

September/October 2009

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The Way Forward

As we enter the second half of the financial year we face a number of challenges. Overall, the prescribing and non-elective budgets have underspends, however both the elective outpatients and inpatients have seen an increase in activity. We see this as an opportunity for education, learning and developing alternative pathways in our practices as we are not performance managers for the PCT.

WH.C AGM

This year's AGM is being held from 7.00 pm until 9.00 pm (sandwich buffet available from 6.15 pm) on Wednesday 18 November 2009 at Bridgwater and Albion Rugby Football Club, Bath Road, Bridgwater, TA6 4TZ. To reserve your place please Email sue.vowles@wyvernhealth.nhs.uk. Attendance at this meeting counts towards your LES1 payment and is your opportunity to debate the way forward for PBC in Somerset.

Optimising Cost Efficiency of Outpatients and Emergency Referrals – Shared Good Practice. Workshop held on Wednesday 30 September

Over 80 delegates attended the above workshop where Paul Bearman (General Manager), Nick Matthews (Glastonbury Health Centre) and Matthew Dolman (Axbridge Surgery) gave presentations – copies of which can be obtained from our website <http://www.wyvernhealth.com/papers.htm>. The focus was on sharing good practice, identifying new ways of working and informing practices about what they needed to do to receive their LES payments for 2009/10.



The non-elective meeting discussed issues around:

- ❖ a range of options to improve access to primary care and opportunities to see patients earlier in the day who were at risk of a hospital admission. Many people requested the following link regarding “Improving Access, Responding to Patients”: <http://www.practicemanagement.org.uk/introduction>
- ❖ publicising SPL more as this is the main point of contact for all the emergency admission avoidance schemes;
- ❖ discussions about whether SPL could hold Community Matron caseloads;

- ❖ raising awareness of the clinical benefits of the Community COPD service, eg 24 hour helpline for patients; oxygen assessment; and pulmonary rehabilitation;
- ❖ how one practice sends all moderate to severe COPD patients a prescription for antibiotics just prior to the Winter. This is an excellent way in which to try and avoid emergency admissions;
- ❖ using the RISC tool to inform review meetings in practices;
- ❖ possibility of placing EoLC forms on our website – see link <http://www.wyvernhealth.com/pathways.htm> (in progress);
- ❖ opportunities for federations to consider developing complex care GP roles.

The workshop on elective outpatient referrals identified a number of actions that could be taken by practices, federations and WH.C:

Practices	Federations	WH.C
<ul style="list-style-type: none"> ❖ Identify education needs; ❖ Develop processes to review referrals; ❖ Undertake referral audits at clinical meetings 	<ul style="list-style-type: none"> ❖ Identify opportunities for locality working on alternatives to hospital services 	<ul style="list-style-type: none"> ❖ Review budget setting process; ❖ Progress alternative pathways, ie advice and guidance; ❖ Consider opportunities for better patient education.

Development Update regarding PBC Information

Ardentia: As you're aware, primary care overspent on its secondary care budget to the tune of approx £7m 2008-9. There a number reasons for this, but no obvious underlying theme: elective inpatients certainly went up, and emergency admissions rose by less than expected. The biggest rise was in out-patient activity. The mechanism by which this is all measured, ie the information within Ardentia, has been under close scrutiny, we have a much clearer understanding of its accuracy and application. To summarise:

- All local Trusts are coding according to rules to a reasonable extent (89% for RUH, 89% MPH, 90+% YDH)
- Part of our confusion regarding Ardentia (and the information in it) was related to us not fully understanding the rules of how episodes are coded, and how they are then applied.
- Incorrect GP information and out-of-date patient addresses meant patients were being assigned to the wrong practice (and cost therefore coming off the wrong budget). A mechanism for screening these out electronically has been set up, and this should now no longer be a significant issue. A couple of practices were identified as having a particular problem, and reasons for this have been established. Overall, the error rate was <5%, and it must be emphasised that whilst it makes a difference to the individual practice budget, as a consortium with "pooled risk", there is no net gain or loss EXCEPT where patients are no longer Somerset residents - there have been some instances of this.

WyvernHealth.Com is looking to work with the PCT on developing a system to query possible coding issues with the hospital Trusts in "real time", ie when a coding change might make a real difference to payments. This is likely to be piloted at the RUH in the first instance. If however you pick up an issue from elsewhere, please don't hesitate to contact us as examples of problems provide opportunities for learning.

