport, it was absolutely vital that we engaged local people with catheter care experience. Their input into the language used in the Passport was crucial – ensuring there was no medical jargon, just plain English that could be easily understood."

My Catheter Passport has now launched across Guy's and St Thomas', King's College Hospital and community services. Work is progressing to roll it out across general practice.

Alice Miles, who has helped develop My Catheter Passport and lives with a catheter, said: "It has been fun being involved in the development of My Catheter Passport. I hope it helps improve care for people with catheters, so they can support themselves and live as independently as possible."