



**15  
16**

**Camden  
Annual Report  
2015-16**





## Contents

What we are working towards – Wellbeing for life	6
What we believe in	6
List of services	8
Camden children’s services	9
Camden Integrated Children’s Service	9
Camden Universal Children’s Services	11
Integrated Adult Services	13
St Pancras Rehabilitation Unit	13
Integrated Primary Care	15
Rapid Access Services	19
CareLink	23
Continuing Care	25
Heart Failure	26
Camden Community Respiratory Team	29
Domiciliary Pathway	30
Key performance indicators	30
Pulmonary Rehabilitation pathway	31
Screening Service	33
Camden Diabetes IPU – Diabetes Specialist Nursing Team (CNWL)	35
Camden Neuro and Stroke Service (CNSS)	38
Palliative Care	41
Camden and Islington Wheelchair Service	44
Podiatry	45

Dear Colleague,

At CNWL in Camden and Islington we are incredibly proud of the work we do in supporting our resident families, patients and carers across the two boroughs. It is with great pleasure that I present a review of 2015-16 to show you some of our highlights from the last year.

We continue our journey to strengthen our locality based work. We have worked hard to recruit new nurses and therapists to join our teams. We have also partnered with community and voluntary sector providers to encourage more local people to consider job opportunities within the NHS.

We introduced the Camden Active Living Group. These are patients employed by the Trust to carry out bespoke pieces of work. They have been very involved in the development and delivery of training modules for staff, learning walks and service inspections, recruitment of staff and designing other mechanisms for patient engagement.

We were pleased to welcome Dr Kate Granger to St Pancras Rehabilitation unit in March 2016, and we have been proud to be supporting the #hellomynameis campaign that she founded. Kate, who passed away in July 2016, was a consultant in elderly medicine suffering from a rare an aggressive type of sarcoma. She spoke to staff, governors, patients, carers and stakeholders about her own experiences of receiving care. She explained that after making the 'stark observation' that many of the staff looking after her did not introduce themselves before delivering care, she decided to launch the campaign, initially using social media, to remind healthcare staff about how important a simple introduction is. 'Hello, my name is...' is the start of a connection that helps our patients feel engaged and at the centre of

everything we do. It focuses us on the small things we can do that really make a difference to our patients, and demonstrate care and compassion.

Our adults services support patients to live better and manage conditions in their own homes, or to return home after an episode of hospital care. This year we have seen an even larger number of patients, delivering high quality evidence-based care in patient homes, dedicated clinics and inpatient settings.

We are developing new care models with our partners across health and social care in Camden, so that all the services patients and carers need are integrated with the same common purpose. The new model of care has one organisation taking the lead, co-ordinating all other providers, and are termed Integrated Practice Units (IPUs).

The first IPU was established in Diabetes last year, and all of the services a patient with diabetes might access are co-ordinated. In 2015/16, under this new model, all of the outcome targets for Camden diabetes patients were achieved.

Further IPU models of care are planned for Respiratory services, case management for frailty, and Heart Failure.

Our children's services are managing a number of projects, including: developing shared clinical reports, working with a group of families to develop shared care plans within the service, and ensuring family choices are reflected in their children's care plans. We are also strengthening our links with Children's Centres and growing our partnership for children and families with complex needs. Universal Children's Services have continued to develop over the course of

the last year, implementing new and innovative programmes to meet the needs of our caseloads. Such innovations include the 'Little Connections' parenting course, the publication of a new handbook to help health and social care staff to increase their understanding of the specific emotional health needs of the young people who are looked after, and the creative development of new School Nursing posts to provide a more clinical focus for children with additional or complex health needs, reflecting the needs of the increasingly complex caseloads in mainstream schools.

Throughout 2016 we have been rolling out new IT infrastructure, replacing all our IT networks, telephone systems, printers, desktops, laptops and mobile phones. The improved networks and technology support mobile working for our clinical staff, and enable us to exchange information more quickly, securely and seamlessly across our organisation, supporting us in providing top quality patient care.

All of the work to remodel and improve services takes place within the strategic framework of the Five Year Forward View for the NHS. CNWL Camden and Islington will continue to play a role in shaping the local implementation of new models of care.

Our annual patient survey told us that 87% of respondents were likely to recommend our services, a 7% increase on last year. 96% (highest across our Trust) felt the treatment helped them. 94% felt we provided compassionate and kind care. This is a credit to the hard work of all of our staff who day in day out deliver high quality patient focused care to patients and their families or carers.

Whatever the service being delivered, our staff pride themselves in putting the needs of patients first. We value feedback in whatever form it is received. Enshrined within everything we do is a system promoting safe and effective care through reflective practice and learning to ensure when lessons from incidents or complaints and positive patient feedback are identified, they are put into practice not only in the service concerned, but across the Trust as a whole.

Each service report highlights their achievements for the year which include a variety of service improvements, patient engagement projects and delivery of key performance targets and outcomes. All pivotal to maintaining a healthy organisation that is looking forward to delivering even more service transformations in partnership with our patients and their families or carers.

We appreciate your feedback and comments. If you would like to discuss anything in this report then do contact me directly. My number is 0207685 5806 or email [Graeme.caul@nhs.net](mailto:Graeme.caul@nhs.net).

Yours sincerely



Graeme Caul  
Borough Director

## Vision

### What we are working towards – Wellbeing for life

To work in partnership with local people to improve their health and wellbeing. Together we look at ways of improving an individual's quality of life, through high quality healthcare and personal support.

## Values

### What we believe in

#### **Compassion:**

We all contribute to a compassionate environment for everyone here; what we say and do helps make the lives of others better.

#### **Respect:**

We will respect and value the diversity of our patients, service users and staff, to create a respectful and inclusive environment, which recognises the uniqueness of each individual.

#### **Empowerment:**

We will involve, inform and empower our patients, service users, carers and their families to take an active role in the management of their illness and adopt recovery principles. We will ensure our staff receive appropriate direction and support, to enable them to develop and grow.

#### **Partnership:**

We will work closely with our many partners to ensure that our combined efforts are focused on achieving the best possible outcomes for the people we serve.

# Year in numbers

## 30,178 patients for 289,449 appointments

**2,840** new babies supported into families in Camden



Delivered **42,649** immunisations



**1,140** admissions avoided by Rapid Response services



Provided in-depth case management support for almost **348** patients



Average length of stay maintained at **30 days** at St Pancras Rehabilitation Unit



**89%** of patients with improvement against their therapy measures



**95%** of patients screened for smoking



**60%** of screened adult's put in contact with services for alcohol



**93%** of Palliative Care patients dying in their preferred place of death





# Service reports

## List of services:

- Children’s Services
- St Pancras Rehabilitation Unit
- Integrated Primary Care
- Rapid Access Services
- Long Term Conditions
- Palliative Care
- Continuing Care
- Carelink
- Wheelchair
- Podiatry





## Camden children's services

### Camden Integrated Children's Service

#### Summary of Service

Camden Integrated Children's Service is an innovative alliance between the London Borough of Camden and four health providers, which are CNWL, Tavistock and Portman NHS Foundation Trust, Royal Free NHS Foundation Trust, and Whittington Health NHS Trust. CNWL is the operational lead for the service, providing strategic leadership and coordinating performance of the service against a set of agreed joint performance indicators.

The alliance brings all children's health staff in Camden together in one service, regardless of employing organisation, to meet the needs of children and young people with additional needs, and their families. Camden Integrated Children's Service operates an electronic single point of referral as the single front door to access services. It provides speech and language therapy, occupational therapy and physiotherapy to children and young people within the borough of Camden. It includes MOSAIC services, for children and young people with disabilities, and their families – MOSAIC CAMHS, Child Development Team, and the clinics Social Communication Assessment Service, Feeding Clinic and the Sleep Service.

#### Activity

In 2015-16:

- 85% Children within every discipline were seen within 8 weeks of referral
- 90% Children with long term input from more than one discipline have a multi-disciplinary or multi-agency care plan
- 91% Children with long term input achieved agreed goals
- 83% Young People aged 16 who were eligible for adult services had a transition plan in place
- Using the Friends & Family Test 98% of families would recommend the service
- We also do a range of user feedback e.g. surveys after therapy, confidence questionnaires after training and parent focus groups.

#### New developments this year

We conducted extensive **user engagement** with parent and carers whose children are known to any part(s) of the service to find out their views on what is currently working well and what areas we can develop. In order to do this, we set up an electronic survey which allowed parents to anonymously provide feedback, and paper copies were also provided to those who did not have access to a computer. A range of parent/carer focus groups were also held in the community. The outcomes included interest in receiving a single MDT report, a shared care plan and better links with acute trusts in coordinating the care

their children were receiving.