Currently, the speed of information update in Ardentia is too slow for coding to be changed under PBR rules, and this is being addressed as a matter of urgency as part of the above project. Until this is corrected, any error may not materially affect payment to the Hospital Trust (see above); they can be corrected on the practice "notional" PBR budget, so it's worth doing from a practices point of view.

Suggested Audit: Activity outside of Somerset operates under full PBR rules, and is, anecdotally more likely to contain errors such as non-registered patients. For most practices, the numbers of these

episodes are low and are easy to identify, and this is a good area to get used to understanding the system.

From the dashboard, log in to Ardentia by clicking the tab on the right side of the screen. At the welcome page, click on PBR activity by provider. This will bring up a list of all the providers where patients registered with the practice have been seen. Click on the number of patients to bring up the details of these episodes - the NHS number/date of birth should be provided.

Questions:

- Is/was the patient registered at the time of the start of the episode;
- Did the practice receive a written record of the episode (out-patients letter or in-patient discharge summary)
- Do the date(s) for that episode match in Ardentia and the discharge summary?
- Look at the HRG code. (a link to a list of the codes and their descriptions can be found at the bottom of the Ardentia welcome screen).
- Does it reasonably mirror the information in the discharge letter?

If the answer is "No" to any of the above, it would be helpful for us to have details of the episode (pbcinfo@somerset.nhs.uk) for further research.

RISC: This is the piece of software which helps to identify patients within our practice populations at greatest risk of admission. All practices should now have a log on, and the Information team lead by Kevin Hudson have been offering training in its use. Please contact Kevin Hudson (pbcinfo@somerset.nhs.uk) or the Wyvern office (01749 836709) if you have any problems with either.

How best to use RISC?

Experience from practices that have:

Its simplest function is to produce a list of patients in rank order of risk of admission. Practice teams will inevitably recognise the names toward the top of the list and be aware of their difficulties. There will also be names which are slightly unexpected, and as RISC is updated quarterly, people will move up and down the lists.

At a Primary Health Care Team meeting, go down the list of patients on the first page: many will be familiar, some will already be case managed if you have a Community Matron. Discuss their situation - recent contacts, District nursing or other input. Is there a recurring problem driving admission or attendance- can this be tackled differently? This forms the basis for a management/escalation plan. Some practices are reviewing these lists as part of their monthly MDMs alongside their palliative care patients, and once an initial discussion has taken place, updating and discussing is not onerous

Identifying patients moving "up the charts", ie whose risk is increasing, may potentially be helpful. There is currently no simple way to do this within the RISC software, though this has been flagged as a development issue. It is however straightforward to do within Excel and again Kevin Hudson and his team can help with this if requested.

Management Plans: It is recognised that a comprehensive written escalation plan for a patient with complex medical problems can be time consuming, especially when discussion with the patient and family have to take place. There is also the issue of how to share it. The key point is to do something - often simple things can make a difference. The plan can always be developed. For example, patients whose main problem is COPD - do they have a supply of steroids and antibiotics in case? Have they been reviewed by the practice COPD team - are they known to the Community COPD team?

Care planning for patients in Nursing Beds can be a relatively straightforward process and helpful to the patient, their family and Nursing Home, as well as the GP and out-of-hours service. Issues such as documenting the circumstances in which the patient wishes to be transferred to a DGH (if at all), resuscitation status etc can give clear guidance to clinicians assessing a deterioration in a patient.

How to share? The practice and patient (or carer if residential). Primary Link and the OOH service have the facility to log special patient messages.

The Dashboard: The information dashboard continues to develop. All practices will have been contacted and invited to download the dashboard. Again, Kevin Hudson's team on the above email address can help if anyone has problems with this process. The latest update now has a facility to check for and update the dashboard automatically, as long as the computer is connected to the Somerset NHS network. The current update is quarterly for PBR (Ardentia) data and monthly for the RMC referral spreadsheets. The plan is to move to monthly updates for all information in the near future. All PBC information will now be posted up to the dashboard and the old "quarterly pack" spreadsheets have been phased out as a separate entity. Orientation and training is available if needed... please contact the WH.C office.

There is a lot of information within the dashboard, not all of which feels relevant. The reason is that the aim has been to develop a tool where anyone within the NHS in Somerset has access to the same information or data in the same format.

