Haringey Council

Scrutiny Review – High Impact Users of Healthcare

A REVIEW BY THE OVERVIEW AND SCRUTINY COMMITTEE

APRIL 2008

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Chair's Introduction

Any visit to hospital has the potential to be a stressful and upsetting experience. If the person involved is old, suffering from one or more chronic conditions or has dementia, it is all the more distressing. Every visit absorbs large amounts of NHS resource and costs the Service a great deal of money.

Since starting this review I and my fellow panel of Councillors have met many people representing our local helath providers, the voluntary sector and Haringey Council. It is clear that are all working very hard to ensure that unnecessary hospital visits are reduced and, as far as possible, those with long term conditions receive appropriate treatment in their own homes or in the community.

However, we learned that there are some very basic but creative solutions that could be applied to the Haringey model of health care. We have used many of them as the basis for our recommendations in this report.

The report is delivered at a time of great change for the NHS. One of the key themes that is emerging is that primary care should be the predominant channel of service delivery. This will require a great deal more joined up thinking but, more importantly, an end to the "silo culture" that has dominated much of health provision up to now. We need to be thinking in terms of seamless service delivery and start the process of an honest and open debate on shared budgets.

This spirit, in tandem with the adoption of our recommendations, has the potential to significantly improve the outcomes and quality of care for the patients groups who are the subject of this study.

The panel would like to extend its warm appreciation to our adviser, Professor Sue Proctor for her constructive help and advice, as well as all those officers, volunteers and health professionals who gave us so much of their time and support.

Cllr David Winskill

Executive Summary:

A relatively small percentage of patients are known to generate a disproportionately high percentage of hospital admissions. The majority of these people are old, vulnerable and come from deprived areas. Many of them could be treated more effectively in their homes but health and social care services require further coordination and development before they will be able to do this effectively.

Although there are currently proposals in the "Healthcare for London – A Framework for Action" report to remedy this, community based services will require up front investment before savings can be achieved: this has still to be addressed. In particular, there will not be the number of GPs in post within the Borough by 2011/12 to deliver the model proposed. Keeping more people out of hospital not only has the potential benefit the NHS in the long term by saving it money and freeing up resources, but perhaps more importantly it can greatly improve the quality of life of patients.

It is the view of the Panel that health and social care services need to be better integrated in order to improve services for high more impact users. There needs to be clarity concerning which patients should be targeted for interventions and how. Good information is key to effective targeting but NHS information systems are currently unable to do this effectively and not compatible with social services systems. Information systems that focus on the overall patient experience rather then episodes of care or diseases need to be developed.

Information technology and telecare initiatives designed to support patients in their own homes currently has some limitations and shortcomings but has immense potential. However, costs can deter patients from taking advantage of it as well as providing a disincentive for Adult Services to invest in it. However, the savings that can be made by the NHS from the use of this equipment can considerably exceed its costs. The transfer of resources from the NHS to Adult Services to support this would not only save it money but would improve the quality of life for patients and carers.

Community matrons are already working well within the Borough but the PCT has not met its target for the number of posts to be created. Although evidence on their effectiveness is not yet conclusive, there are substantial indications that that they are working effectively enough to justify their numbers being increased to target levels within the Borough. In addition, evaluation of their effectiveness should not simply be in terms of reducing hospital admissions and should give prominence to their role in improving quality of life for patients and their carers.

A significant number of high impact users are suffering from mental illnesses and it is important that this is identified by local hospitals. There is a shortfall in psychiatric liaison provision, particularly for older people, at the North Middlesex Hospital and it is important that the TPCT works with its partners to resolve this issue speedily.

High impact users are likely to be significant users of out-of-hours services and it is essential that these are linked into other health and social care services so that appropriate health professionals are properly informed about the patients that they see and other services are alerted to any concerns.

Finally, there is a lack of patient support groups within the Borough for people with long term conditions. These can play a useful self help role in building confidence, sharing information and spreading advice on disease management. A relatively small investment in developing and sustaining them may have the potential to provide benefits and generate savings.

Recommendations:

Strategic Responses:

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**.**

Identifying People at Risk:

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.

Addressing the Needs of High Impact Users - Haringey TPCT:

Recommendation 3:
That Haringey TPCT take 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**.**

Recommendation 4:
That evaluation of the effectiveness of Community Matrons include specific reference to their role in improving the quality of life of patients and the support given to carers.

Services Provided By Haringey TPCT's Partners:

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.

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 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.

The Role Of Voluntary Sector Organisations:

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.

1. Background

1.1 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.

Aims and Objectives

1.2 The aims and objectives of the review were as follows:

- To analyse relevant statistical information on patients presenting at Accident and Emergency and the conditions represented.
- 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.
- To consider whether current provision provides value for money.
- To assess the potential benefit of any proposals for future development of services.
- To consider ways in which health and social care services can work better together to help avoid emergency hospital admissions

Terms of Reference

1.3 The terms of reference for the review were as follows:

"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:

1.4 Councillors David Winskill (Chair), Wayne Hoban, Harry Lister and Toni Mallett.

Sources of Evidence

1.5 In undertaking their review, the Panel received evidence from a wide range of stakeholders as well as documentary evidence. A full list of these is attached as Appendix.

2. Introduction

Definition

2.1 There are various terms that have been used to describe patients who are heavy users of healthcare. “Frequent flyers” was used by health professionals until recently but is no longer used as it is felt to be disparaging to patients. “High intensity users”, “heavy users” and “very high intensity users” are also often used and there are a range of definitions associated with these terms.

2.2 The term “high impact user” was used for the purposes of this review and is used to describe patients who have several - at least three - emergency hospital admissions in a year. The term and associated definition was used in a recent report by from research company Dr Foster Intelligence, which was set up by the DoH and Dr Foster, an independent provider of healthcare information. This revealed that these repeated admissions cost the NHS more then £2 billion per year. Figures for Haringey show that the cost for Haringey was £8,238,884 in 2003/4 and involved 4035 patients.

Characteristics of High Impact Users

2.3 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.

2.4 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.

2.5 Not all patients with one or more LTCs become high impact users. Those that do tend to make additional demands on Accident and Emergency (A&E) and out of hours services and/or suffer from LTCs that have traditionally been managed by the NHS in isolation from social services (e.g. Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart failure).

Prevention of Avoidable Admissions

2.6 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.

2.7 The Panel noted the view from the GP who gave evidence to the review that there is an element of risk in not admitting patients to hospital who are suffering from an episode of illness. Healthcare professionals may therefore vary in their willingness to take on board such an element of risk, especially if they have incomplete information on the patient concerned. However, there are also risks attached to admitting people to hospital the Panel’s adviser, Professor Sue Procter, commented on the dangers of patients catching hospital borne infections, such as MRSA and C. Diff., and the relatively high number of people with an LTC who also have a cognitive or memory impairment which can be adversely affected by hospital admission. These risks are not necessarily taken into account.

2.8 Many older people see hospital as a safe place to go. Accident and emergency (A&E) is particularly often seen as a safe haven. However, A&E takes a long time to deal with people and, more often then not, does not have the full history of patients. In addition, A&E doctors are often at a junior level. If primary and community based care services are able to provide a wider range of services and are seen to be reliable and accessible, patients will be more likely to view then as safe places to go and more prepared to use them instead of A&E. Current proposals to develop primary care services - such as through the creation of polyclinics - may therefore have the potential to reduce pressure on hospitals.

Local Definitions and Terminology

2.9 Haringey Teaching Primary Care Trust (TPCT) does not use either the terms “high impact user” or ACS. They instead refer to “very high intensity users” (vhiu) and define them as “people who are likely to be users of multiple services and have frequent attendances or admissions to hospital because they have long term conditions”. No distinction is made between people who just present at A&E and those who are actually admitted to hospital.