As an outcome of the user engagement work and with the aim of improving care to children and young people, the service has developed and piloted a **shared MDT report**, with good feedback from families and staff. The joint reports have reduced time in writing duplicate information and all information is in one place. Staff report improved liaison between different professional disciplines and that they had a greater knowledge of children's background needs. They were able to provide a holistic view of strengths and needs because of improved links and communication. All professionals reported improved liaison following experience of MDT shared report writing and an increased awareness of other AHPs' input. Family feedback was similarly positive, including comments that the reports were easy to understand, although the timescale in which they are issued needs to be quicker.

In response to the changes in provision for children with Special Educational Needs and Disability (SEND) (Children and Families' Act 2014) we have improved our links with the Local Authority and established a pathway aligning our **Single Point of Referral and the statutory SEND assessment process**. The process improves interaction between the Local Authority and health colleagues, by improving information flow and the ability to meet statutory timescales for assessment.

We have implemented a **new pathway in CDT** to address increasing waiting lists, a fragmented assessment process, increasing complaints about poor communication and stress among staff. The pathway has a structured multi-disciplinary assessment, a parent education programme for

children with developmental delay mirroring the success of the parent programme for children with Autism. It includes the use of coaching strategies and a team planning day once a term. The new pathway has minimised waiting lists, improved collaborative team working, reduced stress among staff and improved family satisfaction.

### Plans for 2016/17

We held our first annual celebration event for the service in July 2016, which was attended by staff and service users, with a very moving set of user presentations.

We will establish Action Learning Sets across parts of the service, including for senior clinicians (both universal and specialist) working in mainstream schools, and for the Single Point of Referral (SPOR) team, which will allow staff to review decision making and problem solving approaches.

We will be developing shared care plans in consultation with families who use the service.

We will broaden the partnership to include Continuing Care, Special School Nurses and Community Paediatrics.

Following sign off of the new amendment to the Alliance Agreement, we will develop a tool for the group of providers to use for decision making about spending the pooled reward grant, and this may include holding money to one side for recurrent investment.

## Camden Universal Children's Services

### Summary of service

This group of services includes Health Visiting, School Nursing, Community and School Immunisations, Looked After Children's Health Team, Child Protection Support Team and Child Health Information Service. These services work co-operatively to provide all elements of the National Healthy Child Programme which specifies the support given to every young person from 0-19 in the form of health reviews, immunisations, prevention of harm and promotion of health living strategies to maximise their potential in life.

### Activity

- Health Visiting Caseload of 12,974 at end of year
- 96% of new birth visits carried out (93% completed within 14 days)
- 100% patient satisfaction in School Nursing service
- 74% Head Teacher satisfaction in School Nursing service.

### New developments this year

Our Health Visiting Service has worked with Camden Children's Centres to implement a new programme – Little Connections which is offered to all new parents in Camden. It provides a friendly group atmosphere in which parents can learn how to cope with all aspects of the care of a new baby as well as promoting improvements to parental mental health.

During 2015-16 we were awarded the School Immunisations Contract for the boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster. This was launched on 1st October with the introduction of a completely new Influenza immunisation for Primary School Children in Years 1 and 2.

Our Looked After Children's Health Team produced a handbook to help health and social care staff to increase their understanding of the specific emotional health needs of the young people in this cohort; and how to use this to promote personal resilience that is so frequently lacking for children in care.

We developed two specific new School Nurse posts this year. The first of these is a paediatric nurse to provide a more clinical focus for children with additional or complex health needs who have previously fallen outside of the School Nurse Caseload. The staff member focuses on children attending Netley, Frank Barnes and Kentish Town Schools. Secondly a Health Promotion Specialist School Nurse to particularly improve the content of our Sex and Relationships Education in Secondary schools. This resulted in a higher uptake of this offer to schools across Camden and improved feedback from young people about how and what they had learnt in the sessions.

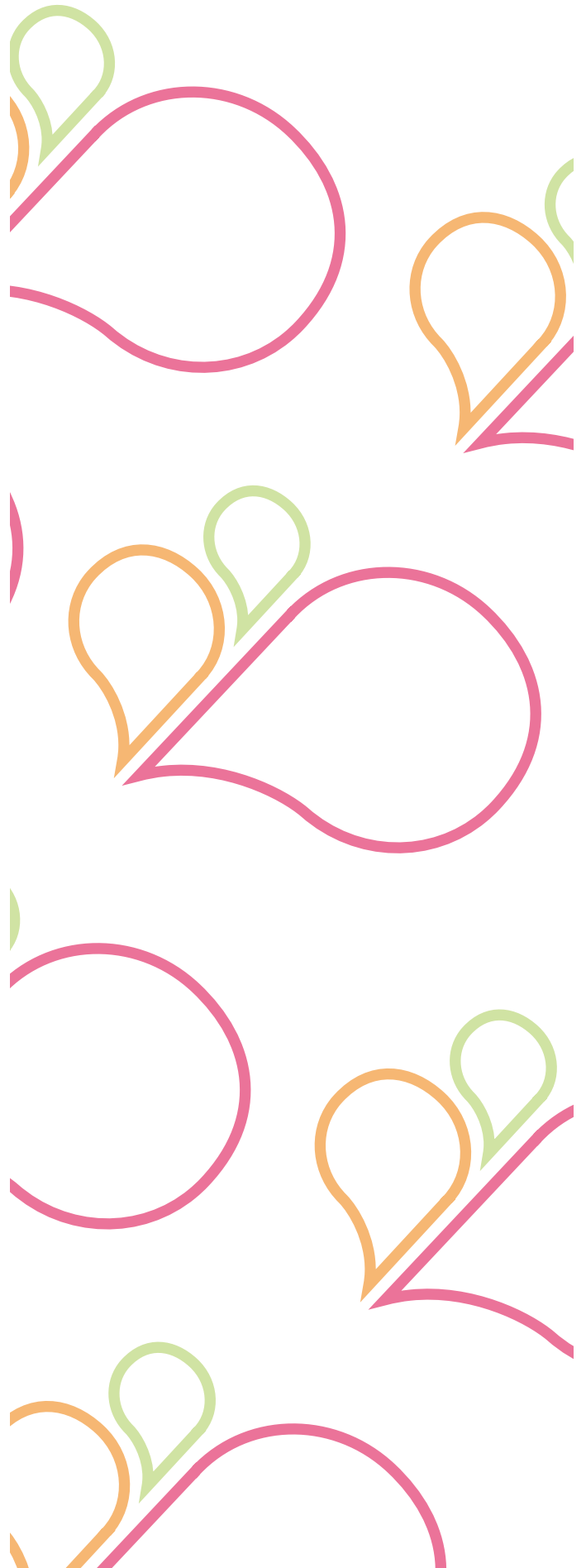
## Plans for 2016/17

Building on an excellent existing working relationship with the Camden's Children's Centres and Family Support Service, in 2016/17, the Health Visiting Service will be working on the implementation of a fully integrated Early Years offer to all Camden families. The integrated service will deliver both the Healthy Child Programme as well as Early Help for families with specific need in order to improve their overall resilience and reduce the need for more complex intervention. The service will provide the simplest/most rapid access to support within its resources without onward referral or signposting.

The Camden Baby Feeding Service was transferred to CNWL from London Borough of Camden on 1st April 2016. By working with community staff in Health Visiting, the service will increase the numbers of Camden women who access help to maintain breastfeeding or who are considering moving on to other forms of feeding.

The School Nursing Healthy Lifestyles, Weight Management Service has been expanded for 16/17. We will increase the number of young people and families to whom we can provide an intensive programme of support that will allow them to adopt and maintain more healthy lifestyles – leading to weight loss, increased physical activity and better diet.

Our Looked After Children's Health Team will be improving access to our specialist health services for this cohort by initiating a new open access clinic in the North of Camden at The Hive on Finchley Rd.



## Integrated Adult Services

### St Pancras Rehabilitation Unit

#### Summary of service

We provide specialist rehabilitation to patients with neurological conditions, complex needs and multi-pathologies. We are staffed by a specialist team of therapists, doctors, nurses, healthcare assistants and therapy assistants who are supported by consultants.

There are three inpatient wards, one large gym, a smaller gym and a kitchen for occupational therapist patient assessment. Our patients are in the majority from the London Boroughs of Camden and Islington, although we do receive and accept referrals from other London boroughs.

#### Activity

St Pancras Rehabilitation Unit supported the rehabilitation needs of 633 patients over the course of 2015-16 (a 17% increase on the 543 patients supported in 2014-15), of these 330 patients were from Camden, 244 from Islington and 59 from other boroughs.

