Agenda Item 6

Haringey NHS
Teaching Primary Care Trust

HTPCT Response to Overview and Scrutiny Review-
High Impact Users of Healthcare

Background to Report

The review was set up in response to a suggestion from the Haringey Teaching Primary Care Trust (TPCT). The term "high impact user" is used to describe patients who have several - at least three - emergency hospital admissions in a year. These repeated admissions cost the NHS more then £2 billion per year. Research has shown that many of these admissions could be avoided, better patient outcomes secured and resource savings made.

1. High impact users tend to have one or more long-term conditions (LTCs). People with LTCs are the most intensive users of the most expensive services. This not only includes primary and specific acute services but also social care, community services and urgent and emergency care. They are responsible for 75% of the occupancy of hospital beds and almost half of GP consultations. The cost of managing LTCs in hospital is predicted to rise by more then 40% in the next 20 years simply as a result of the population ageing. The introduction of practice based commissioning will mean that the financial burden of these admissions will fall upon the budgets of GPs.

2. In addition to having long term conditions, high impact users are characterised by having complex social circumstances and/or additional mental health problems, including anxiety and depression. They are most likely to be older people, who make up a large proportion of people with LTCs, and there is also a link with social and economic deprivation. In addition, there is also a correlation between demand for emergency hospital admissions and the accessibility of primary care services in a locality.

3. Several reports and research findings have highlighted the fact that there is strong evidence that interventions in the community can reduce these emergency admissions, as well as lengths of hospital stay, leading to improved care and the potential for savings to be made. In particular, studies in the US on hospital usage have categorised 19 chronic illnesses as "ambulatory care sensitive" (ACS). For these conditions, timely and effective out-patient care can help to reduce the risks of hospitalisation by preventing the onset of an illness

or a condition, controlling an acute episodic illness of condition or managing a chronic disease or condition. Repeat emergency admissions within Haringey for conditions, which it is felt, are sensitive to such interventions cost the TPCT £1,755,130 in 2003/4 and involved 675 patients.

4. It is a government priority to improve care for people with long-term conditions by moving away from reactive hospital based care towards a systematic, patient-centred approach. This is based on several relevant reports such as the Royal Commission on Long Term Care (1999), Independence, Well-Being and Choice (2005), Commissioning a Patient Led NHS (2005) and Our Health, Our Care, Our Say (2006), as well as National Service Frameworks, such as the ones for older people, coronary heart disease and long term neurological conditions. These emphasise the fact that the majority of patients prefer to be treated close to their own homes.

5. 'National Standards, Local Action' (2004), set the following national target for Long Term Conditions (LTCs):"To improve outcomes for people with LTCs by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (From the 2003/2004 baseline), through improved care planning in primary care and community settings for people with LTCs."

Aims and Objectives of Review

1. To analyse relevant statistical information on patients presenting at Accident and Emergency and the conditions represented.

2. To assess progress in improving the effectiveness of health and social care services in supporting vulnerable patients with long-term conditions that make them a high risk for repeat emergency admissions to hospital.

3. To consider whether current provision provides value for money.

4. To assess the potential benefit of any proposals for future development of services.

5. To consider ways in which health and social care services can work better together to help avoid emergency hospital admissions

Terms of Reference

"To consider the effectiveness of health and social care services and the voluntary sector in supporting people at particular risk from

repeat emergency admission into hospital and, in particular, in preventing avoidable admissions and to make recommendations on how services can be improved to the Council's Cabinet and local NHS services".

Members of Review Panel:
Councillors David Winskill (Chair), Wayne Hoban, Harry Lister and Toni Mallett.

Recommendation 1: That the TPCT work with the Council's Adult Services and in liaison with local NHS acute trusts to develop a specific strategy and action plan to provide integrated health and social care services for people with long-term conditions. This should: • Adopt a strategic evidence based approach • Include clear definitions in order to ensure that there is a common and clear understanding of which patients should be targeted • Provide for financial integration between the TPCT and Adult Services in relevant services • Address how information can be better shared Include proposals for enhancing the role of preventative technology, such as telecare.	**Agree**	-The forthcoming Rehabilitation and Intermediate Care Strategy will outline more clearly the joint HTPCT and LBH direction in relation to the provision of services for people with long term conditions. The strategy will be based on identified health need, clear evidence and best practice in relation to people with long term conditions. -The strategy will ensure that there is clarity in relation to the client groups the strategy is aimed at, and will ensure that all definitions are clear and easily understood. -It is recognised by both organisations that there will significant benefits for people with LTCs in providing the services required in an integrated (Across health and social care) model. This will reduce duplication and 'hand-offs' within the client pathway, ensure that the person is seen by the right professional at the right time and it will also afford economies of scale for both organisations through the reduction in duplication of processes that currently exists in the care pathways. -HTPCT and LBH have a positive history in the use of Health Act Flexibilities through the use of pooled budgets for the Integrated Equipment Store and in lieu of fines being imposed for delayed Transfers of Care. In scoping the Rehabilitation and Intermediate care Strategy, both organisations have recognised that in order to provide an effective integrated service, it will be necessary to use this mechanism to fund the service; this will provide greater flexibility in the use of budgets. -HTPCT and LBH have already used Telecare to good advantage for patients through the Community Matron service us of Wristcare. Both organisations recognise the value of using Telecare solutions in the preventative agenda, and are keen to maximise its use to the benefit of people with LTCs.

