

SEISDON PENINSULA LOCALITY COMMISSIONING GROUP

Practice Based Commissioning Annual Report 2009/10



Seisdon PBC 2009/10 Achievements

Introduction

The Seisdon Peninsula Locality Commissioning Group (SPLCG) consists of 8 member practices covering the areas of Claverley, Kinver, Wombourne, Bilbrook, Codsall, Pattingham and Perton.

The 2009/10 PBC plan focused on:

- proactive hospital admission avoidance schemes
- tackling the health prevention agenda.
- Delivering national policies
- Delivering local PCT objectives

Areas of achievements

In the last year SPLCG has started to shape new services and take forward this agenda. Here are some of the highlights:

- Mental health services - increased number of primary care mental health workers. Won partnership award for the "no delays" service improvement project in the Mental Health Division of South Staffordshire & Shropshire Healthcare NHS Foundation Trust.
- Completed patient & public consultation on prioritising local health services
- Worked towards integrated care with the co location of health and social care staff and additional clinical space for new services at Bilbrook house.
- Developed a community lymphoedema service through partnership working with Compton hospice.
- Began to address obesity by introducing a childhood obesity team and adult weight management.
- Healthnet - new service that works with people who do not routinely access services.
- Established a falls service.
- Performed a review of intermediate care services.
- Developed a practice deep vein thrombosis (DVT) pilot
- Performed a review of community diabetes service
- Held an awareness raising event to further develop partnership working with South Staffordshire District local authority and PBC.

Seisdon PBC Chair wins South Staffordshire and Shropshire Healthcare's Mental health Partnership award

The Seisdon Practice Based Commissioning team and the South Staffordshire and Shropshire Healthcare Foundation Trust community mental health team were recognised for their achievements in joint working to deliver a primary care mental health service to the Seisdon Peninsula area.

The event held on the 15th October 2009 at the County Showground in Stafford, was organised by the foundation trust, under the name of the 'Alternative Oscars'. The awards celebrate the contributions to patient care from various teams and individuals. This year the event was hosted by TV weather girl Emma Jesson and saw over 100 nominations for 12 categories.

Sue Brookes, Seisdon PBC Chair and Kevin Greenhough, Mental Health team leader jointly won the Partnership Award. They were both acknowledged for developing services that are person centred and enable working across organisations. Sue Brookes, Seisdon PBC Chair has worked in partnership with the Mental Health Trust to develop and implement primary care mental health workers that are integrated into the community.

An example of the type of cases/work undertaken is demonstrated in one case study (see appendix 1).

Patient prioritisation survey

Seisdon Peninsula PBC recognises the challenges in the current economic climate and the effect that this has on resources. PBC recognise that any investment or service needs to provide value for money and make a difference to patients. So that services are better directed a survey was carried out to find patients views.

4,500 surveys were sent out to randomly selected registered patients. There was a 30% return rate.

People were asked their views on 10 areas and were asked to rank what they felt should be concentrated on as it was not possible to prioritise them all equally.

The top 4 priorities are:

1. Social and practical support for isolated older people
2. Supporting people who are approaching the end of their lives
3. Supporting healthy lifestyles
4. Support for carers and their families

The areas least favoured were support for parents, subsidised rural transport scheme and chiropody.

65% felt that money should be spent on those with greatest need even if this involved expensive treatment.

68% felt that the NHS will save money long term by spending money on preventive measures.

Bilbrook house

Bilbrook House is a former older people's residential home which is owned by Staffordshire County Council. The building is now an integrated health and social care facility for older people and people with complex needs.

Community teams consisting of district nurses, intermediate care, primary care mental health workers, podiatrists and physiotherapists have been co-located to Bilbrook House with the Social Services Enablement team in Bilbrook on Friday 4th December. This additional facility has provided much needed space to allow more services to be delivered locally.

Lymphoedema service

Lymphoedema is a long term condition that causes swelling due to the retention of lymphatic fluids in the body. For some, it is a condition that they are born with but for others it may be as a result of an injury, surgery or an infection.

The effects can range in severity from mild to severe and complex swelling that can lead to health threatening complications, affecting any part of the body, but most commonly affects the arms and legs.

Seisdon Peninsula Locality Commissioning Group (SPLCG) has developed a new community service to treat lymphoedema, in partnership with Compton Hospice.

Commissioning the service now means that a nurse will be available to care for people in the community who are suffering from mild to moderate symptoms. Severe and complex cases, requiring specialist care will continue to be treated at Compton Hospice who will also provide clinical supervision, support and training for all community lymphoedema nurses.