2.10 It is the view of the Panel that the term “high impact user” is of particular relevance, which is why is has been used for this review. It is more specific in its definition then other similar terms for heavy users of healthcare. It may therefore be more likely to identify those at highest risk of future emergency admission and whose impact on the most expensive services is the greatest. It also feels that the term ACS is of particular relevance as it identifies those patients for whom interventions are likely to be most effective, although it would not wish to suggest that patients with non ACS conditions should not benefit from interventions.

2.11 The Panel feels that it is essential that there is a shared understanding and definition between health and social care services of who this group of patients are, in order that interventions can be appropriately targeted.

3. Strategic Responses

The Chronic Care Model

3.1 Strategic responses to high impact users are typically based on what is known as the "Chronic Care Model", which identifies the essential elements of a health care system that encourages high quality chronic disease (or long term condition) care.

Elements of the Chronic Care Model:

- *The use of community resources and policies to keep patients well, involved and active.*
- *The development of a health care organisation that prioritises chronic care.*
- *Self-management support. This aims to give patients a central role in determining their care and one that fosters a sense of responsibility for their own health.*
- *Delivery system design that assures the delivery of effective, efficient clinical care and self-management support.*
- *Decision support to ensure integration of protocols and guidelines and the promotion of clinical care that is consistent with scientific evidence and patient preferences.*
- *Availability of clinical information such as:*
    - *Means of identifying subpopulations for proactive care*
    - *Reminder systems to support compliance*
    - *Feedback to health professionals providing information on chronic illness measures, such as hypertension or lipid levels*
    - *Registries for planning individual patient care and conducting population based care.*

The Pyramid of Care

3.2 The vast majority of patients with LTCs (70 – 80%) should be able, with appropriate support, to care for themselves and therefore only need minimal input from health and social services. They represent the bottom layer of what is referred to as the "pyramid of care". In the middle layer are "high risk patients", who are people who need more active disease and care management from professionals. Finally, in the top level, are the patients with highly complex needs. These patients are usually aged over 65, and represent a tiny proportion of the population, but account for a large number of emergency admissions to hospital. It is from this group that the high impact users will most likely be drawn.

3.3 The NHS and Social Care Long Term Conditions Model uses a similar model to categorise the care that people require as follows:

- Level 1 (bottom layer): Supported self care. This involves helping people and their carers to develop the knowledge, skills and confidence to care for themselves effectively.
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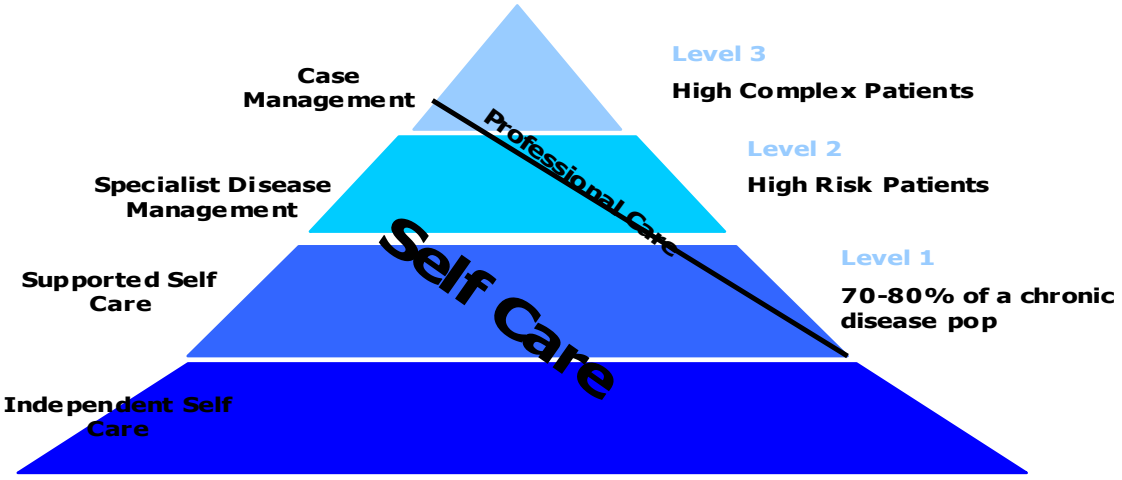
- Level 2 (high risk patients): Disease specific care management. This involves providing people with responsive specialist services using multi disciplinary teams and disease specific protocols and pathways.

- Level 3 (patients with highly complex needs): Case management. This involves identifying the most vulnerable people and using a case management approach to anticipate, co-ordinate and join up health and social care.



3.4 Providing effective care at levels 1 and 2 may help to slow down or prevent patients at the lower levels needing higher levels of care in the future.

Government Policy

3.5 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.

3.6 '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."

3.7 Haringey is currently meeting this target.

Community Matrons (CMs)

3.8 CMs are perhaps the most significant part of the government's strategy for addressing the needs of high impact users. The NHS Improvement Plan (2004) introduced their role. They are expected to be experienced, skilled nurses who use case management techniques to work with patients who are high impact users.

Objectives of case management undertaken by Community Matrons:

- *Help to prevent unnecessary admissions to hospital*
- *Reduce the length of stay of necessary hospital admissions*
- *Improve outcomes for patients*
- *Integrate all elements of care*
- *Improve patients' ability to function and their quality of life*
- *Help patients and their families plan for the future*
- *Increase choice for patients*
- *Enable patients to remain in their homes and communities*
- *Improve end of life care*

3.9 The principle of this model of care is that there is one person who acts as both provider and procurer of care and takes responsibility for ensuring all health and social care needs are met, so that the patient's condition stays as stable as possible and well-being is increased. The CM has a key function as a co-ordinator of care, within the framework of the Single Assessment Process. They develop a care plan in conjunction with the patient that identifies needs and offers solutions as to how they can best manage their long term condition, including any possible deterioration.

The role of community matrons (CMs) is intended to include:

- *Using data to actively seek out patients who will benefit*
- *Combining high level assessment of the physical, mental and social care needs of patients*
- *Reviewing and prescribing medication*
- *Providing clinical care and health promoting interventions*
- *Co-ordinating inputs from all other agencies, ensuring all patient's needs are met*
- *Teaching and educating patients and their carers about warning signs of complications or crisis*
- *Providing information so patients and families can make choices about current and future care needs*
- *Being highly visible to patients and their families and carers and being seen by them as being in charge of their care*
- *Being seen by colleagues across all agencies as having the key role for patients with high intensity needs.*

3.10 A target was set by the government for 3,000 CMs to be in post in England by March 2008 but this was amended by the government after only 1,470 had been recruited by December 2006. This was to allow PCTs to put staff from other disciplines in case manager posts, such as social workers. The target number was subsequently reduced to 2,500 but only 1,600 were in post by the end of March 2007.

3.11 The Healthcare Commission's State of Healthcare report recently revealed 41% PCTs failed to hit the targets for recruiting CMs and case managers in 2006/7 and only a third met the target for the number of people with long-term conditions under the care of a CM. As a result of this, the report stated that 60,000 people who needed this support were not getting it. This was worse than the year before, when 39 per cent of PCTs hit the target for patients being managed by community matrons or case managers.

"Healthcare for London – A Framework for Action"

3.12 The models of care outlined in the recent report by Lord Darzi entitled "Healthcare for London – A Framework for Action" are currently being consulted on by the NHS across the capital. If approved, they will provide a blueprint for the London wide development of services. The report refers explicitly to the need to improve community care to reduce emergency admissions.

3.13 It argues that, in order to cover the needs of just those patients with diabetes, congestive heart failure and asthma and reduce the need for urgent care appointments and emergency admissions, there should be much greater use of systematic appointments with community healthcare professionals. The model of care that he proposes would require over 800,000 GP appointments and 1.6 million nurse appointments. He estimates that this will require 175 more GPs and 350 more specialist nurses. This increase will be offset by a reduction in urgent care appointments and emergency admissions. Haringey currently has 211 GPs but is only currently scheduled to have 208 (3 fewer) by 2011/12 which will clearly not be sufficient to deliver the model of care proposed by Lord Darzi. However, it currently has 13 CMs and is projected to have 21 by 2011/12.

