Care shaped around you

SOUTHWARK & LAMBETH
INTEGRATED CARE

Older People's Programme Newsletter

December 2014 | Issue 02

Welcome to our second edition of the Southwark and Lambeth Integrated Care's newsletter on the Older People's Programme (OPP). This edition will explore how staff working within our partner organisations are preventing unnecessary hospital admissions, making interventions and improving care pathways.

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 that local people can lead healthier and happier lives.

@home is preventing unnecessary admissions

Unnecessary A&E attendance and hospital admissions are being prevented by an increase in @home referrals.

Patients who are referred to @home are visited within 1-2 hours by a physiotherapist and a GP or nurse practitioner. Following an assessment the patient is either taken onto the caseload or referred to other appropriate services, such as enhanced rapid response or district nursing.

These referrals are coming from general practices, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust.

The @home community nurse specialists, based at the hospitals, have played a vital role in avoiding A&E admissions.

The @home team also continue to engage with other services to increase referral rates and take advantage of @home.

@home and London Ambulance Service have launched a clinical care pathway to avoid hospital attendance.

The ambulance service will refer appropriate patients to an @home assessment and intervention, if they do not need to attend A&E.

These patients will be reviewed by the @home consultant or a rapid access HOT clinic the next day.

Since the pathway was launched on 13 November, on average @home receives three referrals a day.

Find out what's happening in the Older People's Programme

Dementia support for care homes

The number of elderly residents in care homes that exhibit challenging behaviours related to mental health issues and Dementia is increasing. In many cases the care homes are not equipped to cope with these instances of challenging behaviour, either through early intervention or accessing the right support before a crisis has been reached.

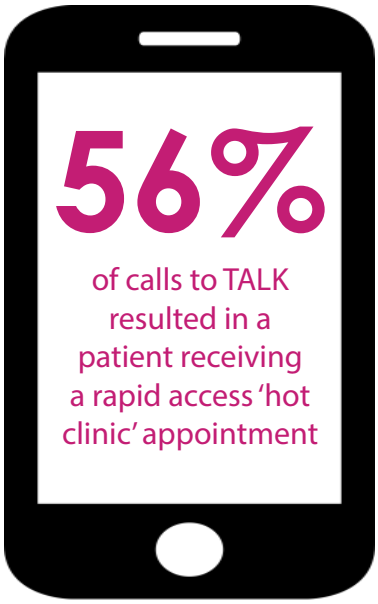
A multi-disciplinary team, called Southwark & Lambeth Mental Health Care Home Intervention Team, has been recruited to address this. They will begin to accept referrals for care homes residents from early December. The team will work with the care homes to provide a series of person-centred interventions to support their residents. They will also work with the staff to help change how they care for these residents.

The aim of this new service is to improve the well-being of this group of residents and reduce the number of unnecessary changes to their care settings.

Referrals can be made from care homes through GPs, hospital teams and other mental health teams across the two boroughs. For further details about the team and referral process, please contact Claire Flanagan, Team Manager, claire.flanagan@slam.nhs.uk.

'Excellent' patient care with TALK

The TALK telephone service was launched to support GPs in the care of frail older people in Lambeth and Southwark, and help prevent unnecessarily hospital attendances. The service has now been expanded to include TALK services for GPs seeking speciality paediatric and acute medicine advice.



Dr Viral Patel, acute physician at King's College Hospital, explained how TALK recently helped a GP with the care of a patient: "I received a call from a GP to discuss a patient who was sitting in his surgery with a headache, vertigo and double vision.

"The GP was going to send the patient to A&E, but after further discussion of the patient's condition, and it was unlikely any investigations would be able to be carried out that evening, we arranged for the patient to be seen the next morning in a planned Medical Assessment Centre appointment at the hospital."

TALK gives GPs access to 24/7 consultant geriatrician or psycho-geriatrician expertise.

Dr Patel said: "The next day the Medical Assessment Centre reviewed the patient, and that day the patient was sent for an MRI scan on their head to rule out an acute stroke. The patient was then transferred back to the care of the GP with the appropriate treatment.

"A hospital admission was avoided and the patient received excellent care."

With winter fast approaching it is vital to manage hospital beds with the increase in A&E attendance.

An alternative urgent response through TALK

The TALK service provides a direct access telephone service for General Practice and Community staff to Consultants in Geriatric Medicine at GSTT and KCH to support you in avoiding an admission to hospital and to provide rapid access to diagnostic clinics. The service is for people aged over 65 and is available 24/7.

CALL KCH: 0203 299 6613
GSTT: 0207 188 1465

Improving transfer of care

Interface Practitioner, Bose Adegbola, started a secondment to King's College Hospital to lead a test on the transfer of care between hospitals and care homes, and advance care planning in the home.