#### New developments this year

- Average length of stay for 2015-16 was 30 days against a target of less than 42 days.
- Continuing with week end therapy within St Pancras Inpatient Rehabilitation Unit has supported us maintaining our low average length of stay.
- The Extended Rochester West Step Down Project commenced in December 2015. Funded by the Better Care Fund, an additional ten beds were opened to reduce delayed transfers of care working closely with the Whole Systems Team for the London Borough of Camden. In 2015/16, there were 33 patients cared for in this additional facility and the average length of stay was 30 days.
- We continue to receive excellent responses from patients in exit questionnaires and scores consistently high with likelihood to recommend the service to friends and family.
- The Unit had its annual Patient-Led Assessment of The Care Environment (PLACE) recently and initial feedback has been very positive.
- Our programme of activities to improve patients' experience includes: bingo, film club, use of individual DVD players and a film library, 'TheraPaws' dog visits and music in hospitals visits.
- We awarded our second 'Christine Scott Compassion in Service Award' (created in honour of a retired Ward Sister) to the team on Rochester West Ward following a quality inspection where the ward was found to be outstanding for compassion.
- A programme of quality improvement work (QI) has commenced to focus on further improving systems and processes to enhance the communication and team working in what is a complex system of care focused on improving the outcomes for our patients, a large number of whom have had life changing events with their health.
- Two consultants who have posts in two of our acute referring trusts commenced work with us: Dr Rhodri Edwards from The Whittington Hospital and Dr Geraldine

Tan from The Royal Free Hospital. Our partnership working continues as the unit is due to appoint a joint post with the National Hospital for Neurology and Neurosurgery (UCLH) next year to further enhance the support for patients on the stroke and neurological ward.

- An artist (who is a former nurse) will be working with us on a dysphagia and feeding art project with a focus around stroke and rehabilitation patients.
- We will continue to innovate in our patient experience programme to ensure that St Pancras Rehabilitation Unit is a place of choice for patients requiring a programme of intensive rehabilitation or step down care.

### **Plans for 2016/17**

- We will be opening Extended Rochester West Step Down Ward on a substantive basis to support with delayed transfers of care. Recruitment to posts on a substantive basis has commenced and we will be working with the Whole Systems Team on a gradual increase in bed numbers when a sufficient number of additional staff have commenced.
- We are developing a Band 5 to 6 programme for St Pancras Rehabilitation Unit and Integrated Primary Care to put Registered Nurses on a pathway to prepare them for Band 6 posts within 12 to 18 months.
- We will be building another new 'wet room' to provide more patient shower facilities on Oakwood Ward.
- We will be adding wet rooms to some of our rooms to create en suite facilities for patients, which will enhance the unit's ability to manage flow by being able to offer more single rooms for patients whose needs dictate they need a separate facility to be rehabilitated e.g. those with an infection.

## Integrated Primary Care

### Summary of service

IPC is part of a multi-disciplinary service across Camden in which teams work together to improve the consistency, continuity, co-ordination and cost effectiveness of care.

IPC consists of three locality based integrated District Nursing (including Complex Care), Physiotherapy (including the Falls Exercise Group) and Occupational Therapy teams, and an Evening and Overnight Team. The service works closely with Rapid Access Services which consists of Post Acute Care Episode (Post Acute Care Episode (PACE)) (Post-Acute Care and Enablement for the Royal Free), Rapid Response (Admission Avoidance) and Rapid Early Discharge Service (Rapid Early Discharge Service (REDS)) (Rapid Early Supported Discharge).

Integrated Primary Care aims to work with patients as partners in their own care to live as well and independently as possible in their own homes including where this is their preferred place of care at the end of their lives.

The Service aims to reduce the use of inappropriate secondary and primary care by:

- Reducing inappropriate attendance at A&E departments
- Reducing preventable admissions to hospital by working closely with GPs to identify and case manage the patients who are most at risk of deterioration
- Reducing the length of time people spend in hospital by supporting medically unstable patients return home from hospital as soon as possible
- Reducing the length of time people stay in hospital by supporting medically stable but socially challenged people to return home as soon as possible
- Supporting housebound patients in accessing health care provision by Integrated Primary Care that would otherwise be provided on an ambulatory basis (e.g. 'flu vaccine, wound care, medicines management, etc.)
- Supporting people who have fallen to regain independence and remain independent
- Promoting health and well-being as well as prevention.

The Integrated Primary Care Service will work with GPs, acute hospitals, Local Authority and voluntary sector to support patients and their carers to live as healthily and independently as possible whilst at the same time ensuring patients feel safe and cared for outside of hospital.

### Activity

- 4,824 new patients seen by day time District Nursing (a 12% increase on 2014/15)
- 1,330 new patients seen by evening and overnight District Nursing (a 24% increase on 2014/15)
- 1,099 new patients seen by the Community Rehabilitation service, and 704 new patients seen by the Falls service.

Some of these patients will be seen by more than one team at a time and therefore it is not possible to create a total with the service.

### Outcome measures (monthly average)

Team	Measure	Target	2015/16 Avg
District Nursing	Avoidable: unavoidable PU	25%:75%	14%:86%
CRT	%of patients with goals achieved	>75%	81%
Falls	% of patient who improved their 180° turn	>80%	88.6%



## New developments this year

This year Integrated Primary Care has focused on the CNWL strategic objectives: High Quality Care and Best Outcomes for patients.

The teams and professional groups have identified key clinical areas for review and potential service development.

Clinical Area	Team/ Profession	Progress to date
Falls	Hunter Street	Audit data collection complete awaiting report and recommendations
Dementia	Occupational Therapists	Literature review underway awaiting report
Obesity	Belsize Priory	Literature review complete. Considering area to focus on
Lymphoedema	Gospel Oak	Literature review initiated awaiting report
Antecoagulation	Rapid Access Team	Literature review underway awaiting report

## Plans for 2016/17

The service has reviewed all its incidents, complaints and concerns and identified three key areas for service improvement. These are:

1. To reduce the number of avoidable pressure ulcers. This will be led by the Pressure Ulcer board
2. To reduce the number of Medication errors in relation to Tinzeparin, Warfarin and Insulin
3. To reduce the number of incidents, concerns and complaints that relate to break downs in communication between the teams.

The workplan for 2016/17 will have SMART goals constructed to ensure that we can measure our success against our aspirations.

In addition to this we hope to develop a night time palliative service (hospice at home) and to take part in a whole systems review of reablement services across health and social care.

## Rapid Access Services

### Summary of Service

The Rapid Access Service comprises of three pathways:

- Rapid Response is an admission avoidance service commissioned to prevent unnecessary hospital admissions. Patients are referred into the service from a variety of sources, including GPs, London ambulance service and hospital A&E departments. Patients are managed under this pathway for up to 10 days receiving acute nursing and therapy input.
- The Post Acute Care Episode (PACE) pathway provides acute nursing and therapy support for patients being discharged early from the Royal Free hospital. Patients are initially supported for five days with acute nursing and therapy. However, this can be extended for a further seven days if needed under Post Acute Care Episode (PACE) Step-down.
- The Rapid Early Discharge Service (REDS) pathway supports the early discharge of therapy only patients from the acute sector and local rehabilitation hospitals. Patients are supported by experienced occupational therapist and physiotherapist alongside a reablement package of care if required.

All three pathways have access to reablement carers for the initial element of the pathway and then up to 6 weeks.

### Activity

Number of patients seen:

- Rapid Response – 1,140 admissions avoided across Rapid Response including Overnight services
- Post Acute Care Episode (PACE) - 974 patients seen (an 8% increase on 2014/15)
- Rapid Early Discharge Service (REDS) - 294 patients seen.

VAS Score (Visual Analogue Score) is assessed on admission and discharge. This gives an indication of the patient's perception of how their health has improved whilst under the care of our team.

Average increase in score pre to post is 17 marks.

## Rapid Response admission avoidance

Referrals received: 817, an average of 68 per month with a peak of 88 in October.

**Admissions avoided: 82%**

Goals set : 1052

Goals achieved: 996

**Overall percentage of goals achieved: 92%**

EuroQOL Visual Analogue Scale (EQ-VAS) outcome measure:

Ave before treatment: 57.1

Avg after treatment: 70.8

**Overall percentage improvement: 19%**

Rapid Early Discharge Service (REDS)

last financial year:

Referrals received: 378, an average of 31 a month with a peak of 47 in September.

**Total beds days saved: 564**

EuroQOL Visual Analogue Scale (EQ-VAS) outcome measure:

Ave before treatment: 44.7

Avg after treatment: 64.6

**Overall percentage improvement: 31%**

## New developments this year

1. Rapid Response and Rapid Early Discharge Service (REDS) have built on the initial expansion which began in the 2013/14 year. This has seen both services become more established and increase the number of referrals made.
2. Discharge to Assess pilot. This project was in partnership with UCLH to provide a supported assessment and rapid discharge for patients with acute delirium.