3.14 In addition to this, Lord Darzi recommends the following:

- The designation of a consultant/nurse and community lead for each long term condition in each PCT area.
- Better integrated health and social care to be developed by requiring PCTs to work with local authorities to develop joint action plans for the management of long term disease.
- Greater use of "assistive" technology
- More support from community pharmacies
- The development of London wide care pathways for long term conditions

3.15 It is envisaged that the re-direction of resources from hospital to community based care required will be achieved by the commissioning process. However, it is the view of the Panel that investment in improved health and social care services to support patients outside of hospital will need to be made before any reduction in urgent care appointments

and emergency admissions can be achieved and it is unclear as yet how it is intended that this can be achieved.

Haringey Strategic Approach

3.16 The Panel noted that current strategic arrangements to support for vulnerable people and reduce avoidable admissions have evolved in an ad hoc way rather then through a strategic approach. The Panel concurs with the view of the Council's Adult Services and other partners that, whilst local services are currently coordinated, a more integrated approach is required to address the issue more effectively.

3.17 An example of the potential benefits that better integrated health and social care may offer is included in the report by Lord Darzi. This highlights the targeted case management of higher risk older people that was undertaken at the Castefields Health Centre in Runcorn and which resulted in a 15% reduction in hospital admissions and a 31% reduction in length of stay. An integrated approach between health and social care was a crucial part of the success. In particular, very quick joint assessments that covered social and medical interventions were undertaken with packages of care put in place speedily. The impact on costs was considerable with over £300,000 saved in one year. Despite the additional health and social care provision that made this possible, the cost was less then that for other areas of Runcorn as it was offset by savings in residential and nursing home costs. There was also no evidence of additional strain on primary care.

3.18 Another important aspect of the Castlefields model was what was referred to as hospital "in reach" which illustrated the importance of the active involvement of acute trusts in effective strategies. The Panel noted the view of the North Middlesex Hospital that the most effective means of keeping people with long term conditions out of hospital was through multi disciplinary, multi agency action, rather then just through primary care.

3.19 Keeping more people out of hospital and, in particular, addressing the needs of high impact users has considerable cost implications for Adult Services. Additional social care services will be required to support a large proportion of them and help them to remain independent. However, although there is potential for savings by the NHS, the cost implications for Adult Services provide a disincentive for them to invest in services which can play a preventative role. A significant difference between the NHS and social services that needs to be addressed is that the NHS is free at the point of delivery whilst services provided by social services were chargeable.

3.20 The Panel noted that Haringey TPCT is currently in a relatively strong financial position and discussions are taking place between it and the Council's Adult Services on how financial resources from the TPCT can be used to support social care activities undertaken by the Council that have the potential to make savings for the TPCT The TPCT is not unsympathetic to the principle of assisting the Council with the additional costs to services. The advent of practice based commissioning and payments by result are making this more feasible.

3.21 Lord Darzi's report proposes that better integrated health and social care should be developed by requiring PCTs to work with local authorities to develop joint action plans

for the management of long term disease. It is the view of the Panel that the benefits of better integrated care are unchallengeable. It believes that Haringey TPCT and Adult Services should be proactive in their approach and not merely wait until required to take action. A strategic evidence based approach should be adopted locally and should go beyond the merely aspirational and seek to make genuine progress. It is essential that the strategy addresses resource issues and that it includes provision for financial integration between the TPCT and Adult Services in relevant services. Clear definitions are also required in order to ensure that there is a common and clear understanding of which patients should be targeted and would benefit most from interventions. A clear strategy, that included relevant definitions, would fit in with the current primary care strategy and assist in the scoping of relevant information systems.

Recommendation:

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.**

4. Identifying People At Risk

4.1 Identifying accurately patients who are most at risk of emergency admission is important in order to ensure that services are directed at those whose need is greatest and vulnerable people do not fall through the net. Accurate and up to date information is crucial to this.

PARR

4.2 The TPCT currently uses a combination of predictive data, including the Patients at Risk of Re-hospitalisation (PARR) software tools plus referrals to identify high impact users. The PARR predictive case finding IT tools were commissioned by the Department of Health and the NHS from a consortium of the King's Fund, New York University and Health Dialog Analytic Services. These software tools are available for use free of charge by PCTs in England.

4.3 The TPCT currently gets monthly reports from PARR1 and PARR2, which both use Hospital Episode Statistics (HES) data, to produce a 'risk score' showing a patient's likelihood of admission within the next 12 months. Risk scores range from 0 – 100, with 100 being the highest risk. The PARR tools use an emergency hospital admission as a 'triggering event' and then apply an algorithm based on diagnostic information from this most recent admission plus information from previous admissions and out patients/day case attendances. The admissions and attendances can be anywhere in the country.

4.4 PARR1 focuses on admissions for specific 'reference conditions', for which improved management can often help prevent future hospital admissions. These conditions represent around 20-25% of all emergency medical admissions and include conditions such as congestive heart disease, COPD and diabetes. PARR2 uses any emergency admission as a trigger and is not limited to admissions for a 'reference condition'. Because it focuses on a larger number of patients, it produces risk scores for more patients than PARR1 but has a slightly lower rate of predictive accuracy for comparable risk score bandings. However, due to the higher number of patients found, PCTs are able to use a higher risk threshold cut off point than for PARR1 in order to find a comparable number of patients. Particular attention is paid to patients with risk level of more then 50%. However, there are limitations to the usefulness of PARR data, as in some cases, patients have moved on or changed circumstances by the time that figures come to light. There is also a need to distinguish between false positives (i.e. patients identified as at risk of readmission who are not at risk) and false negatives (failure to identify people who are at risk of hospital admission).

Other Software Tools

4.5 A third tool has been developed which combines secondary care data with community based data, such as GP electronic records and social care data. This third tool will have the added power of being able to predict the risk of hospital admission for those patients who have not yet experienced a recent emergency admission. The ability to identify emerging risk enables organisations to plan early interventions to minimise or prevent emergency admissions. This tool is not yet in use in Haringey.

Other Sources of Information

4.6 People identified as being most at risk may be eligible to receive assistance from Community Matrons (CMs). Referrals do not rely just on PARR and come from a range of sources:

- PARR (40%)
- GPs (36%)
- Admission prevention (17%)
- Other (7%)

4.7 In all cases, CMs make the final decision on who they can work with after consulting with the relevant GP and finding out more information. All GP practices now hold disease registers and these can be referred to.

4.8 If the patient has more than one long-term condition, lives in Haringey and is not already in nursing or residential care, the CM will carry out an assessment. From this they decide if there is a role for them in helping to co-ordinate the patient's care and help them manage their condition better. If they do not take them on, they will inform the GP and consider if there is another service that it would be appropriate to refer them to, including social or voluntary sector services.

Shortcomings of Current Information Systems

4.9 The Panel's expert adviser reported that current NHS information systems are designed to react to rather then prevent ill health. They do not easily enable identification of current or potential high impact users. The PARR formula is a reaction to these current deficiencies in routine data collection and the accuracy of its predictions can be variable. Systems are not joined up and much essential information, such as District Nursing notes, is manual rather than electronic and therefore cannot be interrogated. Records normally give information on episodes of care or incidence of a single disease, rather then people. In some cases, conditions are not always immediately obvious and therefore the coding may not be correct. NHS IT systems are also not currently compatible with those used by social services departments. However, efforts are being made locally to enable A&E staff to have read only access to Adult Services data. This would assist A&E staff by flagging up potential issues.

4.10 The government is currently modernising NHS information systems and hopes to connect every family doctor and hospital in England and provide online records for 50 million patients by 2010. This should allow doctors to access information about a patient, via their record, whether they are at their local GP surgery or at a hospital. The declared cost of this was £6.2 billion but the Department of Health has estimated that the final cost of modernising NHS computer systems could rise to between £18.6bn and £31bn.

