Livewell Southwest

Long Term Conditions Service

The Long Term Conditions Service is delivered throughout Tavistock and West Devon, by the Community Matron and supported in the area by a Health Care Assistant

Tavistock and West Devon
Emma Spettigue
07989 203166
Or 01752 436508

Monday—Thursday 08:30–18:00
(excluding Bank Holidays)

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

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 Long Term Conditions (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 LTConditions caseload.

What we deliver:

- An in depth health needs assessment / CGA for Over 65s.
- Medication reviews as 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/Multi Disciplinary Team (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 one 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 one of the following criteria:
    - One or more unplanned admissions/non-conveyed calls in the last year
    - One or more contacts with urgent care services in the last year eg. CCRT, AAU
    - Polypharmacy or concerns regarding medication management
    - One 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

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 Complex Care Team Meeting / MDT meeting / enquiry with LTC Nurse
- Complete referral form and send to: E-Referral

All staff carry identification badges

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Partners in Care

@livewellsw

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