## Summary

- There were a total of 12 patients discharged on the D2A pathway from the 24th of March to the 27th of May 2015. This was an average of 1.5 a week.
- 11 out of the 12 patients had a background of dementia, most of whom had developed a delirium prior to their hospital stay.
- The average discharge time was 14:50.
- 11 out of the 12 patients had an Occupational Therapy and nursing review.
- 11 out of the 12 patients were appropriate for the service.
- 50% of patients were discharged via Acute Medical Unit adjacent to Emergency Department, the rest of the cohort from various wards in 'The Tower'.
- The average 6CIT score (dementia screening/ memory test) on day of discharge from hospital was 17 out of 28.
- 50% of patients required 24 hour care upon discharge from hospital, the High Dependency CareLink package of care.
- 33% of patients did not require on-going care once discharge to assess was completed.
- It is clear from this project that each patient benefited from a rapid and supportive discharge with an emphasis on care that is individualised to each patient's needs. It is clinically the most appropriate management for delirious patients and promotes faster recovery through individualised care that can be adjusted on a daily basis and suits the need of each patient.
- For each patient that entered the pathway we have reduced the risk of entering permanent institutionalised care and exposure to hospital acquired infections that can be life limiting for such a vulnerable group of patients. The service was well received by family and friends who were relieved and reassured that such an all-encompassing care package was provided in the first days of discharge whilst the patient reconnected with their familiar environment.
- The viability of a long-term service continues to be explored, potentially funded by Systems Resilience ('Winter Funding').

## Plans for 2016/17

1. Continue working towards greater integration between health and social care reablement with an optimal model to be submitted to the JCC in the summer 2016. This project will examine a range of options to provide a more seamless referral process and improved experience for referrers and patients.
2. Improving admission avoidance in partnership with UCLH. This project has proposed embedding Rapid Response clinicians within the acute admissions areas of the hospital in order to identify and prevent unnecessary hospital admissions.
3. Greater integration with London Ambulance service in order to prevent the unnecessary conveyance of patients to A&E. Initial discussions have led to LAS auditing the common conditions that are conveyed with a view to establishing how many of these may have been suitable for Rapid Response. Benchmarking is due in regards to other areas that have established greater integration between these two services.
4. Nursing staff to provide increased support and training to local residential and care homes to prevent unnecessary hospital admissions.
5. Nursing staff to develop greater links with 'hard to reach' groups within Camden.
6. Continue developing the mini 'MDT' working where specialist teams such as Diabetes, Tissue Viability, Palliative Care, Heart Failure etc. attend the IPC Team meetings each month to discuss complex cases and provide training and education.
7. Greater engagement with GPs in the south of Camden who traditionally make fewer referrals than the North GPs.
8. Partnership working with the MS society and local MS Nurse Consultant in order to establish a Neuro-response service in Camden for MS patients suffering from UTIs. This pilot could lead to a similar service for other Neuro patients such as PD.
9. IV cellulitis pathway. Work is currently underway to establish a pathway for patients requiring IV antibiotics in the community for lower limb cellulitis. This will include 'first dose' and on-going treatment/monitoring.

## CareLink

### Summary of Service

Carelink provide supportive and enabling care for a number of pathways. All Carelink pathways are community-based and staff visit clients within their homes.

The following pathways were offered by Carelink last year:

- Rapid Response - aims to avoid unnecessary hospital admissions, Rapid Early Discharge Service (Rapid Early Discharge Service (REDS)) and Stroke Rapid Early Discharge Service (Stroke Rapid Early Discharge Service (REDS)) - Carelink provide short term (six weeks) enabling care in order to support clients through the process of being dependent on support/care provision to living in their own home independently.
- Palliative Care - This service is offered to clients who are at the end stages of life.
- Night Sit in Service – This service is offered to clients that are referred to Carelink from Community Rapid Response, Rapid Early Discharge Service (REDS), Stroke Rapid Early Discharge Service (REDS) and Palliative Care services.
- Out of Hours referrals – This service is operational seven days a week. Out of hours referrals are available up to 8pm Monday to Friday and on the weekends 9am to 3pm.

### Activity

Pathway	2015/16 activity
Community Rapid Response - POC	73
Hospital Rapid Response - POC	82
Rapid Early Discharge Service (REDS) - POC	246
Stroke Rapid Early Discharge Service (REDS) - POC	24
Night Sit in	81
Palliative Care - Hrs	3263
Out of Hours Referrals - POC	258

### **New developments this year**

Further demand for Carelink Rapid Early Supported Discharge Service:

Rapid Early Supported Discharge Service has over performed again this year by a further 25%. This increase is in addition to the adjusted commissioning target set last year in acknowledgment of the increase in demand.

The Rapid Early Discharge Service has seen a year on year increase in demand - 157% since 2013-2014.

Additional in year investment for Carelink was required to provide additional early supported discharge capacity for stroke patients to alleviate winter pressures.

### **Plans for 2016/17**

Continuity of Care provided by assigned Team Leader per client:

Continuity of care is being provided by the Carelink Team Leaders, who will endeavour to see each and every client in their locality at least one a week.

Clients will have the opportunity to discuss issues, concerns with the named Team Leaders in order to acknowledge and bring about a satisfactory conclusion.

Weekly assessment of reablement goals.

The clients will be encouraged to participate in weekly assessments of goals by the named Team Leader.

The Team Leaders will assess client goals and their progress by updating individual weekly goals sheet in order for support workers to follow/implement and report back progress.



## Continuing Care

### Summary of service

The continuing care team consists of a team of nurses, an Occupational therapist and an administrator. The team assess and case manage clients who have very high needs which in turn signify a primary health care need. The case management is done on behalf of the CCG who commission the care for these clients. The client base is mainly in four particular areas:

- Nursing care for clients in nursing homes in Camden – These clients are placed by adult social care in nursing homes in Camden. The nurse assessor from the continuing care team assesses their needs. The assessment determines if they client receives funded nursing care or if they meet the requirements for a full continuing care assessment.
- Assessment of all community patients once referral is received to determine if they are eligible for NHS Continuing Care funding.
- Receipt of all fast track continuing care cases – palliative care patients who have a rapidly deteriorating condition and this service assists to facilitate their choice of place of death.
- Assessment of all patients who trigger a full assessment within UCLH and present these cases to panel of the responsible CCGs.

We not only see patients in Camden, but we can see and do see patients of Camden GPs who live across the whole of the country, although these are a small minority of our caseload.

### Activity

The team:

- Saw 978 patients over the course of the year, of which 276 patients were new
- Had 579 open cases at the end of 2015/2016.

### New developments this year

- The team have continued to provide community assessments for continuing care. The referrals have continued to increase to approximately 4–7 referrals per week. These come from adult social care, GPs, community services.
- Funding for the post within UCLH has been agreed on an on-going basis. This post will also be responsible for training of staff within the hospital.

### Plans for 2016/17

- Potential to increase our team in order to provide assessments for our inpatient rehab wards in St Pancras.
- Potential to increase our team in order to provide assessments for other acute inpatient units that are part of the UCLH such as the National Hospital for Neurology and Neurosurgery.

## Heart Failure

### Summary of Service

- The Community Heart Failure Team is a specialist nurse-led service with clinical support provided by a consultant cardiologist
- The team is made up of one team lead, three heart failure nurse specialists, one band 3 health care assistant and a part-time administrator
- Independent nurse prescribing is well utilised within the team and the remaining staff member to obtain this qualification is working toward it
- The third quarter of last year saw the team shaping up to become a robust team of four heart failure nurse specialists with a combined 45 years of nursing experience, 39 of which are in heart failure or cardiology.

### Activity

- There were a total of 215 new referrals from seven sources
- There were 1898 face-to-face contacts over the 12 month period between April 2015 and March 2016.

Friends and Family questionnaires were sent out and responses were sent directly to Trust HQ.

There was some interesting data collected in collaboration with Camden CCG, UCH and Royal Free (Camden Heart Failure Steering Group) for Public Health England that showed progress in the management of heart failure in Camden.

- Camden has a prevalence of 0.6% compared to 0.72% in England
- Prevalence in Camden is 4th out of 32 CCGs in the strategic clinical network (SCN)
- Camden CCG is 3rd out of 11 demographically similar CCGs
- Of the 27 GP practices in Camden 15 have a prevalence of between 0.7% and 1.2%
- There are 1,596 people diagnosed with heart failure in Camden CCG.

The data explained below was put together (from hospital episode statistics (HES)). The chart and table below show the number of readmissions, non-elective and elective admissions (28 days) for heart failure per 100,000 patient population.