With the increased focus on rises in clinical activity/referral rates and budget over-spends, the dashboard can provide objective information regarding areas of high referral activity (and high cost). A tool to help guide clinician discussion has been developed and is attached to the elective trend reporting spreadsheet, but feedback suggests that the discussions using this information have been helpful in a much broader way: identifying learning needs, highlighting difference in practice between clinicians and throwing up potential organisational issues - helpful for audit, appraisal and revalidation.

Cardiology Flexible Healthcare Update

WyvernHealth.Com's proposals for the following diagnostic tests; BNP testing, an Open Access Echo pilot in the Yeovil locality and Ambulatory ECGs are currently under discussion with the Flexible Healthcare Group. We hope to give you further details regarding the timescales for implementation of these initiatives later in the year.

You will soon receive a GP Questionnaire from the Flexible Healthcare Team regarding Ambulatory ECGs and Direct Access Echo/BNP testing in Primary Care. Please do not miss the opportunity to comment on these proposals and have your views heard.

CAMHS Service Specification Workshop –Thursday 5 November 2009

The Commissioners for C&YP Mental Health and Psychological Wellbeing are organising a half day workshop with Somerset Partnership NHS Foundation Trust for Strategic leads from stakeholder organisations, young people and carers. The aim is to progress implementation of the new CAMHS Service Specification and there will be an opportunity for delegates to discuss the challenges and opportunities it brings. The draft strategy for mental health and psychological well-being will also be included with the half day with a wider group of stakeholders.

Events Details are:

Date: 5 November 2009

Time: 9.00 am – 1.00 pm

Venue: TBC

Refreshments: Tea, coffee and water only

Copies of the draft strategy for mental health and psychological well-being and the CAMHS Service Specification will be supplied via email before the event for your information.

Please inform Jo Sangster JSSangster@somerset.gov.uk at your earliest opportunity if you wish to attend.

Osteoporosis Review

As a practice you may have already done some work around osteoporosis; however we are conscious that this is an area that as a PBC group we need to look to address. There are relatively simplistic ways in which this can be addressed by targeting groups of patients as per our treatment guidelines and the **NICE technology appraisal TA160 and 161**.

The main focus of these reviews is to identify and to treat patients who are identifiable as in need of bone protective therapy by having certain known risk factors. This has a great many benefits naturally for the Practice, WH.C and, of course, patients.

The proposed review will help you meet the requirements outlined in NICE Technology Appraisal TA160, TA161 and the DES, as well as providing us with definable end-points for reducing hip fractures and possibly, a reduction in secondary care admissions.

In order to do this we have been offered the assistance of a team of pharmacists supplied at the expense of ProStrakan pharmaceuticals **but independent of them**. The pharmaceutical company will offer an independent pharmacist to carry out the work with **minimal** impact on your staffing resources. The audit review involves searching for patient groups at high risk of falls and fracture who may require calcium and vitamin D3 supplementation as follows:

- Patients with a diagnosis of osteoporosis currently untreated
- Patients currently treated with a bisphosphonate, strontium and not receiving calcium and vitamin D
- Patients >65 on long term oral corticosteroids (7.5mg prednisolone or equivalent >3 months)
- Patients over 75 with a previous low trauma fracture from the age of 50
- Patients currently non compliant with calcium and vitamin D3 defined as missing 1 Rx in 5
- Ambulatory elderly patients in nursing and residential care homes at high risk
- Patients currently receiving lower dose, non-evidence based calcium and vitamin D3
- Or any other specified by the practice

Once the patients have been identified, the assessment will need to be approved by a GP. When signed authorisation has been received, the independent pharmacists will implement any changes that the GP wishes on your computer system and letters will be generated accordingly, to ensure a minimal impact upon your time.

No switching, changes or additions to medications would be carried out, unless authorised by the practice. The company used adheres to all necessary patient confidentiality and data protection legislation.

The whole process should be completed within a day for an average practice and will take very little time of the GP involved and/or Practice Manager

To arrange the Osteoporosis Review please contact:

Diane Wilson, Medical Representative, on 07962341767 or via Email: Diane.Wilson@prostrakan.com

AUTISM AND ASPERGERS SYNDROME

Somerset Branch

Autism, in all its manifestations, is currently high on the agenda.

Responsibility for Asperger's Syndrome lies with the Community Mental Health teams of Somerset Partnership NHS Foundation Trust, supported by a small part-time Asperger Syndrome Consultancy team. Those with an identifiable Learning Difficulty, with or without a diagnosis of autism, come under the adult learning disability services administered by the Local Authority.

