

# JUNE NEWSLETTER



VOLUME 1, ISSUE 7

Delivering the 2007/08 plan is a continuing priority for us and in this newsletter we have an article on community matrons and we thought it would be useful if we provided some examples of the types of patients who can benefit from being reviewed by the Acute Care GP at MPH or YDH which can be accessed via SPL (01749 836700).

In 2008/09 and beyond there will be a greater emphasis on the public health agenda and the promotion of health lifestyles. We have provided details of a service being delivered in Taunton for information.

## **WH.C MANAGEMENT MATTERS**

### Membership Issues

Last month we wrote to practices about the contribution towards WH.C costs that we would be requesting from the PBC LES1 payments. It is likely that we will not be able to receive this directly from the PCT and we will have to invoice practices individually. Invoices for the 2007/08 payment of 10p per patient will be issued shortly. Invoices for the 2008/09 payment of 20p per patient will be issued later in the year once the PBC LES1 for 2008/09 has been made by the PCT.

### Freed Up Resources (FUR)

We wrote to you earlier this month about the FUR from prescribing savings; we wanted to clarify that these are based on work done by practices to deliver prescribing savings and not PBC LES targets. These are practice savings rather than WH.C savings to be used under the guidelines issued by the PCT but if a practice wishes to allocate all or some of them to the PBC schemes being developed by WH.C that would be helpful. The PCT has stated that monies not committed by practices will be passed to WH.C.

### Management

We are becoming increasingly involved in a wide range of patient care pathways and to take on more responsibility for the commissioning of new services under PBC we are planning to expand the management team with two new Implementation Managers. They will hopefully be in post in September; in the meantime we are seeking additional external support to progress our commissioning agenda.

As our profile raises we are being increasingly asked to identify GPs to attend specific events and we have written separately to GPs about a number of these. The Board is beginning to establish a register of GPs with an interest in specific areas and negotiating with the PCT locum costs for GP attendance at these events.

**[www.wyvernhealth.com](http://www.wyvernhealth.com)**

Please remember to check the website. Your feedback is appreciated.

## **COMMUNITY MATRONS**

The target for Somerset Primary Care Trust as agreed with the Strategic Health Authority is to employ 25 whole time equivalent (wte) Community Matrons. This would ensure that all GP practices have access to a Community Matron to support the agreed caseload of between 50-80 patients for their practice area.

As of 1 June 2008 there are 18.75 wte Community Matrons in post. This is provided by 20 members of staff. (Please see attached Matrons organisational chart).

During 2007/08 there has been an active recruitment programme which has included a review of the job profile with the advice and support of the Department of Health. Initially Community Matrons were recruited from within the District Nursing teams locally and this was then extended to a national campaign to include applications from Practice Nurses and Specialist Nurses.

The Community Matron action plan agreed and signed off by the Strategic Health Authority in Spring 2007 committed to providing access to a Community Matron for all 75 GP practices across Somerset.

There are currently vacancies in the following areas:-

- 1 wte College Way Surgery & Warwick House Medical Centre Taunton
- 1 wte Cannington, East Quay Bridgwater & Nether Stowey Surgeries
- 0.75 wte Dulverton, Dunster, Minehead & Porlock Surgeries
- 0.6 wte Ilchester, Queen Camel & Castle Cary Surgeries
- 1 wte Crewkerne, Hamden & West Coker Surgeries
- 0.6 wte, St James Surgery Taunton

The Community Matrons are developing escalation plans that are able to be implemented by the patients or by external agencies; for example the ambulance service and therefore prevent admissions.

The service concentrates on optimising health and managing ill health appropriately and needs to work in close partnership with patients and primary care clinicians in order to identify those patients who are most at risk of an unplanned admission. They are currently developing a close working partnership with the new COPD service, undertaking training in ECG and Spirometry to enhance their diagnostic skills.

All Community Matrons are required to submit monthly activity data to include the number of patients on their caseload and the number of Acute Hospital Trust admissions prevented. Caseload information is then cascaded to the CATUs and Primary Link on a monthly basis. This data has begun to demonstrate that the service is effective in reducing unplanned emergency admissions and there is no reason that this cannot increase as more matrons come on line and the links with other health services expand.

It is anticipated that a central spine of data will be developed with specialist IT support in order that all relevant health services can access the health assessment information and individual patient escalation plans for all of the clients being case managed by the Community Matron programme. This will eventually include OOH GP services, A&E departments and GP practices.

Whenever possible Community Matrons are based in surgeries or health centres however some are in community hospitals. Irrespective of their base they endeavour to form strong communication links with the patients' GPs.

The Community Matron Service is managed by a Community Matron Co-ordinator. Please do not hesitate to contact her should you have any queries regarding the service. Her details are as follows:

Ann Horrocks, T. 01935 848243, E. [ann.horrocks@somersetpct.nhs.uk](mailto:ann.horrocks@somersetpct.nhs.uk)

## **ACUTE CARE GP SERVICE**

Examples of patients suitable for the service are those who do not require acute / specialist nursing care or admission to a hospital bed but who require more intensive investigations and / or a second opinion to enable them to be cared for in the community either at home or in another setting. Possible clinical scenarios include the following:

- Chest pain of uncertain aetiology when the patient is clinically stable (?PE, ?MI, ?chest infection)
- Abdominal pain when the patient is clinically stable
- Breathlessness of unknown cause
- Possible septic arthritis
- Elderly patients, off legs who could be sent to a community hospital / CATU once investigations have been done
- DVTs if care pathway not in operation
- Any relatively well patient where there is some diagnostic uncertainty.