CCG	Readmission	Non-Elective	Elective
National Average	15.33	131.81	11.29
Camden	7.01	78.27	6.65
Barnet	10.54	120.26	8.03
Haringey	16.39	120.93	12.13
Islington	13.21	106.08	2.98

### New developments this year

We have begun work with the District/Community Nursing Teams on integration. We are looking to set out a robust process to move this forward and will be meeting with the District Nurse Consultant to make this happen.

We have taken over Telehealth triaging and this is working well. We will be working closely with the Telehealth and Self Management Project Lead to continue moving this forward and to collect invaluable supporting data.

We are part of the CIDR (Camden Integrated Digital Record) pilot and the project has continued to develop. This provides integrated patient information from all health and social care organisations in Camden. Having access to CIDR has been a positive step and is enabling:

- Safe monitoring of patients' blood results following initiation/titration of medicines
- Timely intervention
- Access to patients diagnostic information.

We are part of the CIDR Clinical Advisory Group that meets quarterly. The first meeting was on 28 April 2016.

### Plans for 2016/17

We are going to invest more time in our GPs and work with them to manage our joint patients.

We will soon be distributing newly designed patient leaflets and posters to all Camden GP surgeries, CNWL Health Centres, District Nursing Bases, Royal Free and UCH and at South Camden Centre for Health.

The future of heart failure in general is exciting thanks to the upcoming launch of the new drug Entresto that has been added to NICE Guidelines for the management of heart in April 2016.

As a service we are excited about becoming involved and caring for patients commenced on this therapy in Secondary Care. We are looking forward to discussing the roll out at the next Camden Heart Failure Steering Group Meeting that we have been asked to take over coordinating and hosting.

We are planning to acquire an ECG machine for the service. We are going to identify a suitable ECG training course for our Band 3 HCA. The purpose of the ECG machine will be to:

- Guide us when we initiate/titrate beta blockers i.e. ascertain heart rate/rhythm, rule out heart blocks
- Support us in optimising therapy i.e. identify prolonged QRS complexes and refer for cardiac resynchronisation therapy (CRT)
- Pick up undiagnosed atrial fibrillation (AF).

We will be supporting and working with PACE/ Rapids team in-reaching to Secondary Care to identify heart failure patients and facilitate early discharges with a robust heart failure management plan in place. The aim of this is to offer a seamless service for heart failure patients and increase prevalence in Camden.

## Camden Community Respiratory Team

### Summary of service

The service is staffed by a mixture of Specialist Respiratory nurses and physiotherapists. The service also makes use of psychologists for their patients, and also utilises the expertise of respiratory consultants from both acute trusts within Camden for clinical guidance. There are four main pathways:

- Screening and Assessment Clinics
- Pulmonary Rehabilitation (PR)
- Domiciliary Pathway
- Camden Integrated Care Service (CICS).

We have been involved in the Camden COPD Redesign Project with the CNWL Team leading on one of the sub groups – Home Oxygen and Assessment Service.

We have participated in a National Audit of PR Services.

We continue to participate in the Responsible Respiratory Prescribing Group (involved in creating local guidelines and recommendations for pharmacotherapy).

We have continued to support GPs both with clinics and home visits.

We have supported the expansion of the Telehealth Project in identifying appropriate patients post PR, post hospital discharge and GP referrals and supporting the clinician delivering this.

We have participated in the BLF 'Love Your Lungs Campaign' and continue to work in an integrated way through MDT working and visits to GP practices.

### Activity

Total Number of Referrals to the Team (this does not include patients seen at South Camden Centre for Health via Camden Integrated Care Services (CICS)).

	Total referrals
COPD Screening	493
COPD domiciliary	154
Pulmonary Rehabilitation	356
Grand Total	1003

## Domiciliary Pathway

### Key performance indicators

#### Overview of year

Annual totals	2015 - 2016	2014 – 2015 Comparison
Exacerbations	202	217
Unplanned admissions	60	80
GP appointments saved (KPI)	423	371
Hospital admissions avoided (KPI)	107	73
Hospital appointments saved	7	8

#### Summary:

- Reduced exacerbations
- Reduced unplanned admissions
- Increased GP appointments saved
- Increased hospital admissions avoided

## Pulmonary Rehabilitation pathway

Referrals	356	
Assessments completed	217	
Enrolment to programme	158 (73%)	
Completion rate	75%	Nationally 71%

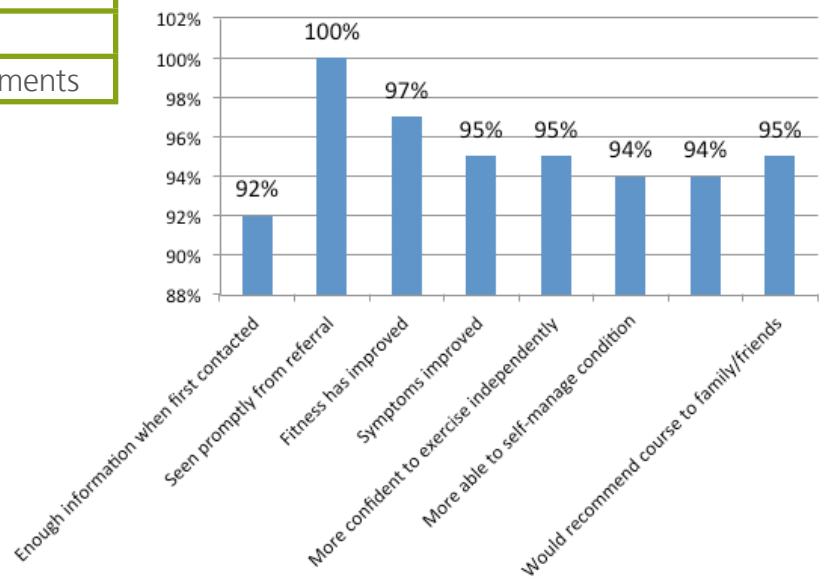
35% of referrals were not assessed – see table below for breakdown

12%	Declined
22%	Did not attend assessment
6%	Duplicate referral
6%	Non-COPD referral
13%	Medically unfit
2%	Out of Area
4%	RIP
28%	Unable to make contact
2%	Unable to attend –other commitments

Camden PR programme was involved in the National Pulmonary Rehabilitation Audit and the results were published in Feb 2016. Overall the national audit provided evidence to support that Camden is providing a standardised and effective PR programme. It demonstrated that patients who completed the course gained benefits in both exercise capacity and health status.

### PR Patient Satisfaction

After completing the Pulmonary Rehabilitation course, feedback forms were given to patients. A total of 63 forms were returned. Feedback for 'Excellent' and 'Very good' have been combined to give the percentages in graph below.



The patients were offered the chance to write any additional comments at the bottom of the feedback form. Listed below are some examples of the positive feedback received:

'This is a wonderfully beneficial course and I am grateful for being referred. I have enjoyed every minute.'

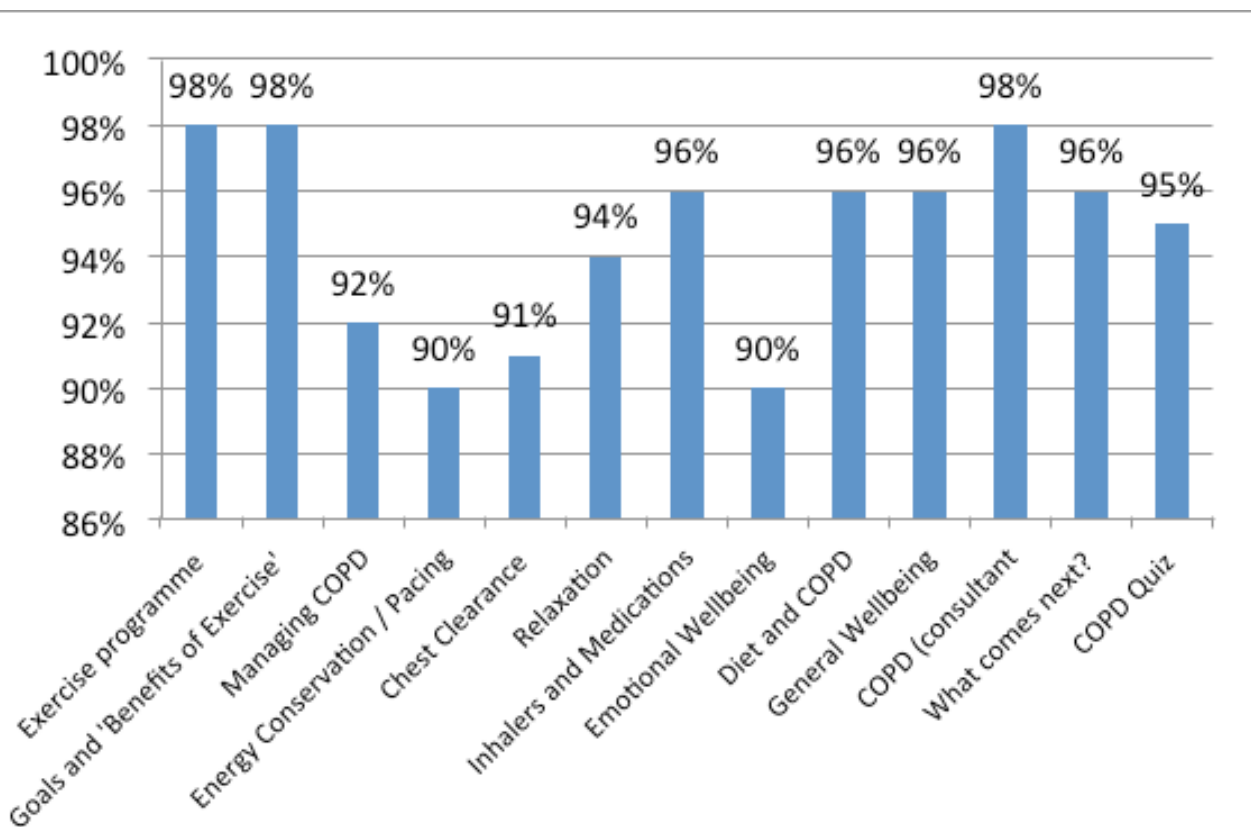
'The staff are the best I have encountered in all of the Hospitals I have been involved with. In the six weeks I have been attending, my health has improved 100%.'