The powerful and moving "I exist" campaign on behalf of adults, was closely followed by a National Audit Office Survey revealing serious gaps in support for individuals and their families wrestling with a difficult condition. A private member's Adult Autism Bill is awaiting a third reading in the House of Lords. The Department of Health is currently working on an Adult Autism Strategy, following last summer's consultation exercise. Ministers have promised full support.

Both NHS Somerset and the County Council took the consultation seriously, arranging two events for families, agencies and providers from which Commissioners were able to draft a cross sector "Somerset" view.

Whilst awareness is much more widespread than hitherto, recognition, diagnosis and understanding is still difficult, particularly for families affected by High Functioning Autism/Aspergers Syndrome.

Whilst the general practitioner is most likely to be the first point of contact, the recent NAO report found that many GPs would welcome more information, particularly around Asperger's Syndrome.

My Branch is therefore mailing every practice manager in Somerset with copies of a simple flyer "A GPs guide to adults with Asperger's Syndrome", together with a particularly useful booklet "Social care" *Assessment of need for adults with an autistic spectrum disorder*, both published by the National Autistic Society. I hope you will find these useful. I can supply additional examples if required.

Campbell Main
Branch Officer
Email: campbell.main@farming.co.uk

Podiatric Surgery in Somerset

Interview with Julian James, Consultant Podiatric Surgeon

In 1998 Podiatric Surgery was first made available to patients in Somerset, through GP fund holding arrangements in the Bridgwater area. Initially patients travelled to facilities in Exeter for consultation and surgery undertaken by the Consultant Podiatric Surgeon, Clive Percival. In 2001 funding was transferred to Mendip Primary Care Trust as part of the reorganisation of Podiatry Service provision across Somerset. This provided the opportunity to provide a more accessible service for patients with Outpatients clinics developed in Bridgwater and Surgery lists at Minehead hospital. The service continued to be linked to the original surgeries in Bridgwater, and in 2006 expanded to primary care in the Minehead area.

As a small service it gradually increased and the decision to submit a business plan for expansion of the service was presented to the Primary Care Trust who commissioned the expansion of the Service across county.

In April 2009 the Podiatric Surgery Service was expanded to provide outpatient and surgery at West Mendip Hospital and outpatient clinics at Minehead hospital with an increased number of surgery lists there as well. The Podiatric Surgical team was clinically lead by Clive Percival, and managed by Alison Birket, Head of Podiatry and Professional Lead for Somerset Podiatry Service, under the umbrella of Somerset Community Health. Following Clive Percival's retirement in August 2009 the new Consultant Podiatric Surgeon, Julian James, took over clinical leadership.

Julian has put together FAQ on the Podiatry Service:

- 1. Are there many Podiatric Surgeons?** There are currently about 50 Podiatric Consultants employed within NHS Trusts. Podiatric Surgery has made an impact nationally on the provision of foot surgery.
- 2. What type of patient can be treated?** As this is day case surgery, the post-operative period is very important. All patients undergo pre-operative assessment prior to surgery and their suitability for the procedure and their aftercare in their own home is always considered. Patients should therefore be fit enough to undergo surgery, have home circumstances that make it safe for them to return home the same day, be physically and mentally able and willing to comply with the postoperative regime. The demographic profile for the last 5 years shows 65% of surgical patients are between the ages of 50 to 74 years and 82% are female.
- 3. What sort of surgery is undertaken?** All of the Podiatric Surgery locally is currently undertaken as elective day case carried out under local anaesthetic. It is very well tolerated by the patients and they are driven home by a relative or friend shortly following surgery. I am personally passionate about bunions! The commonest problem I see is the Hallux valgus deformity and the associated secondary problems of the hammer toe deformity. The deformity is corrected by cutting the bones, then realigning and fixing the bones with screws. It takes about 40 minutes and the patient is soon back on their feet, albeit on crutches for the first two weeks. These patients are so well motivated that they do really well post-operatively and are back to gentle walking mostly within 4 weeks. Lesser metatarsal pathologies, digital deformities, Morton's Neuromae, and soft tissue pathologies are very common but basically we operate on anything within the foot that requires correction. Some patients can present a real challenge such as the Rheumatoid Arthritics. I am fortunate to have had a lot of experience in this field and patients that I have previously treated have done very well following foot surgery. A small number of cases are more complex and present with problems which require rear foot and midfoot surgery for conditions such as posterior tibial tendon problems or multiple procedures. These cases take up more surgical time and require more intensive follow-up in post-operative out-patients but the results are worth it. The service has a wide selection of patient information leaflets which will be available on the Somerset Community Health website very soon and there are well established pathways into the acute Trusts in the unusual case of post-operative complications. I use a nationally recognised audit program to monitor surgical outcomes and I am proud to have a low rate of post-operative infection.
- 4. How do GPs refer to the service?** As with many Primary Care Trusts, NHS Somerset uses the Musculo-Skeletal Interface Service (MSIS) to triage referrals. All referrals have to pass through the