4.11 The shortcomings of national NHS information systems are considerable and not something that can be rectified easily or quickly. There is also limited scope to take action on a local basis. However, there will still be some need for information systems to be developed locally in order to better join up services. It is particularly important that

information sharing with the Council's Adults Services is further improved. It is essential that that these are patient centred, rather then being episodic or disease based and compatible with the Adult Services IT systems. People involved in commissioning or providing services need to be involved in the development of such information systems as well as IT professionals. In addition, it is essential that Camidoc and all other relevant providers are included in information sharing.

Recommendation:
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.

5. Addressing The Needs Of High Impact Users - Haringey TPCT

5.1 Local services address the needs of patients who are identified as being at greatest risk of hospitalisation in a number of ways and in accordance with national frameworks. Haringey TPCT has the most significant role in this as both a commissioner of services and a provider.

Community Matrons (CMs)

5.2 This is the principal means by which Haringey TPCT addresses the needs of those at greatest risk from hospitalisation within the Borough. The overall approach adopted CMs within the Borough is based on a pilot project that was undertaken in Haringey and known as TeamHealth which provided telephone support to people with heart disease, heart failure and/or diabetes. An evaluation of this project was undertaken and the learning from this used to help support development of the current programme. Information on what has been successful in other such projects and described in the Kings Fund report of December 2005: *'What Works in Case Management of High Risk Populations – Identification of Key Components to Improve Effectiveness'* was also incorporated

5.3 Haringey currently has two sorts of CM: generic and specialised. CMs do not only work with people who have more than one long-term condition and are high impact users of services but also those people who are considered *likely to become so*. All the generic community matrons link to a commissioning collaborative and are based within a community nursing team for their locality. They have close working links with and make referrals to a variety of health, social care and voluntary services.

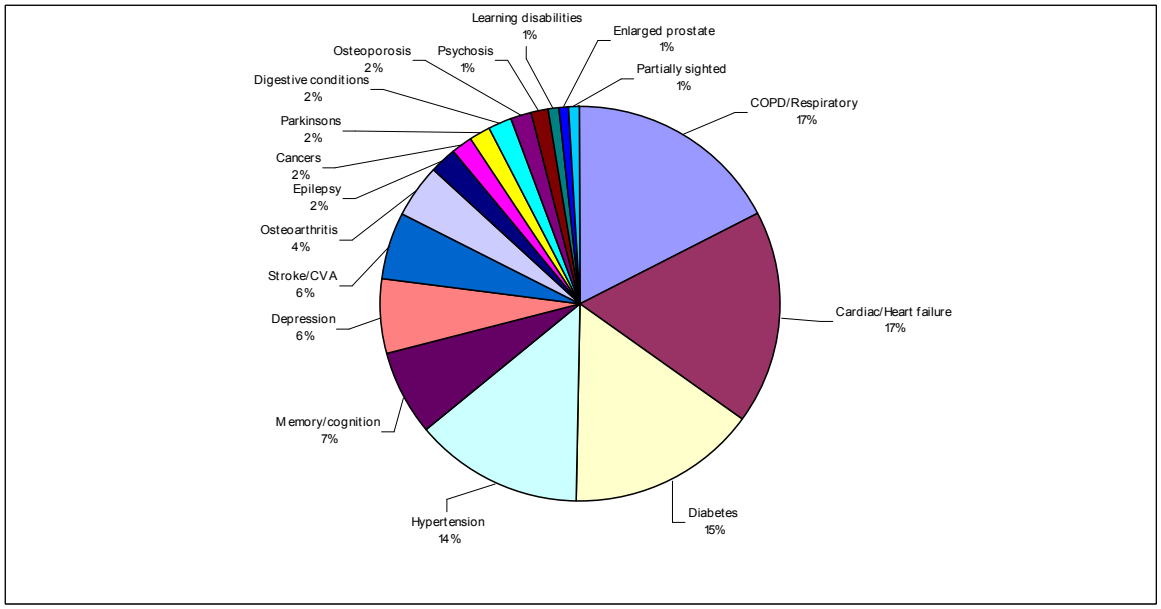
5.4 The specialist CMs cover a range of conditions and client groups including diabetes, palliative care, older people and homelessness. In addition, there are two specialist CMs, one for TB and one for HIV, who work with Haringey residents but are part of a wider north London sector network. There are also a range of specialist nurses and other health professionals who support the management of high impact users and provide case management and work in a similar way to CMs.

5.5 The Panel noted information from the TPCT that 544 patients are currently in touch with the CMs. In addition, another 415 patients are case managed by other health professionals, working such as District Nurses or Occupational Therapists. The more prevalent long term conditions are the most common such as COPD, heart disease and diabetes. There are also a number of people with mental health problems and a significant number with cognitive or memory impairments, which may reflect the number of older people on the caseload.

5.6 The target for Haringey was to have 21 CMs in post by March 2008. Haringey currently has 13 posts, with 11 being currently filled and has therefore not met this target. Some of these roles have been designed specifically as CM posts whilst others have developed from existing specialist nurse posts, who were already working in this way. In addition, there was also a target for 950 very high intensity users to be receiving a case

management service this year. This has been met, with 959 residents having benefited from the service.

Community Matron Service – conditions of patients in touch with service:



Monitoring and Evaluation

5.7 The TPCT has not yet increased the number of CM posts to meet the appropriate target levels as it feels that clear evidence of their effectiveness should first be forthcoming. The effectiveness of the CM role in reducing hospital admissions over time is therefore currently being evaluated by the TPCT, although there is not as yet a clear date for when this process will reach its conclusion. The Practice Based Commissioning Collaboratives will consider how best to commission services for high impact users in the future.

5.8 The TPCT recognises that evaluating the effectiveness of CMs is complex. It is not necessarily the case that someone who has had a high number of hospital admissions in one year is at high risk of further ones in the next year. A significant number will not be re-admitted, irrespective of any intervention. Reasons for hospital admission are also multi-factorial; a percentage of patients will have had a high number of admissions as they are nearing the end of their life and there may also be some others who refuse to change their behaviour and their way of managing their health. The TPCT therefore feels that the effectiveness of the service may not be demonstrated by hospital admission statistics alone. Consequently, the CMs are therefore using proxy measures to evaluate the service, such as service user feedback, numbers of medication reviews, individual admissions avoided and GP feedback.

5.9 The Panel noted wider evidence that the CM role has not yet been proven to have a significant effect on hospital admissions. The National Primary Care Research and Development Centre (NPCRDC) analysed the nine pilot schemes conducted in England between 2003 and 2005. The NPCRDC's evaluation found that, while the model made positive improvements to patient care and reduced GP workload, it did not reduce

hospital admissions. The author of the report commented that it was unrealistic to have expected them to do so. The US model, where admissions were cut, was accompanied by an intensive home-care system. The patients did not stop getting ill but were instead cared for at home instead of being sent to hospital. The study also showed that the UK pilot schemes suffered from a lack of effective IT systems and poor integration between the pilots and local hospitals. Out-of-hours and primary care services were also not set up to prevent hospital admissions.

5.10 However, the Panel received evidence from its expert adviser that the role is currently in its infancy and will need longer-term evaluation before its effectiveness can be assessed accurately. Other evidence shows that the approach is effective and that patients are benefiting from it by being alive and well, still living at home and avoiding hospital. Many PCT boards are also very pleased with local evidence showing that community matrons have more than covered their costs in emergency admissions saved.

5.11 The Panel noted the view of Adult Services and the North Middlesex Hospital (NMUH) were of the view that CMs were working well within Haringey. In particular, NMUH felt that CMs had made a significant impact on success in admission avoidance. They worked well with the CMs work and felt that they had been particularly effective in addressing asthma and COPD. However, they noted that some CMs post are still vacant.