'The staff are an asset to the NHS. I would definitely recommend the class to others.'

'I have felt enormous benefit from this course, not only in terms of breathing, but in terms of flexibility and general mobility.'

Most patients reported that they would like the course to be longer or for there to be a maintenance class introduced: 'I would like to see the class extended so we could come once a week after we finish our 6 week course, so that we could continue with the same level of support that we don't get in the community gym as the team here know us and understand our symptoms.'

The patients were also asked to rate the educational sessions that they attended during the course. The graph below represents the feedback rated either 'Excellent' or 'Very good'.





## Screening Service

The COPD Screening service has been in operation since January 2013. Just over 2000 patients have been assessed and screened.

This is the data for this year:

Total number referrals = 508

Total number screened = 289

Total Number on Waiting List = 45

Other (see below) = 174 (examples of this are inappropriate referrals, patients out of area, seen already, on the waiting list.

## Patient Satisfaction

- Patients feel extremely positive about the clinicians who visit them. Feedback collected specifically regarding the visiting specialist has been 98.3% positive. This is further supported by the content of the written comments, with 13.7% of written comments left commending the specific staff member which visited them
- Patients feel extremely positive about the service given to them, with 98.3% of patients rating the service they received positively. 29.6% of the written comments specifically mentioned that they felt more able to manage their COPD
- Patients feel extremely positive about the service/respiratory team, with 100% of patients reporting a positive experience. This is supported by the 24.1% of comments which commented positively about the team
- Several comments mentioned that the intervention by the respiratory team reduced their visits to hospital/to their doctor
- No aspects of the programme were rated negatively.

## New developments this year

- We have begun work in conjunction with the Community Heart Failure Team to increase integration of the LTCs into DN Teams by creating Community Respiratory Team Locality Leads
- Telehealth Project
- Streamlined Screening and Assessment Service running clinics out of the following areas:
  - Peckwater Centre
  - St Pancras Hospital
  - CHIP (Camden Health Improvement Practice)
  - James Wigg Practice
  - Belsize Priory Health Centre
  - Hampstead Medical Centre
- Delivered training to mental health staff on basic COPD assessment and management and when and how to screen patients for diagnosis of COPD.

## Plans for 2016/17

- The COPD Redesign project is currently with the CCG and we are waiting to see what parts of the project will be commissioned going forward
- Continue to benchmark our PR service against National Standards
- Review how we can provide PR classes that are consistent with National Standards:
  - Post exacerbation
  - Other respiratory diagnoses
- Staff are in the process of gaining their Spirometry Accreditation through the Association of Respiratory Technology and Physiology (ARTP)
- Evaluate Telehealth Project and publish data nationally (parameter setting, outcomes around hospital avoidance and GP appointments saved)
- Introduce education around Advanced Care Planning into PR educational talks.

## Camden Diabetes IPU – Diabetes Specialist Nursing Team (CNWL)

### Summary of service

- Camden Diabetes IPU (Integrated Practice Unit) is a multi-partner organisation providing the diabetes service for people with diabetes registered with a Camden GP. It's one of the first of its kind. The partnership agreement and contact started in June 2015 – the four main contractual partners are Royal Free Hospital NHS Trust (lead provider), UCLH, Haverstock Health and CNWL
- CNWL provides the podiatry service, Diabetes Specialist Nurse (DSN) service to Tier 3 and Nurse Consultant post which is strategic across the tiers. In addition the district nursing service, day and overnight provide the tier 4 support where the majority of patients are supported
- The Community DSN Team is a specialist nurse-led service lead by a Diabetes Nurse Consultant and additionally clinically supported by Diabetes Consultants (shared between UCLH and RFH)
- As this is a multiple partner organisation there are limitations in providing a report for only one part of the service
- The team is made up of one Diabetes Nurse Consultant and two DSNs
- All members of the nursing team are independent non-medical prescribers.

### Activity and Outcome Data

The figures below are based on information from EMISWeb, the system used by all partners in the IPU.

Referrals to DSN Tier 3 part of service:

- Referral to DSN – 227
- Referral to DSN Preconception – 5
- Referrals joint DSN and District Nurse Team - 45.

Diabetes Population Outcomes for 2015/2016:

1. Number of people with Hba1c < 53mmol/l – Target > 48% achieved
2. Diabetes and Controlled Blood Pressure <140/80 > 68% target achieved
3. Diabetes and Controlled Cholesterol 4mmol/l > 42% targets achieved
4. Admissions Ketoacidosis – Under 48 episodes not achieved
5. Admissions for hypo and hyperglycaemia – under 72 episodes achieved
6. Improvement in Diabetes Control for people with diabetes in acute care – first year was baseline data from two main hospital trusts with agreed standardised measurement and a planned quality improvement methodology embedded in system completed and therefore achieved.

## New developments this year

First year of contract for Diabetes IPU.

Changes in staffing and lead roles. Diabetes Project Manager role completed in May 2015. Diabetes Nurse Consultant role expanded to undertake some of the Project Manager's role, working closely with Operational Team from RFH and Clinical Lead of the Diabetes IPU. The Diabetes Nurse Consultant is also the clinical lead for the DSN not only in Tier 3 but also Tier 1 and 2 and linking in the DSN in Tier 4.

Diabetes Outcomes set for the Diabetes IPU. At end of Year 1 – awaiting full data as SUS data delayed it appears we have made all outcomes except one.

We have built on the work with the District/Community Nursing Teams and rehab unit staff on integration and clinical support.

- All patients on insulin that are not under the hospital diabetes teams that are registered with a Camden GP are on the DSN caseload
- Quarterly Case Discussions with DSN and DN Team
- Named DSN for each DN team
- A full study day running twice a year for District Nurses and staff on Rehab wards
- Joint home visits for some of our complex patients
- Implementation of new BG meter for staff use across CNWL and Camden, together with updated Policy on BG monitoring
- Development and Implementation of Administration of Insulin Policy across all of CNWL including Camden.

We have built on work of **Diabetes MDT** which also provides clinical supervision. It is held twice a month with extended time. It is attended by Diabetes Consultants, DSN, Diabetes Dietitian, Diabetes Podiatrist, Psychologist and ICOPE worker. Initially started as a clinical lead MDT but now as expanded to include psychology/ICOPE. We have now started making links with Psychosis IPU with representation by mental health teams for better joint working.

Pilot of **Bengali Structured Education** together with Dietitian, Project Lead and Interpreter. It has been successful and we will be rolling out the programme for 2016-17 as a core part of our service.

Development of **Joint DSN and Psychologist Clinic**. This is for complex patients referred to the Diabetes Service who have a clinical need and stress that impacts their diabetes management.

Better **Engagement with Primary Care** – the Diabetes IPU have taken over the Consultant Practice Visits from the CCG which is part of current Diabetes LCS.

Continue supporting General Practice with local **Diabetes Course and annual Diabetes Conference**.

Part of the **North Central London (NCL) Prescribing Group** – developed guidelines for Insulins in Type 1 and Type 2 Diabetes. In process of developing a guideline for tablets in the management of blood glucose.

**Diabetes UK Voluntary Group** – worked with Diabetes UK to relaunch the group – meeting monthly and based at Diabetes Service – Mary Rankin St Pancras Hospital. We provide a speaker and increase advertising to group and recruitment. Important to get user involvement and to hear the users' voice.