This testing will focus on:

- Examining how an improved discharge process can reduce readmissions rates and improve the discharge experience for residents
- Developing community PEACE (Proactive Elderly Advance Care) documentation and support for advance care planning to reduce the rates of admissions to hospital as well as improve end of life care in the homes.

This testing will help support and develop the relationship between hospitals and care homes, as hospital admission and discharge can have a detrimental impact on the well-being of our frailest residents.

This work has started with a series of workshops and will be tested from November to January. For further information about this test, please contact Bose Adegbola, bose.adegbola@nhs.net.

Community team tackling malnutrition

The community dietetic team has begun to test two models of care.

The models being tested are; a training based intervention in Southwark and a direct clinical care model in Lambeth.

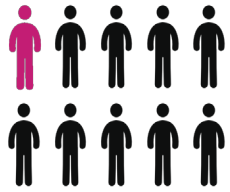
In Southwark, the team has already started training community staff on how to use the Malnutrition Universal Screening Tool (MUST) and action planning, and will begin their work with care homes and GPs over the coming weeks. The team will also run a dietetic clinic in the Older Persons Assessment Unit at Guy's Hospital and in the near future a clinic at Dulwich Hospital.

In Lambeth, the dietitians will provide domiciliary and care homes visits. They will also provide specialist care to malnourished patients receiving intermediate care. They are also available to make joint visits to patients with other health care professionals.

Liz Weekes, the consultant dietitian leading the project, said: "Malnutrition is a problem that can affect anyone but it is more common among older people. People who are malnourished find it difficult to undertake everyday activities such as shopping, and are more likely to need to visit their GP or be admitted to hospital.

"We will be working with health and social care professionals to improve the recognition of nutritionally vulnerable individuals and ensure they have access to the services they require."

The community dietetic team have moved into Dulwich Hospital and are located with other community based teams. To find out more about the dietetic team, please contact Liz Weekes, elizabeth.weeks@gstt.nhs.uk.



1 in 10 people over 65 living in the community are malnourished or at risk

Malnutrition Advice Line

A new advice line for health and social care staff to discuss potential referral of individual patients and to signpost to relevant nutritional care services.

0203 049 7675

Patient story: Catheter passports

The catheter passport is a document full of useful information and contact details for people with catheters, and allows health and social care professionals to keep a record of the patient's catheter care.

The passport is currently being tested at Guy's and St Thomas' Hospital and King's College Hospital.

Irene Karrouze, Continence Nurse Specialist at King's College Hospital, explains a common catheter care problem, which could be reduced with the introduction of the passport.

"Mr W, aged 79, lives alone in sheltered accommodation, and has a urethral catheter in-situ due to benign prostate hypotrophy. Between March and September 2014, Mr W presented in A&E eight times dues to catheter problems.

"On discussion with Mr W, he said that when he experienced catheter problems he would ring an ambulance instead of calling his district nurse. So I gave Mr W a catheter passport, and explained that his catheter problems could be resolved by his district nurse, whose contact details were in the passport. We later discharged Mr W, with the catheter passport completed.

"However, Mr W attended A&E once more after we gave him the passport. Mr W's care manager said Mr W had called the ambulance before they had chance to sort out the problem.

"I'm now confident that Mr W will be managed better, because of the passport and an individual care plan has been put in place to prevent catheter blocking and A&E attendance."

Health and social care professionals who provide catheter care should begin to see patients with catheter passports. If you care for a patient without a catheter passport, please tell them where to find it and encourage them to have it with them during any catheter changes.

Irene is offering monthly catheterisation skills workshops for all community staff, practice nurses and care home staff. If you would like to attend one of these sessions, please contact Irene, irenekarrouze@nhs.net.

18% of inpatients are catheterised annually

Of these 7.7% develop a urinary tract infection

It's estimated to cost £1,700 to treat a catheter acquired urinary tract infection

In 2013/14 5% of 65+ year olds who attended A&E, at Guy's and St Thomas', had a urinary tract infection or catheter problem

Useful contacts

Southwark Dietetic Team (Dulwich Hospital)
0203 049 7676

Lambeth Dietetic Team
0203 049 7671
(House bound patients
0203 049 5422 / 0203 049 6378)

Malnutrition Advice Line
0203 049 7675

Strength and Balance Helpline
0203 049 5424

Unified point of access
0203 049 5751

Southwark & Lambeth Integrated Care
0207 188 7188

Lambeth and Southwark Older People's Information Directory
directory.ageuklambeth.org.uk

We want you to get involved

@slicareorg

info@slicare.org