5.12 The Panel also noted that there is strong evidence that CMs improve quality of life of patients. This will not only be just for the patient but for carers and relatives as well. There is always likely to be sufficient demand to fill hospital beds so it may be unrealistic to expect significant savings. In addition, many studies on their effectiveness are based on the US experience, which is not comparable to the UK due to structural differences. Finally, if no distinction is made between conditions which are sensitive to primary care interventions (ACS conditions) and those that are not – as would appear to be the case within Haringey - CMs may be intervening with patients for whom a reduction in hospital admissions may not be an achievable goal.

5.13 The Panel is of the view that CMs are effective and improve the quality of care and life of patients that they work with. They are a mainstay of current government policy on addressing the needs of people with LTCs. This is unlikely to change in the short term and, until such time that more effective alternatives are identified, the Panel believes them to provide the best option for improving the care of high impact users. It therefore believes that numbers of them should be increased and that the TPCT should take action to meet its target level of CM posts for March 2008 of 21. It notes the fact that the target for the number of patients receiving a case management service from the TPCT has been met but feels that this work would be more appropriately undertaken by CMs rather then through the various different health professionals that have been utilised by the TPCT to meet this target.

5.14 The Panel feels that the role of CMs should be evaluated thoroughly in order to monitor their effectiveness and ensure that they are utilised to their full potential. However, the criteria for assessing their effectiveness should not focussed disproportionately on savings achieved. The benefits that they may bring to patients, in terms of quality of life, should be of paramount importance.

Recommendations:

- That Haringey TPCT take 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**.**
- That evaluation of the effectiveness of Community Matrons include specific reference to their role in improving the quality of life of patients and the support given to carers**.**

5.15 The Panel noted evidence from the TPCT that CMs form only one part of their strategic approach and that, on their own, they cannot manage all high impact users within Haringey. The TPCT's recent Primary Care Strategy presented their future plans for supporting people with long term conditions, which included:

- The development of care pathways that support effective prevention, management in primary care and ensure clarity and coordination between different elements of service provision. A diabetes care pathway has already been developed and, in addition, a model of diabetes care is being developed to deliver improved outcomes. This model will involve improving and bringing together care within primary care and will help the TPCT in developing its overall model for long-term conditions.

- Locality services for long term conditions to be developed with the primary care commissioning collaboratives. These will bring together a range of clinical inputs such as GPs with a special interest in a certain condition, nurse practitioners, dietetics, physiotherapy, foot health, psychological support as well as a route into a range of community and self care support services.

- Intermediate Care and Rehabilitation strategy (rehab strategy). The TPCT are working on a rehab strategy together with the Council which it hopes to consult upon shortly. This aims to provide care as far as possible in people's homes and to provide a single point of entry into services, integrating health and social care teams including community matrons**.**

- Improved access to support for self care including the Expert Patient Programme for people who have recently been diagnosed with a long term condition and the DESMOND programme which promotes a structured self management approach for people with diabetes. The Panel received specific evidence about both of these schemes.

The Expert Patients Programme (EPP)

5.16 This is a generic course open to people with long term conditions. Referrals came from a wide range of sources including self referral, community matrons and other health professionals. The programme was piloted in 2004. It is not aimed at any particular conditions nor intended specifically for high impact users. The emphasis is on self management and the long term consequences of conditions. It is led by volunteer lay people who have a long term condition themselves. It aims to address a range of issues including loss of confidence, stress management, relaxation and living with pain. It promotes physical activity and a problem solving approach. Its overall objectives are to

help people become more self sufficient and overcome the symptom cycle. The group structure provides a means of support for people as well as social benefits. The sessions all take place in community settings.

5.17 The EPP scheme is now in its fourth year of operation in Haringey. Last year, 80 patients took part in the scheme and 76% completed it. 7 courses were run, including one aimed at Turkish speaking people as part of the Race for Health programme. There was also a course aimed a people with communication impairments. Three generic courses are planned for this year plus one each for Turkish people and people with Aphasia. In addition, a specific course is planned for people from the Greek and Greek Cypriot community with cardiac conditions who have a low take up rate of cardiac rehabilitation. Referrals for the scheme are steadily increasing and good links to the Mental Health Trust's team of psychologists have been developed. Mental health users constitute the largest group of those referred (1/3). Other conditions that participants have had include chronic pain (25%), arthritis (21%), diabetes (17.5%), COPD and angina.

5.18 Encouragement is given to people on the courses to continue meeting and twice-yearly reunions are held. Consideration is being given to franchising the programme to appropriate support groups so that they could run them themselves. The intention is to increase the number of courses run next year and a bid for expansion has been put in. This is part of a four year plan and would mean that more courses could be run.

5.19 Evaluation of the course has shown that patients feel that they have benefited from an increased level of physical activity, social benefits and increased confidence. Monitoring of take up is undertaken but there is a lack of information on how effective the courses are. No data is kept on whether people who have completed the course are more likely to comply with their medication. Consideration could be given to assessing the effectiveness of the courses by looking at how well people were self managing before and after they had been on the course. This could include take up of exercise, diet, levels of confidence and how well they communicated with health professionals.

5.20 A national evolution of the pilot phase of the scheme concluded that it had increased patients' self-efficacy by a moderate amount, and had had a relatively smaller impact on the amount of energy people reported (energy was chosen as the health status outcome most relevant to people with a range of long-term conditions). However, there was no change in health services utilisation although overnight hospital stays and use of day case facilities were reduced.

DESMOND

5.21 DESMOND is a 6-hour group education programme designed for all people who have newly diagnosed type II diabetes. It aims to offer a style of education that is patient led and centred. There is particular emphasis on communicating to patients that they are responsible for managing their condition and DESMOND has been designed to support people in becoming an expert in self-managing their condition. GPs have an important role prior to attendance on the course to ensure certainty of diagnosis and preparing the patient for a life of self-management.

5.22 The courses have met with mixed success in Haringey. From December 2006 to October 2007, the TPCT ran 8 courses, with 82 patients referred. Of these, only 32 completed the course. The courses and the training to deliver them are expensive as DESMOND has been copyrighted and was set up, first and foremost, as a business. It costs £3000 to train one person.

5.23 There are currently only four educators who have been trained. Two of these have since left the organisation and one is on maternity leave. Referrals are made from practice nurses and GP's but there are only 15 practices that are regularly referring patients. The number of attendees for the course has been low as a result of not being able to get GP's to refer or encouraging patients to attend and general staffing issues.

5.24 An action plan to deliver DESMOND has nevertheless been developed. The current budget is £27,000 per annum. It is hoped to train a further 10 people to deliver the DESMOND training by October 2007. By January 2008, it is also hoped to start to roll out further programmes within a central location in each of the four GP collaboratives. It is envisaged that 2-4 rolling programmes could be run per month alternating between the collaboratives. There may be scope to run quarterly programmes for Turkish speakers. Patients will be identified through a combination of case finding and community development approaches within their own community groups.

6. Services Provided By Haringey TPCT's Partners

Introduction

6.1 The TPCT work closely with partner organisations to address the needs of high impact users. The Council's Adult Services commissions and provides social care, which is essential to keeping more people out of hospital. In addition, acute services (i.e. hospitals) not only play a role in identifying patients who are at risk, they are increasingly being involved in community based initiatives that aim to bring services to the patient and prevent acute episodes.

Adult Services and Social Care

6.2 Services provided by Adult Services include home care, meals on wheels, advice and support and rehabilitation on leaving hospital or to prevent hospital admission. In addition, assistance and respite is also provided for carers. Services are provided for 2 500 older people, including 600 people in care homes. These cover a wide spectrum of need.

6.3 The Integrated Care Team has the necessary skills to keep many people at home. The team includes a range of professionals, including social workers. There are a range of networks available to identify vulnerable people and staff make contact with GPs if there are sufficient concerns. There are particular issues with low level dementia and COPD. Agreement has been reached so that people with dementia can be referred to day hospital via their GP. Not all GPs are helpful and the response in some cases is to assume that conditions are just the inevitable consequence of getting old.