Tackling obesity

1. Childhood obesity team

HEALTHY KID5 - SOUTH STAFFS DISTRICT is an integrated child healthy weight programme developed in partnership with Seisdon Peninsula PBC, South Staffordshire District Council and South Staffordshire School Sport Partnership.

The programme currently consists of 2 levels:

- Promoting a healthy weight and preventing overweight/obesity
- Support children and families who are known to be 'at risk' of becoming overweight or obese.

A wide variety of activities are undertaken, usually in partnership with other health workers, (eg: school nurses, health visitors), Children's Centres, Community Learning Partnerships, local district council. For example: promoting healthy eating and activity at school sports days, healthy lunch box talks in schools, weaning talks.

The Team consists of a specialist school nurse, advanced paediatric dietician, physical activity workers and a programme support worker. They deliver prevention activities as well

as providing individual advice and support to children and their families who are at risk of becoming overweight or obese. The team will work closely with other professionals involved in supporting children from birth to sixteen and their families by agreeing health goals. They will provide regular follow-up and support, advice from a physical activity worker and access to physical activity programmes.

2. Adult weight management schemes

Slimming on referral

SPLCG have introduced slimming on referral scheme run by Weight Watchers to help people who have health issues and who would benefit from losing weight. This scheme is not for those who normally attend commercial slimming classes.

Patients are referred by their GP or practice, whereby patients are given a set of vouchers to attend any meeting at a Weight Watchers that best suits them at a local venue. People will be asked to attend 12 sessions.

Waistlines - adult management programme

Waistlines is a Tier 3 specialist weight management service that aims to support weight reduction for people with a BMI greater than 40 or at risk of requiring bariatric surgery. This is a Cognitive Behavioural Therapy (CBT) NHS dietician led service.

Service criteria is:

- BMI >35 plus co-morbidity
- BMI >40
- Or unsuccessful on other programmes and need more support.

This dietician led service consists of a mix of an assessment and up to 6 follow up sessions, 1-2 months apart. Support consists of behavioural motivation/lifestyle/ complex issues and advice on undertaking physical activity.

In addition this service treats people with morbid obesity within the Community/Primary Care setting. The Service will be suitable for patients with morbid obesity for whom Tier 2 and the Waistlines interventions in primary care have not been successful. This service will ensure that all options have been tried before someone is considered for bariatric surgery.

Healthnet

The Health NET project is a partnership service which provides information, advice and support to individuals/families in need, enabling them to address issues within their lives by accessing appropriate support services. This service is jointly funded between health and Social Services.

This service is aimed at individuals and families with multiple or complex needs which make it difficult for them to access available services and has a proven track record of being able to deliver a much needed service to the most disadvantaged members of the community, particularly; people of low income, lone parent families, homeless individuals/families, people with learning disabilities/difficulties and people with mental ill health.

Health NET is now being developed so that it can provide a targeted prevention service rather than the referral basis it has previously operated under.

Partnership working with the Provider Arm

PBC have worked closely with the Provider Arm and Intermediate Care team and developed a proposal for a Care Closer to Home team for the case management of people with long term conditions and those with high complex needs and at highest risk of hospital emergency admissions.

Work is ongoing with the Provider Arm to continue to shape this service.

Practice Deep vein Thrombosis (DVT) pilot

Practices in Seisdon are piloting offering a near patient testing for people with suspected DVT in their own practice.

A patient presenting to the GP with a suspected DVT has a clinical prediction of DVT made by using the Wells tool. If there is a low probability of DVT, a D-Dimer test is performed. If negative, a diagnosis of DVT can be safely excluded.

Review of community diabetes service

A review of the current community diabetes service has been undertaken with the objective to commission and ensure the delivery of a high quality integrated health service to people with diabetes in the Seisdon Peninsula. This service should be:

- Patient centred
- Community focused
- Education based
- Integrated between primary and specialist care

Work is ongoing with the Provider Arm to implement this service redesign.