## **ACUTE CARE GP SERVICE - QUESTIONNAIRE**

Devon Health have asked for views from GPs who have referred to the ACGP service. We would be grateful if you could complete and return the attached questionnaire as soon as possible to Martin Shaw by email at: martin.shaw@devondoctors.nhs.uk or by post to: Devon Health, Unit 10 Manaton Court, Matford Business Park, Exeter, EX2 8PF.

## **WATER EXERCISE FOR PATIENTS WITH A WEIGHT OR BODY IMAGE PROBLEM**

Jenny, the diabetic nurse at Quantock Vale Surgery, has negotiated the private use of St James' swimming pool in Taunton for an exercise session on Tuesdays from 3:00 to 3:30. Initially intended for her obese diabetics, she has extended the invitation to all patients in the Taunton area who have a weight or a body image problem or those who have difficulty in getting any exercise at all for other health reasons.

All Taunton area practices have previously been circulated with details and a couple of patients from other surgeries have joined the group. We would like to remind practices of the project as the patients who attend are having fun, getting exercise, becoming fitter and losing weight. The sessions are self-funding and Jenny is asking people to commit to a ten week session at £2 per session.

She has tailored the sessions for people with a weight problem - the session is completely private, thus reducing the embarrassment factor, she has had an especially wide set of steps built to get into and out of the pool and she can direct people to suppliers of larger swimming costumes! Not everyone who attends can swim but all can use the support of the water to exercise gently. There is a lifeguard on duty but people who attend must take responsibility for their own health.

Those who wish to attend, or sample a session, should simply turn up at the swimming pool on a Tuesday and meet Jenny in the main foyer.

## **FEEDBACK ON PROPOSED MODEL FOR NEW DIABETIC SERVICE**

Many thanks to the 33 member practices who returned a completed questionnaire about the proposed new model for adult diabetes care in Somerset that was circulated in April. The following is a brief summary of the results.

### **1. Omissions in the three level model proposed**

It was pleasing to find that only seven practices (21%) highlighted any omissions in the proposed model. The majority of these are actually covered in the model – e.g. training for new and established diabetics, patient held records, hotline to specialist advice, podiatry.

### **2. Main gaps in diabetes services provided locally**

There were only three practices (9%) who felt they had no service gaps locally.

The services most frequently identified as local gaps were:

- Podiatry (poor access, long waits)
- Access to advice regarding when to initiate insulin
- Long waits for insulin conversion
- Access to Diabetic Nurse Specialist level skills
- Lack of specialist dietetics + weight management programmes
- Lack of psychological support
- Inappropriate patients maintained within secondary care
- Lack of patient education services

All of these issues will be addressed by the proposed new model.

### **3. Practice aspirations to provide some or all of the level 2 services**

13 practices (40%) stated they would like to provide all level 2 services.

No practice wanted to provide none of the level 2 services.

20 practices (60%) stated they would be interested in providing some elements of level 2 services.

Encouragingly this suggests a strong desire for practices wanting to extend their practice based diabetes services. This is in line with the vision of the new model of increasing provision of services closer to the patient in the community.

The full list of responses along with a pdf file of the draft model can be found on the website at [www.wyvernhealth.com](http://www.wyvernhealth.com)

As to the next steps, the model will be discussed by the PEC at its June meeting. To extend local engagement, the model will then be shared with healthcare professionals, patients and other stakeholders in order gain further feedback and sign up. WyvernHealth.Com will now work with the PCT to develop a costed plan, taking into account feedback from the engagement process, to be presented for subsequent approval by the PCT Board from which a service specification will later be developed.

If you have any questions you would like to raise on this Tier 4 commissioning project, please contact Dr Geoff Sharp at: [geoff.sharp@parkmedicalpractice.nhs.uk](mailto:geoff.sharp@parkmedicalpractice.nhs.uk).

## **WORKSHOPS AND MEETINGS**

### **Telecare Strategy Group**

An opportunity has arisen to work with Somerset County Council to develop and agree a strategic approach to the future of telecare / telehealth in Somerset. If you would be interested in joining this strategy group please contact Ann Anderson ([ann.anderson@somersetpct.nhs.uk](mailto:ann.anderson@somersetpct.nhs.uk)).

### **Heart Failure Workshop – Wednesday 2 July (12.30 – 5pm), The Shrubbery Hotel, Ilminster**

The ageing population together with increasing survival rates following myocardial infarction and other life threatening cardiac conditions has led to an increase in the numbers of people living with chronic heart failure. The publication of the National Service Framework for Coronary Heart Disease in 2000 and the National Institute for Clinical Excellence Guidelines for the Management of Chronic Heart Failure in Adults in Primary and Secondary Care in 2003 has done much to drive improvements in the care of this group of patients. The Healthcare Commission Review of Heart Failure Services identified some excellent examples of services which are currently provided in Somerset in a variety of settings.

The purpose of this workshop will be to enable a range of healthcare professionals from primary and secondary and palliative care, patients and the public, representatives from the voluntary sector, social services and managers representing providers and commissioners to contribute to the development of future models of care.

We plan to run the workshop with a mixture of presentations and breakout sessions which will enable delegates to contribute to the design and development of the ideal model of care. Presentations will include the findings of a recent audit of heart failure services in Somerset, prevalence of heart failure and the development of a primary care based Heart Failure Service in Gloucester. The Map of Medicine, prescribing issues and the role of the pharmacist, palliative and end of life care will also be topics of presentations to help inform our discussions later in the day.

This is an opportunity for you to have your say and influence the future care of the increasing number of people with heart failure. Your contribution will be really valuable and we hope you will be able to attend.

A flyer and a booking form are attached to this newsletter. Please return the booking form to: [linda.snowden@southwest.nhs.uk](mailto:linda.snowden@southwest.nhs.uk)