6.4 The Panel noted that until recently, the focus of attention had been on getting people out of hospital more quickly. Some progress with this has now been achieved. The government has allocated money that was previously put aside for fines for delayed discharges to local authority social services departments. Adult Services have used this money creatively and are investing in appropriate projects such as therapy, home care, advocacy and a rapid response scheme with the TPCT. However, these are still at the embryonic stage. A five year strategy for integrated care services has now been drafted. The intention is to have a single point of access to services that people can be referred to but which provides a multi disciplinary response and access to hospital beds if required. The service feels that the position would be helped if it was possible for patients to have intravenous antibiotics at home, as happens in some other areas.

6.5 The Panel noted that intravenous drug administration at home is becoming more prevalent and feels that if the vision of primary care being able to radically reduce hospital admissions is to be achieved, it will be essential to have a primary care intravenous drug administration service. However, potential demand for intravenous antibiotics is currently low with only 2 potential cases identified in the past year and there are also practical difficulties to be overcome.

6.6 The TPCT is currently reviewing its options for increasing intensive nursing at home and the Panel is of the view that the feasibility of setting up a home intravenous drug

administration service should be considered as part of this. The Panel is of the view that, in order to obtain sufficient demand or critical mass to make provision of such a service viable and sustainable, consideration of the issue should not just focus on the administration of antiobiotics but intravenous drugs in general as this will make it more likely that sufficient critical mass or demand will be achieved to sustain the development.

Recommendation:
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.

Telecare

6.7 The Panel received evidence from the Council's Community Alarm Service on the use of IT to support vulnerable people. This is mainly done by monitoring emergency calls via a warden's call out system for people living in Supported Housing and dispersed units for people living in their own homes. It has expanded over the years and currently supports up to 4500 people within Haringey.

6.8 Following improvements in information technology, the government set up the Preventative Technology Grant scheme to expand services that were provided. This was done in order to encourage the greater use of such technology and create greater links between local authority social service departments and other organisations and individuals that provide support for people, such as occupational therapists, integrated care teams, home care agencies, Housing Association supported housing officers, district nurses, community matrons and GP's.

6.9 In Haringey, people are now considered for telecare as part of assessments that are undertaken in response to referrals. The scheme aims to;

- Reduce hospital admissions and readmissions
- Reduce dependence on care services and families
- Provide security in the home and enable greater independence.
- Reduce anxiety
- Improve the quality of life for patients and informal carers
- Delay the move into long-term residential care.

6.10 The basic systems just involve a button that is carried around the neck and can be pushed by clients in the event of an emergency. This is connected to a telephone line and alerts relevant staff. There are also a range of other sensors such as ones that detect movement, flood, carbon monoxide, falls, property exit and epilepsy. The equipment is battery operated and does not require hard wiring. It provides a warning to the control room when batteries are low.

6.11 Door exit sensors can be particularly effective for individuals with increasing dementia, which can be exacerbated when people are removed from home into residential care.

The sensor monitors when the client leaves the home and, if and when they do, a call is generated and received in the Control Room where appropriate action is taken.

6.12 The funding that is allocated to local authorities from Preventative Technology Grant is intended for the purchase of equipment. However, it is important for the applications to be supported by appropriate staff. Haringey's system is backed up by a call centre that is covered around the clock and based at Woodside House on Wood Green High Road. There is also a response service which ensures that calls are acted upon. Some local authorities have installed systems but do not have the support systems to respond effectively to calls.

6.13 The service has also set up a pilot scheme in partnership with Primary Care Trust involving the use of Vivatech Wrist Care. This entails the individual wearing a wrist alarm, which sends wellness data via the internet to Vivatech. This is passed onto community matrons. Community matrons are able to assess a range a data including sleep patterns and well being, which are measured by the patient's circadian rhythm. As the patient's level of health improves, the patient is moved off wrist care and assessed by the Community Alarm service for Telecare products.

6.14 The Panel noted that considerable savings can be made as a result of the use of telecare equipment.

Case History 1:

Mrs R had been taken to hospital 4 of times at a cost of £400 for ambulance calls. She also had a high level of dependency on her sister, who had to travel from Brighton to take her out. When Mrs R was given a wrist alarm and Community Matron input, she began to go out every day, after notifying the control room of her movements. The knowledge that help was never far away increased her confidence and independence. There was a reduction of hospital admissions to zero over a 6 month period. The Community Matron was able to utilise the data and spot the start of urinary tract infection early enough to prescribe antibiotics and avoid hospital admission. It reduced the number of journeys that her sister made. In fact, the roles were reversed and her sister was admitted into hospital with Mrs R visiting her in Brighton.

The cost savings were as follows:

4 Ambulance calls £404.00
- cost of alarm for 6 months £154.86
= £250.86

- Cost of wrist data 25 x 6 £150.00

Saving of £100.86

Case History 2:

Mrs L had COPD and heart failure. She had had 6 hospital admissions over a year at a cost of 3518 x 6 = 21,102. In the 6 months prior to wrist care installation she had 3 admissions to

hospital at a cost of £10,051. In the 6 months since having the wrist care alarm, there had been no admissions to hospital and a reduction in the number of community matron visits.

Cost savings:

9 Community Matron Visits at £50 per visit = £450
Wrist care alarm and wellness data = £304.86
Total cost over 6 months = £754.86

Savings to the Primary Care Trust = £9296.14

6.15 In addition to direct benefits to the individual, the sensors can help give carers and relatives peace of mind.

6.16 The service is currently in the process of launching another telehealth scheme called Doc@home. This is a portable device which is left in peoples homes for a minimum of 3 months. It can ask the patient specific questions about their health and take readings of blood oxygen levels, ECG, weight, pulse and blood pressure. The data can be monitored via the internet. If a patient's health is deteriorating, it can produce alerts that can be picked up and acted upon by CMs. Doc@home can be used alongside a telecare alarm so that urgent emergency alerts can be made when necessary. Using the doc@home helps to educate the patient to take responsibility for monitoring their health and carrying out healthy practices such as eating healthily and reducing smoking and consumption of alcohol. Studies have shown very good results and reduced hospital admissions. The scheme is being undertaken in partnership with the TPCT and is aimed particularly at high impact users, such as people suffering with COPD. In addition to reducing the number of visits to the hospital, it also reduces anxiety. Doc@home has been tested in several EU countries as well as 15 PCTs. It is initially being used with 30 patients.

6.17 The Panel noted that the cost of emergency care is as follows;

- Accident and emergency attendance: £101
- Cost of ambulance: £100
- Hospital admission £3,518

6.18 Wellness data can be of considerable benefit to health professionals. For example, sensors can detect whether people have had a restless night. CMs can access this data via the internet and pick up the possibility of patients having a Urinary Tract Infection (UTI). It has therefore been of great benefit.

6.19 The Community Alarm Service generates money from a range of sources, including Housing Associations and Supporting People. The TPCT pays for access to relevant data if the patient has been referred by them. The service saves the NHS money by reducing the need for hospitalisation but the income that the team receives does not cover the cost of it providing the service and this effectively works as a disincentive to investment.

6.20 The basic cost to the client is £5.95 per week for an alarm on its own. Additional items are charged at 50p. per two items. Each local authority has its own way of charging. The service tries to keep the cost low and has taken advice on fair charging. The Panel noted that the cost deters some people from taking the equipment although people who are on certain benefits can get help with the cost.

6.21 One particular initiative that has been undertaken was the "virtual community ward". This is being piloted by Croydon PCT. This involves a network of virtual wards caring for the top 0.3% of the PCT's registered population ranked according to predicted risk of emergency hospital admission in the following year. Each ward has a capacity to care for 100 patients and is linked permanently to a group of GP practices. The clinical work is led by a community matron. Patients are cared for at different intensities according to need: of the 100 patients, 5 are reviewed daily, 35 weekly and 60 monthly. When a patient falls below the top 100 for the ward's catchment area, discharge is considered. In the first two years following discharge the GP practice conducts quarterly rather than annual reviews.