Recommendation 2: That the TPCT adopt the principle that all future local information systems that are developed be patient centred rather then focussing on either episodes of illness or disease based and compatible with software used by the Council's Adult Services.	**Agree**	New systems being implemented (RIO), do provide a person centred approach to information management. HTPCT has been exploring with LBH for some years, ways in which the IT systems of both organisations can be better integrated. However, much of this is reliant upon strategic work at National level.
Recommendation 3: That Haringey TPCT takes specific and urgent action to increase the number of Community Matron posts to achieve its target level for March 2008 of 21 by September 2008.	**Disagree**	**-** HTPCT is no longer specifically targeted on the numbers of community matrons. In the light of this, HTPCT commissioners and provider services have been reviewing the role of the community matron through the mechanism of the community matron action plan. It has become clear that there is a greater need to provide skill mix within the community matron service, and more explicit pathways from the community matron service, to and from other services. **-**The model of care that will be recommended in the Rehabilitation and Intermediate Care Strategy will provide a better integration of services, and will provide community matrons with the resources that they need to more effectively manage patients, such as rapid access to physiotherapy, occupational therapy, psychology, home care and equipment- for example. In the meantime, the roles of case manager and community matron assistant have been implemented to provide the service with additional resource. The role of community matron for nursing and residential care homes has also become operational over the past 4 months, and has already had considerable impact. **-**Work is also on-going around falls services which will see clearer care pathway implementation and better links across London Ambulance and the Integrated Therapy Team; this should reduce the workload for such patients going into the

		community matron service.
Recommendation 4: That evaluation of the effectiveness of Community Matrons by the TPCT include specific reference to their role in improving the quality of life of patients and the support given to carers.	**Agree**	This has been picked up through the on going evaluation of the services, where a client satisfaction survey will become part of the evaluation of the service.
Recommendation 5: That the TPCT, as part of its consideration of the extension of intensive nursing at home, commission a feasibility study on the potential benefits of the setting up of a primary care intravenous drug administration service.	**Agree**	HTPCT recognises that there is a growing need to provide such a service in the community. This will enable increased numbers of people to avoid unnecessary hospital admissions, and greater numbers of people to remain at home at the end of their lives. This service will be further explored through the development of an End of life Strategy over 2008/2009.
Recommendation 6: That the TPCT, in liaison with its partners, takes urgent action to improve the levels of psychiatric liaison at the North Middlesex Hospital and, in particular, that which is provided for A&E and to address the needs of older	**Agree**	This will be explored through the development of an Older People's Mental Health Strategy over 2008/ 2009. Discussions are already taking place across HTPCT, BEHMHT and NMUH.

people.		

Recommendation 7: That the TPCT improves information sharing with Camidoc and that this includes taking into account data from Camidoc in helping to identify appropriate high impact users for CMs to case manage and systematically informing Camidoc of complex cases, including all high impact users that CMs are working with.	**Agree**	This is being picked up through the implementation of Urgent Care Pathways for Older People. The systems implemented will be able to include all vulnerable older people, as the work progresses. Work currently being progressed around Falls services will act as a 'pilot' project for links with Camidoc and LAS in terms of highlighting HIUs, and sharing agreed care management plans. The roll out of the client held record for people with long term conditions over 2009/2010, will act as a further mechanism for information sharing across organisations. It will contain information about all LTCs that a person may have, including results of tests, and care management plans.
Recommendation 8: That the TPCT undertake, in liaison with Haringey Adult Services and appropriate voluntary sector organisations, a programme of capacity building work to develop patient support organisations and networks.	**Agree**	This is another theme picked up in the Rehabilitation and Intermediate Care Strategy. Both organisations recognise to importance of having strong voluntary sector organisations that are willing and able to respond to their commissioning needs for low level supportive and preventative services.

PATIENT JOURNEY

CURRENT

OLDER PERSON HAS A FALL AT HOME, AND IS FOUND ON THE FLOOR BY A NEIGHBOUR-

NEIGHBOUR DIALS 999

Ambulance arrives, staff assess client and find that she has not sustained serious injury, but will need some support and rehab in the short term.
Referral made to East/West Integrated Team

Ambulance arrives takes client to A & E

Client triaged in A & E, and waits to see Doctor

Doctor examines client, client is shaken and bruised and wrist swollen and painful, but has not sustained serious injury, can go home, but will need assistance on a short term basis

Referred to 'Rapid Response Team'

Waits to see Rapid Response Team who request home care and refer to ICT

Waits for ambulance to take home

Arrives home waits for home care (will be seen by ICT next day)

FUTURE

East/West Integrated Team assess referral – OT visits within 2 hours of referral bei
CURRENT
PATIENT JOURNEY
FUTURE ng received, and assesses client, and refers client to following services

District nurse to attend to wound to leg sustained in fall

Home Care Service – package put in place/

OR, admitted to nursing/ residential care home for short period- according to assessed need

East / West IT Physio

HICES – raised toilet seat

Metropolitan Care and Repair – make safe loose carpet

Meals on Wheels

Community Alarm Service

Referral to community matron/ case manager-if appropriate

Referral to case manager to track patient following interventions