## Plans for 2016/17

Away day occurred in May 2016 with representation from all key stakeholders with Diabetes IPU where plans for delivery of the service in current financial based on the tighter outcomes, high incentives but also risks for year 2 of the contract.

Expand the Diabetes MDT expanding to include mental health teams and link in with psychosis IPU which is led by Camden and Islington NHS Foundation Trust.

Bengali Structured Education becoming core part of service.

Continued joint working with Primary Care including the new Planned Care Local Enhanced Scheme for GPs (LES) planned in September 2016.

Implementation of Diabetes Patient Reported Outcome Measure (PROM) questionnaire to get baseline information from people with Diabetes in Camden and set target improvement based on this.

## Camden Neuro and Stroke Service (CNSS)

### Summary of service

- The Camden Neuro and Stroke Service delivers multi-disciplinary therapy assessments and interventions for people with neurological diagnoses in the community. The team consists of occupational therapists, physiotherapists, speech and language therapists, psychologists and rehabilitation assistants. Staff have clinical expertise in neurology. Referrals are most commonly via GPs and hospitals and once known to the team, service users can self-refer themselves back to the team
- We provide a number of intervention pathways:
  - Early Supported Discharge for stroke (Stroke ESD)
  - Rehabilitation, including admission avoidance for people at risk of injury/deterioration who would require hospital admission without timely assessment at home
  - Progressive conditions, supporting and anticipating deterioration
  - Complex neuro- navigator
  - Community learning disabilities physiotherapy (funded through SLA by local authority Learning Disabilities Service)
  - Target (transitional community exercise programme) supporting people to exercise without health input in the longer term
  - The service also provides psychology input for respiratory team clients and speech and language therapy for primary care teams and palliative care services.

### Activity

Number of referrals to Neuro and stroke team in 2015/16:

- 574 patients were referred to the team with a neurological diagnosis, 336 of these referrals being new patients to the team
- 210 patients were referred for palliative care and integrated primary care speech and language therapy
- 27 patients were referred for Psychology for clients with a respiratory diagnosis
- 25 patients were referred for Camden Learning Disabilities Service physiotherapy.

The team completed 7,095 face to face appointments with neurological patients.

Neurological patients are sent an anonymised 'Patient feedback questionnaire' with stamped addressed envelope on discharge from the team. Responses to the survey included:

- 100% felt they were treated with dignity and respect
- 98% were satisfied that therapy was tailored to their needs
- 98% of patients would recommend the service to friends or family.

## New developments this year

We are currently working with colleagues at Imperial College London leading on the community arm of an upper limb study investigating the efficacy of an upper limb intervention to augment improved arm function following stroke. To date we have screened thirty patients and recruited three to the study.

We have introduced regular education seminars, open to all health staff working with adults across Camden. Entitled 'St Pancras Neuro-rehabilitation Seminars', these aim to support the continued professional development of staff and encourage cross team working. Examples of presentations to date include 'Parkinson's Disease, Parkinsonism and Best Practice Guidelines' and 'Managing expectations of recovery: How stroke professionals manage patients' verbalised expectations'.

We have widened our ESD catchment for stroke patients to include rehabilitation units, e.g. St Pancras Inpatient Rehabilitation Unit. This aims to facilitate the supported discharge of patients with stroke who have received inpatient intervention and who would now benefit from intense rehabilitation in their home setting, thus freeing up inpatient bed space and hence further relieving pressure on acute beds.

The Systems Resilience Group (SRG) money received this year enabled us to support our work with patients with stroke and meet our standards of seeing all ESD patients within 24 hours of discharge from hospital. A major challenge for the service and Camden overall in 2016/17 will be managing demand to a service with finite capacity.

We co-chair the North Central London (NCL) Stroke Rehab group, which includes all stroke rehab providers across NCL.

Our complex Neuro navigators co-chair the pan London complex navigation network.

## Plans for 2016/17

The service is currently involved in several new developments focused on improving local and national aspects of community based neurological care.

Multiple Sclerosis (MS) project – We are currently engaging with Neurology consultants and looking to engage the CCG in a project focused on supporting patients in the community with MS. Specifically, the scope of the project hopes to focus on two pathways. Firstly, improving access and support with disease modifying therapies (DMT) during the early stages in MS. Secondly, improving and enhancing the progressive management / symptoms control (rehabilitation) model of MS.

National Neurology Project – Camden has been selected as a pilot centre to trial a novel method for the provision of Neurological Services. Working with NHS England Imperial College Health Partners and Barnet CCG, the project is initially focusing on three areas (Parkinson's disease, Headache and Epilepsy) and hopes to improve all aspects of neurological care provision, including community based therapy across all neurological conditions.

Stroke Pathway Review – The service is currently involved in a project covering North Central London focusing on the stroke pathway, and more specifically post-acute care. The ESD aspect of the CNSS team is working with local providers to review current service provision and helping to define and establish a post-acute stroke pathway that meets and surpasses the needs of stroke survivors.

Complex Navigation and NHSE - Camden CCG and CNSS were one of the first services to pilot and subsequently commission a Complex Neurological Navigation role, focused on the timely transition and discharge of highly complex patients from specialist rehabilitation back to the borough. Recent engagement with NHS England has seen growing acknowledgement and support for the role, which is now seen as integral to the pathway. There is a current focus to further explore how the role can continue to support NHSE and locally commissioned rehabilitation – with regard to Delayed Transfers of Care, but most importantly to managing and supporting patients and their families' expectations as they transfer between services.

Speech and Language Therapy videos – in collaboration with UCL speech and language therapy department, patient videos are due to be developed for students as a teaching resource. The videos will focus on different forms of dysarthria - speech production difficulties.



## Palliative Care

### Summary of service

The Camden, Islington ELiPSe , North Westminster and UCLH & HCA Palliative Care Service provides specialist care in community and hospital settings for patients with life-limiting illness.

Our palliative care specialists include nurses, doctors, occupational therapists, physiotherapists, social workers, clinical psychologists and assistant practitioners.

The team provides palliative care and advice to adults at home in the boroughs of South Camden, North East Westminster and Islington, and to teenagers and adults in University College London Hospital (UCLH), Princess Grace Hospital, Harley Street Clinic and Harley Street at UCLH. We also provide palliative care support for children in UCLH.

### Palliative care for adults:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement support, as indicated
- enhances quality of life, and may also positively influence the course of an illness
- is applicable early in the course of any illness, in conjunction with other therapies that are intended to prolong life, such as in the case of cancer, chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

## Activity

Total number of referrals across the service – 2,879

Total number of visits across the service – 22,178

Patient experience measures – we measure aspects of patient experience across a range of performance metrics, including responsiveness to referrals, whether patients are dying in their preferred place of death, whether advance care planning conversations are taking place. We also monitor our staff training in various competencies to ensure they can appropriately meet the needs of patients and their loved ones. Finally, we carry out a number of audits to monitor patient satisfaction with our service.

## New developments this year

A significant development in the service over 2015/16 has been the introduction of patient reported outcome measures (PROMs). These are used regularly during the course of a patient's care under the palliative care service, to provide a measure of various aspects of a patient's health and wellbeing, and ongoing progress (or deterioration) against these. These can be completed by either the patient or our staff. From a team perspective we can then use these recurrent scorings to determine whether the treatments being provided are proving effective in managing the symptoms of a patient's illness. On a wider scale, they can also be used more generally to measure the service's effectiveness in caring for its patients. Thus far they have been introduced in a trial state, with a view to fully introducing them across the whole service in due course.

This year the service has also taken forward significant pieces of work to further engage with our patients, and to capture learning from their experiences and inform service developments. We carried out a series of discovery interviews with patients to hear about their experience and the treatments provided to them; similarly we have helped patients write their patient stories of their experiences – both of these are powerful messages for us as a service over the positives and limitations the service provides. Where we identified specific problems experienced in a patient's care, we have discussed this more fully with them to enable us to develop learning around this. We have also begun developing Recovery College modules in partnership with our patients – our first two looked at Resuscitation, and Advance Decision Making. These are training

sessions which can be available to both patients and other staff to inform them over these aspects of palliative care service provision, so that they are more informed and enabled should such conversations come up during the course of treatment. We have also worked with patients to develop the template for an individualised last days of life care plan. Finally, we have begun developing a Facebook page for our patients and carers to access, share their experiences, and provide feedback. This is still very much in the development phase but we hope to complete it soon.

The therapy team were integrated into the Rapid Access Service. The benefit for patients is that they can now receive a 7 day service when required, and the team will have access to additional specialist peer support which will enhance their development.

