Discharge criteria:-

- When patient's condition is optimised and is at optimum level of self-management, and management plan is in place.
- Patient non-concordant/not engaging.
- Patient moves out of area.
- Patient refuses service and has mental capacity to do so.

How to refer;-

- Discuss at Virtual ward / MDT meeting / enquiry with LTC Nurse

Complete referral form and send to;- E-Referral

All staff carry identification badges

Livewell Southwest

Partners in Care

@livewellsw

21/01/2019

Livewell Southwest

Long Term Conditions Service

The Long Term Conditions Service is delivered throughout Plymouth, by Community Matrons supported in the city by Associate Matrons

Plymouth:
North Locality—01752 434548
East Locality—01752 434155
South Locality—01752 434332
West Locality—01752 434627

Monday—Friday 09:00–17:00
(excluding Bank Holidays)

Out of Hours
If you need medical assistance call 111
For urgent care call 999

Supporting people to be Safe, Well and at Home

Introduction

The role of the Community Matron is to work as an autonomous nurse at an advanced level, making complex clinical decisions, and using expert clinical judgement to improve clinical and quality of life outcomes for individuals with complex health conditions. Many in the LTC team have independent prescribing and Advanced Clinical Skills Qualifications.

We aim to improve the management of patients with unstable or unpredictable health conditions and reduce GP calls out; unnecessary hospital admissions whilst improving quality of life. Patients who are at risk of being unstable without intervention are also seen.

We seek to empower patients and their carers by providing education and support to maximise their health and wellbeing and improve their independence and ability to self care.

The duration of time we see patients depends on their needs and our ability to effect a positive outcome.

Once optimized and a clear Management Plan is in place, we will discharge from the Long-Term Conditions Caseload.

What we deliver:

- An in depth health needs assessment / CGA for Over 65s.
- Medication review—many of the Matrons are independent prescribers.
- Formulation of an individualised plan of care to help patients manage their health condition more effectively.
- Referral to other professionals for further investigations or assessment if needed.
- Multi-disciplinary working.

Referral Criteria;-

The inclusion criteria has been relaxed to encourage GP/MDT discussion and a focus on achievable goals, rather than on a problems-based approach.

Inclusion Criteria:-

People must be 18 or over, registered with a GP in the Livewell footprint and have consented to referral.

- Individuals must have at least 1 long term condition that is unstable or impacting on their health or potential for health deterioration.
- There must be an identified outcome to plan for and have at least 1 of the following criteria:
  - ◊ 1 or more unplanned admissions/non-conveyed calls in the last year
  - ◊ 1 or more contacts with urgent care services in the last year eg. CCRT, AAU
  - ◊ Polypharmacy or concerns regarding medication management
  - ◊ 1 or more falls in the last year
  - ◊ Discussed with LTC team/MDT and deemed at high risk of deterioration or increasing frailty

Exclusion criteria:-

- Anyone who does not fulfil referral criteria
- Where a patient has social needs only
- Emergency referrals
- Patients not registered with GP in Livewell footprint
- Patient declines the service or unable to make contact with person
- Patient proven to be non-concordant with reason for referral.