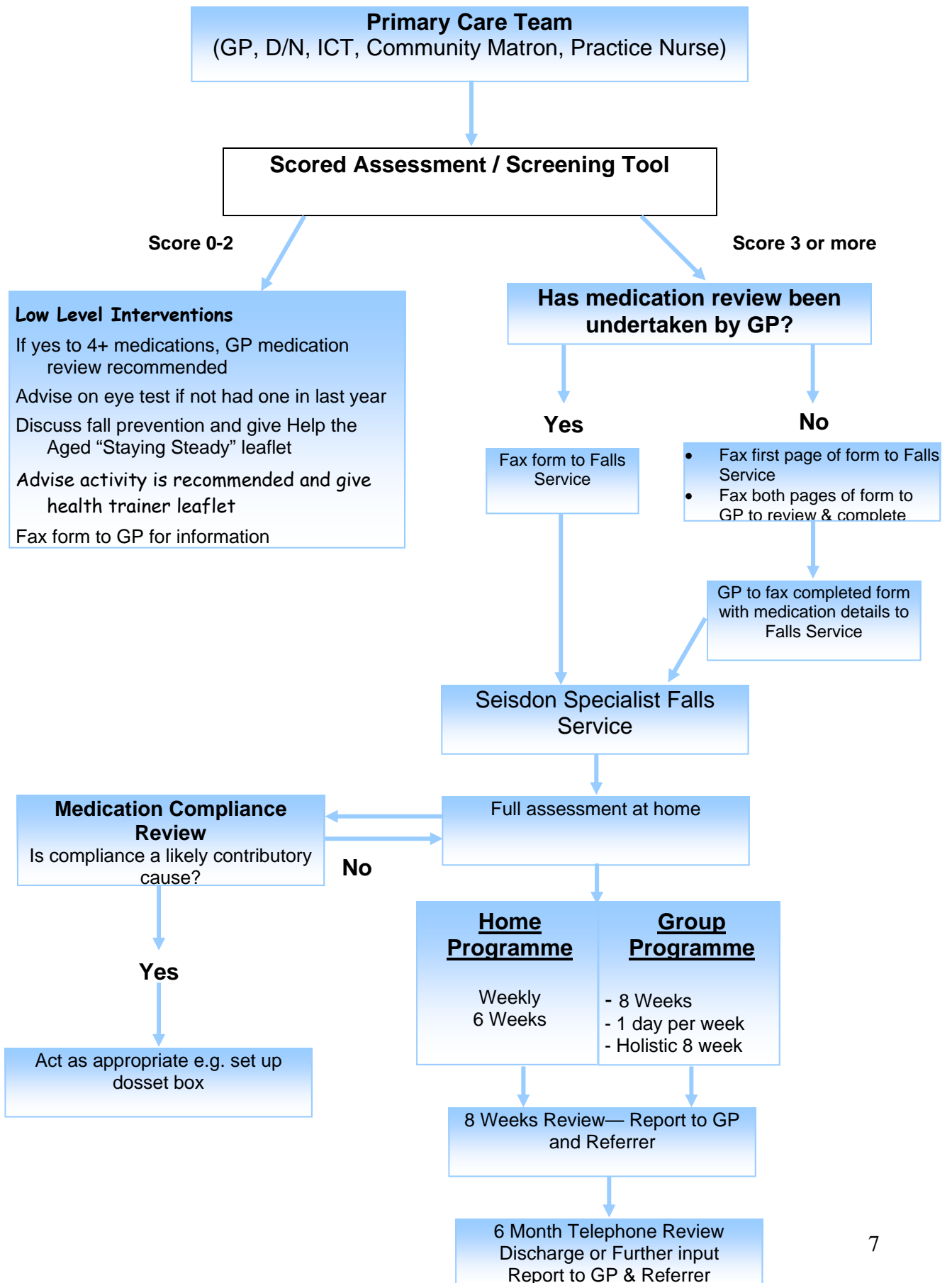
Falls service

A new falls service was introduced this year to reduce the risk of elderly people falling.

GP or healthcare professionals identify suitable patients and carry out a risk assessment to identify suitable course of action. Those who are at a high risk of falling are sent to the falls team for an assessment.

See pathway below for details.

Seisdon Falls Pathway



Partnership working

South Staffordshire district council local government event

Seisdon PBC Chair and clinical lead held a joint event with South Staffordshire district council with a focus on understanding how practice based commissioning works. The evening was well received with examples of cross border issues being highlighted that affect health and local government.

This has led to presentations being set up with locality working events across the South Staffordshire district council area.

Appendix 1

Case Study Simple Phobia Primary Care Mental Health Workers

This case study has been completed in accordance with South Staffordshire and Shropshire Foundation Trust Policy to protect confidentiality.

Brief client history

The client is a 36 year old women married with 2 young children. She has experienced irritable bowel syndrome since the age of 8 and reports that this has always had a large impact on her life. She felt that she has always lacked confidence, low self esteem and found social situations extremely difficult. The client had had a previous episode of depression aged 22 when she was prescribed anti depressants.