6.22 The Panel noted evidence from Professor Procter that there was very little UK evidence so far on the effectiveness of telemedicine. Its implementation was still beset by technical problems. It required a well maintained system of response and worked best when linked to telecare and call alarm systems. An evaluation undertaken in NE London indicated that telemedicine aided communication between patients and health care professionals and could lead to the resolution of seemingly intractable problems. However, it was not universally acceptable to all high impact users. In addition, patients and families already experiencing high levels of stress may not welcome additional stress when technical problems are experienced with telemedicine. In respect of the "virtual ward" used by Croydon PCT, Professor Procter stated that its effectiveness had not yet been evaluated. Performing this accurately would be very complicated.

6.23 Although it may have limitations and there may currently be some technical problems with it, the Panel feels that telemedicine offers considerable potential for improved care for patients and it is for this reason that it is of the view that it should form an integral part of any strategy for improved care for high impact users. It is likely that the majority of the technical issues will be resolved in the fullness of time and pilot projects will provide the TPCT and Adult Services with the necessary information on how to use it most effectively. However, it is essential that financial issues are resolved first as the current arrangements do not sufficiently encourage either Adult Services to invest or patients to take such equipment. Potential savings to the NHS could be considerable and are likely to be far more then the cost of installing, maintaining and responding to telemedicine equipment.

North Middlesex University Hospital (NMUH)

6.24 NMUH has a First Response Team (FRT) who have proven to be effective in helping to avoid admissions and/or reduce their duration. They provide a highly visible, co-ordinated therapy and discharge service by means of early specialist assessment and intervention, internal/external networking and referrals, as well as fast track access to health and social care services. The main benefit of the service is the provision of integrated services for patients, allowing a concentration and continuity of care from admission to

the discharge of patients. This incorporates promotion of care standards and the screening of medical and nursing interventions in order to assess for potential issues that might lead to a delayed discharge or readmission.

6.25 FRT is multi disciplinary and has links to other teams of professionals who are based at the hospital including the Rapid Response Team, the Intermediate Care Team, Community Matrons and Haringey Adult Services. There are fortnightly meetings to discuss follow-up on recent FRT hospital discharges to community services and frequent attendees with long term conditions. There are also reviews of patients with significant social issues.

6.26 The team does not just operate in Accident and Emergency but is a constant presence across the hospital and particularly in assessment and care of the elderly wards. The service is not available 24 hours per day – its hours are 8:00 a.m. till 6:00 p.m. They have a particularly important remit in respect of care of the elderly and a key part of this is falls assessment.

6.27 The Trust is currently in the process of expanding the FRT as it has proven to be successful. It has been particularly effective in identifying episodes where long term conditions may be a significant factor leading to a presentation at A&E. For example, a patient presents with a fall whose root cause was COPD/heart failure but is only treated in relation to fall.

6.28 Mental health issues are a significant factor in the attendance of a comparatively high number of patients attending NMUH. The Mental Health Trust (MHT) currently provides only limited psychiatric consultant cover for A&E. In addition, support from mental health community teams is currently below required levels due to staff vacancies and sickness, leaving the hospital with reduced cover, particularly at weekends. NMUH has some liaison psychiatric cover for adults but there is currently no specialist service for older people. Some additional liaison cover was provided by the MHT as part of an informal arrangement but this stopped on 1st October 2007. The resourcing of mental health in acute trusts is generally not good but NMUH has the third busiest A&E in London and feel that out of hours community support is in need of improvement.

6.29 There is agreement amongst all partners that current provision is inadequate and that there is a need for additional cover, particularly for older people. However, there is as yet no agreement on how to resolve the issue. Haringey TPCT is currently addressing this in consultation with the MHT and NMUH. The Panel is of the view that the current situation is unsatisfactory and is concerned that the lack of agreement on how to resolve the issues is impacting on patients. It feels that the TPCT should, as a matter of urgency, take action to commission appropriate provision at NMUH and ensure that it is put in place as soon as possible.

Recommendation:
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 people.

6.30 The Panel noted a NMUH scheme that has been very effective in keeping people with sickle cell disease out of hospital;

NMUH Home Care Outreach

There are growing numbers of patients at the North Middlesex who suffer from sickle cell - there had been 470 admissions from Haringey residents last year due to it and 80% of those had been treated at NMUH. The dominant symptom is severe pain and there is a very high rate of hospitalisation amongst patients. A small number of patients had actually spent more time in hospital then at home. A four year study in the US had shown a similar picture. There is a particularly high rate of readmission.

Previous attempts to address frequent presenters had included counselling and case management. Whilst these had both been successful to some extent, the initiative that had worked best had proven to be the Home Care Outreach Nursing Team. The team works with patients to help manage uncomplicated pain out of hospital. It takes a multi agency, multi disciplinary approach with the emphasis on providing continuity of care. There has been a steady increase in patient numbers and the service now had 1.5 staff and was currently dealing with 87 patients. There has been a 19% drop in admissions and a 32% drop in duration of admissions and satisfaction levels with the service were high.

It is not clear whether the service saves money but it is felt to be a better quality service for patients that improves their quality of life. More patients are managing more or less independently now and many patients just use the home care service and are rarely admitted to hospital. However, there are nevertheless patients who continue to be admitted, as well as using the home care service. A CM is working with the small number of patients who are still being regularly admitted.

The service had been particularly helpful for children as they were much more comfortable being treated at home. In 2000, the first Roald Dahl paediatric home care nurse for children with sickle cell disease had been appointed at the North Middlesex Hospital in London. These posts had been highly successful. Care was now more home based from the start. The nurse provided general education and insights for families and was their first contact. They had changed the whole expectation of care needs. The 'then' 10 year olds were now all self caring 17 year olds. There were patients as young as 10 who were now able to self manage their condition. It was now unusual for child to be hospitalised 'just' for pain management.

6.31 The hospital was now getting more patients from other Boroughs and this has enabled "critical mass" to be achieved. The Panel is of the view that this model demonstrates the potential for integrated, multi disciplinary action and should be considered by the TPCT as a possible template for action to address other long term conditions such as COPD and asthma.

The Whittington Hospital

6.32 The Whittington Hospital addresses the issue of high impact users at both a strategic and specialist level. It works together with key local partners to jointly address the issue.

There is a lead nurse at the hospital and they also keep a "top 100" of their most prolific service users. It has a Rapid Response team, whose role is to identify such vulnerable people and work with partners to avoid hospitalisation and, if this is not possible, to reduce their length of stay. This work involves social workers, occupational therapists and a nurse. This service is currently funded by Islington PCT. There is also a close working relationship with CMs and the matrons working within the hospital. In addition, there is also close liaison between discharge teams at the hospital and local authority social services departments.

6.33 The hospital had been asked by Islington PCT to take part in a pilot project called "Right Care, Right Place" that involved appropriate patients being redirected to primary care. The pilot is supported by clinical protocols to ensure safety and involves the triage nurse at A&E identifying appropriate patients. The pilot is being fully evaluated by Islington PCT. The proposal by Haringey TPCT to situate one of its super health centres at the hospital will provide the opportunity, in due course, for Haringey patients to be redirected effectively. This will also apply to NMUH, where a super health centre is also planned.

6.34 The Whittington's Respiratory Team provides treatment, education and support to COPD patients to help them manage their condition more effectively. The Respiratory Early Discharge Service (REDS) helps patients admitted as an emergency to get home earlier and avoid readmission. This service is provided by a multi-disciplinary team of nurses, physiotherapists and doctors and works in conjunction with primary care services in Islington and, to a limited extent, Haringey. The aim of the REDS team is for patients to be discharged from hospital as early as possible and to continue their treatment and recovery in their own home under the care of their GP. The Respiratory Team also has an active pulmonary rehabilitation programme that works with colleagues from leisure in both Islington and Haringey and involves Breathe Easy, a self help group for patients.