### **Plans for 2016/17**

We will be continuing the work we began in 2015/16 to develop patient reported outcome measures – this will include their further integration into the day to day practice of the service, development of more streamlined methods of capturing and analysing the data, and developing more ways of analysing the data to ensure it is used most effectively. We will also be continuing the work we have initiated to capture more patient experience of our services – so more discovery interviews, more recovery college modules, and the finalisation of the Facebook page.

We will be working in partnership with both Camden district nursing and Islington district nursing when commissioners decide to look at the provision of a hospice at home service.

We are continually looking at new ways to grow the service and a number of initiatives are at the planning stage.

## Camden and Islington Wheelchair Service

### Summary of service

The Wheelchair Service provides wheelchairs, buggies, special seating, cushions and other postural and pressure-care accessories to all children and adults with a GP registered in Camden or Islington. We work with all ages and diagnosis/conditions across both boroughs. Although primarily based out of the Peckwater Centre in Kentish Town, we also run regular clinics in local schools and nursing homes as well as in client's own homes.

### Activity

Over the period of 2015-16 we have seen 1,419 referrals (705 Camden / 714 Islington). 1,011 (522 Camden / 489 Islington) were managed through direct prescriptions where the equipment can be ordered based on community occupational therapist or physiotherapists assessments, via local screening or via the use of a self-assessment questionnaire. This cohort of clients did not require a face-to-face appointment. The remaining 408 clients required a face-to-face assessment. The total number of face-to-face appointments carried out was 1,982 (973 Camden / 1,009 Islington). Out of the face-to-face appointments we saw 268 at our Drop-In Clinic.

### New developments this year

We have redesigned two of the administrator roles within our service to therapy assistant roles under the 'Clinical Support' group. This will increase the team's clinically trained staff, and provide better client care by enabling the therapy assistants to be part of the clinics, making them better able to respond to queries, and screenings and prescriptions coming in by phone, email and fax.

We have also improved the way in which we provide Partnership Vouchers to those clients requesting them meaning that we are now able to provide equipment through the partnership voucher scheme at CNWL Framework prices, making it a fairer deal for our clients.

### Plans for 2016/17

Due to on-going low levels of attendance to our User Group we are setting up a Facebook page which will enable us to engage with our users in what we feel is a more user-friendly way as it enables our clients to provide us with feedback and keep up to date with our news without having to attend a meeting. We continue to run our Drop-In Clinics on Wednesdays each week where clients can still attend for a face to face discussion when needed.

We will be running more Prescriber's Courses to train referring occupational therapists, physiotherapists, healthcare assistants and therapy assistants to assess for and prescribe standard equipment.

## Podiatry

### Summary of service

The podiatry service provides assessment, diagnosis, advice, treatment for a wide range of foot conditions.

This is provided in health centres, acute and community hospitals, mental health sites and the homes of housebound patients. A transport service is also available for patients who are immobile but not housebound.

### Activity

Number of appointments/visits 21,885 + 3,500 from our SLA with UCLH  
Total: 25385

Patient experience measures based on 2014/15

How would you rate your most recent experience of using this service?	
Excellent	45%
Good	45%
Satisfactory	8%
Poor	2%
Missing	

Were you given a choice about your care or treatment?	
Yes, definitely	49%
Yes, I was given some choice	31%
No, I was not given any choice	20%

Did you understand the information you were given about your care and treatment?	
Yes, definitely	80%
Yes, to some extent	17%
No	3%

## **New developments this year**

Improvement in the call waiting times and capacity has been the big drive this year.

Patient access to the service via the contact centre has been improved with the new call waiting system which allows patients to know where they are in the queue. This has resulted in a reduction in complaints.

We have also dedicated set times for patients calling for their first appointment enabling us to manage the contact centre in a better way so that patients are able to access the service as necessary.

The work continues with the new referral pathways which have been developed based on NICE guidelines for diabetic patients depending on their clinical 'risk'. This enables diabetes patients especially with 'high risk' feet and active foot disease such as ulceration to access care with the right skills. The pathways have also improved integration of patients between community and the acute sites and more prompt access to multidisciplinary care.

The step up step down clinics continue to work well and patients have been reassigned to the correct tier according to their needs.

We have also continued with redefining the 'risk categorisation' of non-diabetes patients' foot needs. This will be undertaken for existing patients within the service and new patients. This will enable the service to become more responsive to the patients' needs and inform capacity planning of the service.

The nine point process for all diabetics has been introduced and this forms part of the holistic approach to treating the condition.

Governance has been strengthened with regular supervision of all staff, and later on in the year the introduction of an in-house clinical 'Peer Review'.

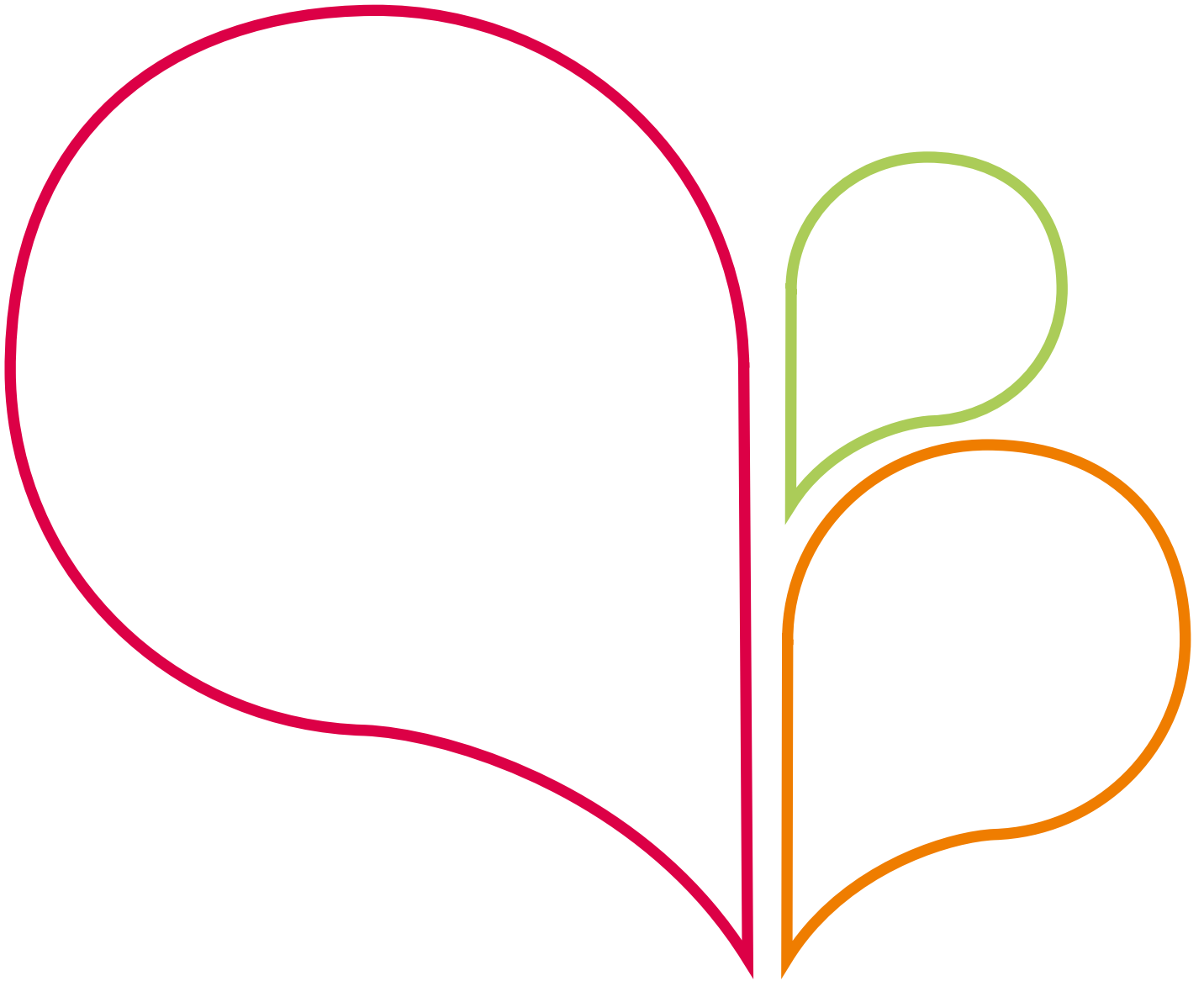
## **Plans for 2016/17**

The podiatry eligibility criteria are being reviewed with the help of a 'Champion' GP. This will focus on patients being prioritised on a needs basis giving greater access to those that need our help.

The service is now focusing on ensuring that patients are given a clinical needs based risk assessment of the foot, taking into account the patient's foot problem and underlying medical condition.

The service has also designed its new referral form so that referral to the service is made easy and we get all the necessary information to triage appropriately.





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