Presenting problem

The client presented with symptoms of depression and anxiety, but had declined anti depression medication from her GP and instead expressed that she wished to challenge her thoughts and behaviours.

The initial assessment enabled us to gather information as to the extent her symptoms were impacting on day to day living. The initial assessment also enabled us to identify clear and appropriate treatment goals combined with regular scheduled reviews of therapy, using the PHQ9, GAD7 measurement tools.

On investigation, it became clear that the client's perception of her IBS further increased her anxiety, and she had consequently developed unhelpful behaviours to cope with her perceived problem. These behaviours included: avoidance, numerous safety behaviours for example: wearing incontinence pads, carrying spare change of clothes, she always wore dark coloured trousers and the occasional use of medication (Imodium) because of her fear of unexpected incontinence.

These behaviours served to maintain her fears and severely restricted her activities particularly with regards to interaction with her children. They also had an impact on her mood, and led to negative thoughts of being inadequate as a mother and therefore a failure.

Although there appeared to be a clear link between the client's anxiety and the IBS; dietary factors were also taken into consideration and we therefore discussed the option of returning to the G.P. for further investigation.

Goals for treatment

- Gradual improvement over longer periods
- Bring about small specific changes which are helpful to the client
- Helping the client lead a fuller life within the constraints of IBS
- Reduction of distress associated with the problem (anxiety, depression and low morale)

Treatment interventions

It was important to socialise the client with the cognitive model which provided a basic mental set for understanding the nature of treatment. This included education around CBT, discussion on the patient's own role in treatment, reading material to assist socialisation and a demonstration of the model used i.e. the links between cognition, anxiety and behaviour

Outcome

PRE THERAPY

PHQ9 = 16
GAD 7 = 19

POST THERAPY

PHQ9 = 3
GAD7 = 5

Sessions: 12





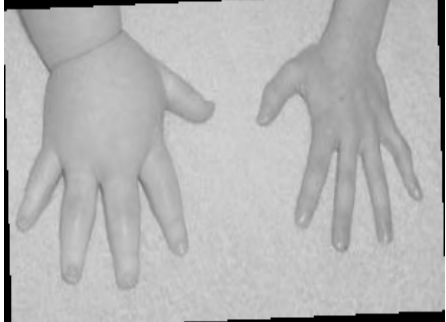
The client had a significant decrease in mood, anxiety and physical health problems (gastrointestinal disturbance)

On the last session the client summarised how her life had changed;

"I feel so much better, and feel so proud of how I now challenge my thoughts. I now manage to go to school everyday without thinking "I need to go to the loo". I feel more confident in making decisions at home less dependent on my husband and enjoy taking the initiative.

I have now joined the school PTA and am comfortable being with a circle of people and have taken on tasks I would not have done before and I now feel I have my life back and can be a proper Mum."

Services Seisdon Peninsula PBC have introduced

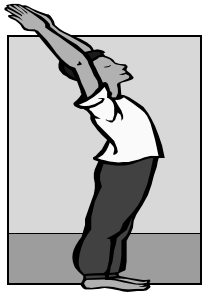
	<p>Weight management programmes</p> <ol style="list-style-type: none"> 1. Slimming on referral - voucher scheme with Weight Watchers (Tier 2). 2. Waistlines - NHS specialist dietician service. (Tier 3)
	<p>Falls prevention team aims to reduce the number of falls experienced by elderly patients. The team will assess risk of falling and then offer training and education to reduce your risk.</p>
	<p>Health Net offers advice and information to people worried about finance, housing, health, employment, education or experiencing difficulties in their day to day lives.</p>
	<p>Primary care mental health workers This service is available for people with mild to moderate mental health/anxiety. The primary care mental health workers will spend time on a 1:1 basis with the option of a variety of community venues in different locations.</p>
	<p>Lymphoedema community nurse. All referrals are sent via Compton Hospice. A nurse will be available to care for people in the community who are suffering from mild to moderate symptoms.</p> <p>Severe and complex cases, requiring specialist care will continue to be treated at Compton Hospice.</p>



Health Trainers work with a wide range of other support services to make sure that you have the best support and advice for your personal lifestyle needs.



Community Alcohol worker provides a holistic assessment and treatment for people with problem drinking.



Musculoskeletal Integrated Service - increased community physiotherapy and reduction of waiting times.