6.35 The Whittington is leading a new self-management programme in diabetes care with colleagues from both Haringey and Islington PCTs. It has been successful in being awarded the Health Foundation Co-creating Health programme; a 3 year programme aimed at empowering people with diabetes and improving self-management of long-term conditions. This will involve partners working with nurses, clinicians and GPs to develop support programmes and linking in with the work already undertaken as part of the Expert Patients Programme and DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed). There will be 3 elements to the programme; an advanced development programme for clinicians; a self-management programme for people with Diabetes and a service redesign programme, across the health economy. The programmes developed could eventually be applied to other conditions in due course.

Camidoc

6.36 High impact users are likely to also use Haringey's out of hours GP service, Camidoc. Camidoc holds a large amount of information of patients and can, for instance, provide lists of all patients that have called them more then a certain number of times. The IT software that they use has various embedded reports that can be run if required. At the moment, information from Camidoc is not directly taken into consideration by CMs in identifying patients for them to work with.

6.37 Clinicians working for Camidoc also do not have access to GP patient notes. However, they have what are referred to as “special patient notes”. These are patients whose notes have been shared with them by GP practices or other health professionals. They are generally cases where there are particular issues of concern. Camidoc is not yet systematically informed of complex clinical cases and CMs in Haringey do not habitually refer cases of people they were working with to them. In Camden and Islington, CMs have visited Camidoc to share information on patients that they are working with.

6.38 Camidoc doctors are legally liable for the care of all patients that they deal with. Access to more relevant background information would help their doctors better able to make informed clinical decisions. 6-7% of callers are referred to hospital via A&E or ambulance. Doctors are more likely not to refer patients to A&E when there are concerns if they have access to relevant information and can be more confident that any level of risk involved is acceptably low.

6.39 The Panel is of the view that there needs to be closer liaison between the TPCT and Camidoc to ensure that the information that they hold is taken into account by CMs in identifying appropriate patients to work intensively with. In addition, Camidoc should be systematically informed of complex cases and high impact users that CMs are working with.

Recommendation:
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.

7. The Role Of Voluntary Sector Organisations

7.1 Voluntary sector organisations can play a number of different roles in respect of high impact users. They can bring service users together, act as their advocates and also provide services. Efforts were made to obtain a user perspective on services and this was obtained through evidence from Breathe Easy and the Sickle Cell Support Group. Evidence was also received from Age Concern and the Alzheimers Society but this was in the context of them being service providers, such as advocacy.

Islington and Haringey Breathe Easy

7.2 There are approximately 12 people who are actively involved in the local group. The aim of the group is to make life as comfortable as possible for its members. Its members suffer from a range of lung conditions such as COPD, asthma and asbestosis and meets on a monthly basis.

7.3 Most people with lung disease have their own way of managing their condition and the ability to self manage is very important. The group is integrated into the Whittington's hospital's rehabilitation programme. Referrals can be made by the hospital, who provide some support for the group.

7.4 Exercise is of great benefit for people with lung problems. The group is currently trying to set up a regular exercise session for its members and is trying to obtain suitable funding for this. One particular aim for the group is to publicise lung conditions as they feel that there is a lack of appreciation of their range and what they entail.

Enfield and Haringey Sickle Cell Support Group

7.5 The support group was been set up in 1985 and was the first in the country. It is a voluntary group and currently receives no funding. They are currently trying to register as a charity. They have over 800 members and help to signpost services and increase awareness of sickle cell disease. In particular, they feel that there is a need to increase awareness amongst health and social care professionals and especially the fact that cold weather can trigger it off. They have good links with the NMUH medical team at the George Marsh Centre. They are trying to get into schools to increase awareness amongst young people.

7.6 The Group feel that there had been a great improvement in service when the NMUH had introduced its outreach service where nurses went out to visit patients who were experiencing problems. However, it was felt that the service could be improved further if there was a greater availability of nurses. At present, patients are only able to have two visits in 24 hours and have to wait till a nurse was available. The nurses are very busy and are not available overnight. Nurses are often required to administer opiates to help control pain and these could only be given by appropriately qualified professionals.

Age Concern

7.7 Age Concern provide a service that involves acting as an advocate in cases where elderly patients from Haringey are subject to delayed or failed discharge. This covers situations where patients do not want to go to where they have been allocated or where they have been unable to find accommodation. Sometimes people cannot afford care or find it hard to accept it. Local authorities are fined £120 per day unless for delayed discharges, unless they were the fault of the NHS. In addition, they can provide benefits advice. Advocacy is currently only available in hospital and is provided at both the North Middlesex and the Whittington.

7.8 It was noted that there are gaps in the provision of advocacy services. This is especially true of the Whittington Hospital, which has experienced problems with patients refusing to move out of the hospital. Age Concern's service was established using pooled budget money with the North Middlesex and the Whittington and services are commissioned jointly with them. The objective of the service is to try and assist in resolving difficult issues, where an impasse had been reached. In addition to addressing delayed and failed discharges, advocates can also help to prevent readmission to hospital. For instance, preventative action could be taken to reduce the risk of falls.

Alzheimer's Society

7.9 The Alzheimer's Society is a small, national charity that provides a number of services within Haringey including advocacy, a drop in facility and a café. There are approximately 1400 people in Haringey with dementia and there is a high prevalence of vascular dementia within the Borough. Significant numbers of them are treated at St. Ann's Hospital.

7.10 Dementia can present problems if people were admitted to hospital. They can, for instance, refuse to get into an ambulance. Dementia also affects those who care for people with the condition. Carers can, however, play a key role in helping to keep people out of hospital**.**

7.11 They felt that there was a particular problem with out-of-hours care. People with dementia are particularly prone to wandering and other problems at night. Provision of a 24 helpline and training on dementia for relevant health staff would also assist. In addition, there is a need for improved respite care and better integrated day care and training for carers. The Panel noted that the majority of respite care provided through the Council was for carers looking after people with dementia. £1/2 million was currently spent on such facilities.

7.12 The Panel noted that there is a lack of groups that bring patients with long term conditions together across the Borough. In particular, the local diabetes group has ceased to exist. In addition, such groups that do exist appear to be under funded. The Panel feel that such groups can play a useful role in helping patients to help themselves and raising awareness of conditions. They can also provide a very useful channel for health and social care services to communicate with patients and provide appropriate information guidance that might assist them to remain healthy. It was felt that some capacity building work needed to be undertaken by the TPCT to encourage and assist patients to develop support networks**.**

Recommendation:
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.

Appendix A

Participants in the Review

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Lisa Donegan, Head of Nursing, North Middlesex University Hospital

Siobhan Harrington, Director of Primary Care, the Whittington Hospital

Tom Brown, Assessment and Care Manager, (Commissioning) Adult, Culture and Community Services, Haringey Council

Lesley Prince and Paulette Blake, Community Alarm Service, Haringey Council

Norman Mattis, Islington and Haringey Breathe Easy

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Appendix B

Documents referred to in the preparation of this review

Keeping People Out of Hospital; The Challenge of Reducing Emergency Admissions – Dr. Foster Intelligence

Healthcare for London; A Framework for Action – Professor Lord Darzi

PARR 1 and PARR 2; A Brief Guide – Department of Health/NHS

Keeping It Personal; Clinical Case for Change – David Colin-Thome, National Director for Primary Care, Department of Health

Case Management and Community Matrons for Long Term Conditions – Editorial, British Medical Journal

Case Managing Long Terms Conditions – The Kings Fund

Self-Management for Long Term Conditions – The Kings Fund

Supporting People with Long Term Conditions - Department of Health

Castlefields Health Centre: Chronic Disease Management Evaluation – National Primary and Care Trust Development Programme