Referral Management Centre. There is a very experienced Podiatrist on the MSIS team who redirects referrals that require surgery. However many patients can be helped with the conservative care that they undertake. I personally take the view that all conservative care should be considered before entertaining surgery.

5. **Future development** I am really keen to expand the service further and get out into the community and meet up with as many GPs as I can. I am hopeful that I will be able to visit group practices during their lunchtime meetings to chat to them about how the service can help their patients. I really want them to know who they are referring to and for them to have a chance to chat about their concerns. Successful foot surgery relies so heavily on patient education and understanding and so that's why I always ask patients to feedback to their GP about our service.

A patient undergoing Hallux Valgus correction by osteotomy. The first metatarsal is cut, realigned and held by the clamp prior to being fixed with Titanium screws. The patient is fully conscious but not watching!



**Julian M James,
Consultant Podiatric Surgeon**

Email: Julian.James@somersethealth.nhs.uk



An Introduction to the Medical Electronics Department

The Medical Electronics Department (MED) is based at Musgrove Park Hospital (MPH). It maintains 9,000 devices for MPH, and a further 2,500 devices in community hospitals, surgeries and health centres. The Medical Electronics Department provide specialist technical and scientific expertise. These skills underpin their planned electrical and functional testing service.

They are also able to repair many items in-house, and in doing so keep turnaround times to a minimum.

The department provides a wide-ranging service, to include:

- A telephone fault-finding advice line
- The testing of new equipment, prior to deployment in practices
- Co-ordination of manufacturer/ third party repairs when necessary
- Asset purchasing and disposal advice

The services provided by MED also ensure that your GP practices comply with National Standards.

A Financial Anomaly

The current position is that services are provided to 40 surgeries, some of which are charged for, and some of which aren't. (In passing there are therefore another 35+ surgeries in Somerset which presumably have made arrangements with other third parties).

The MED Team, under their manager Paul Derrick, have explained to WH.C that they need to be paid for all of the work they do. Individual GP practices can therefore expect to receive quotes for both testing and repairs of patient connected equipment, from now on.

The 'Bigger Picture'

They suggest that there may be a general need to cover this area of risk in a comprehensive way, because whilst the above puts a charging mechanism in place, it is not the same as having a contract which wraps this area up properly.

To this end they have offered to help practices by providing the following information:

1. A document explaining the significance of this area from a business risk point of view.
2. If you would the MED team to help you evaluate this area on an individual practice basis, they ask you to:
 - Register your interest by email: medical.electronics@tst.nhs.uk
 - Email your equipment lists to them **by 23 October**, a template is shown below.
3. Individual practice quotations together with a detailed service level agreement specification will be sent out as soon as possible thereafter.

The MED Team have asked that those who wish to sign-up for their services do so by the *end of December 2009 please*. This is to assist their resource planning.

After this time, MED will only be able to test and repair items from individual GP practices, if an underlying signed agreement exists between the parties concerned.

Equipment Template:

	A	B	C	D	E	F	G
1	Device No	Old Device No	Serial No	Model	Manufacturer	Description	Estimated Purchase Date
2	13187	SPSURS001	7 693 320 191	EKG503V ECG M/C	Philips	EKG503V Mains/battery ECG Machine	27/09/07
3							
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31	Columns A - E are crucial fields.						
32	Please try to complete as much detail as possible and identify any new kit that has not been assetted by serial number/model/manufacturer. We will						
33	add these items to our database when seen by a technician.						

This is the old asset number which will eventually be replaced by the new numeric 'Device No'.

This is the numeric asset number generated by our new database. This will be on new equipment purchased since August 2008 and on all equipment seen in ME since August 2008. This number replaces the 'Old Device No'.