

MINUTES OF THE SCRUTINY REVIEW - HIGH INTENSITY USERS TUESDAY, 30 OCTOBER 2007

Councillors: *Hoban, Lister, Mallett and Winskill (Chair)

* Member present

LC9. APOLOGIES FOR ABSENCE (IF ANY)

None received.

LC10. URGENT BUSINESS

None.

LC11. DECLARATIONS OF INTEREST

None.

LC12. MINUTES

AGREED:

That the minutes of the meeting of 2 October be approved.

LC13. PROGRESS WITH REVIEW

It was noted that independent expert advice has been sought from the City University, where there was a centre with a specialism in primary care and long term conditions. If this option did not prove to be fruitful, other options would be explored.

On particular area that could be considered by the Panel was the issue of telecare. This involved the use of IT to monitor remotely vital signs from patients in their home and could be particularly useful in cases of hypertension, diabetes, asthma and heart failure. There was specific grant funding available from the Department of Health for local authorities to fund such innovations. In addition, the report by Professor Ara Darzi (Healthcare for London - A Blueprint for Action) recommended that PCTs and local authorities develop joint action plans to address long term conditions. It was agreed that this and the issue of telecare would be raised with Adult Services and Haringey TPCT to see if any local action had already been taken on these issues.

LC14. HIGH INTENSITY USERS

The Panel received evidence from:

- Norman Mattis from Islington and Haringey Breathe Easy
- Dr. Anne Yardumian, Lee McPhail and Lisa Donegan from the North Middlesex Hospital
- Siobhan Harrington from the Whittington Hospital
- Tom Brown from Adult, Culture and Community Services

Breathe Easy

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Mr. Mattis stated that there were approximately 12 people who were actively involved in the local group. The aim of the group was to make life as comfortable as possible for its members. Its members suffered from a range of lung conditions such as COPD, asthma and asbestosis. It met on a monthly basis. He was referred to it by the Whittington Hospital, who provided some support for the group. His condition was changeable in its severity – he could be fine some days and not so good on others. However, there was a slow overall deterioration. Exercise was of great benefit for people with lung problems. He attended the gym on a regular basis. In addition, the group was currently trying to set up a regular exercise session for its members and was trying to obtain suitable funding for this.

Most people with lung disease had their own way of managing their condition and the ability to self manage was very important. Ms Harrington stated that the group was integrated into the hospital's rehabilitation programme. The Respiratory Team at the hospital valued their relationship with the group.

Mr Mattis stated that his condition was related to his previous work as an engineer, which had involved him working with asbestos. One particular aim for the group was to publicise lung conditions. There was a lack of appreciation of their range and what they entailed. He felt that this was leading him to having difficulty in obtaining compensation for industrial injury as well as a disabled badge.

North Middlesex University Hospital

Dr. Anne Yardumian, Lee McPhail and Lisa Donegan from the North Middlesex Hospital reported on action that was undertaken at the hospital to reduce the level and duration of hospitalisation of people with long term conditions. They had a First Response Team (FRT) who had proven to be effective in interventions to help avoid admissions and/or reduce their duration. They worked by providing a highly visible, coordinated therapy and discharge service by means of effective early specialist assessment and intervention, internal/external networking and referrals, as well as fast track access to community services or other health/social environments. There were now officers from Haringey's Adult Services who were based on site. The main benefit of the service was the provision of integrated services for patients, allowing a concentration and continuity of care from admission to the discharge of patients. This incorporated 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.

They were a multi disciplinary team and had links to other teams of professionals including the Rapid Response team at the hospital, the Intermediate Care Team, Community Matrons and social services. There were fortnightly meetings to discuss follow-up on recent FRT hospital discharges to community services and frequent attendees with long term conditions. There were also reviews of patients with significant social issues which included the participation of FRT, Community Matrons, HICCT, Day Hospital staff and the FRT consultant which aimed to prevent readmissions.

The Trust was currently in the process of expanding the FRT as it had proven to be successful in its role. It had been particularly effective in screening episodes where long term conditions may be a significant factor leading to a presentation at Accident

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and Emergency e.g. a patient presents with a fall whose root cause was COPD/heart failure but is only treated in relation to fall.

The team did not just operate in Accident and Emergency but was a constant presence across the hospital and particularly in assessment and care of the elderly wards. The service was not available 24 hours per day – its hours were 8:00 a.m. till 6:00 p.m. They liaised closely with triage at Accident and Emergency and worked with a range of therapists. Links with social services departments and PCTs were very important.

They had a particularly important remit in respect of care of the elderly. A key part of this was falls assessment. Community matrons had made a significant impact on success in admission avoidance. The link between the FRT and the Community Matrons worked well and they had been particularly effective in addressing asthma and COPD. However, some posts were still vacant. Community physiotherapists had been very effective although it was sometimes difficult to attract suitable qualified staff. They felt that the most effective means of keeping people with long term conditions out of hospital was through multi disciplinary, multi agency action, rather than just primary care.

Dr. Yardumian reported on a scheme that had been effective in keeping people with sickle cell disease out of hospital. There were growing numbers of patients at the North Middlesex who suffered from sickle cell. There had been 470 admissions from Haringey residents last year due to it and 80% of those had been treated at the North Middlesex. The dominant symptom was severe pain. There was a very high rate of hospitalisation amongst patients. A small number of patients had actually spent more time in hospital than at home. A four year study in the US had shown a similar picture. There was a particularly high rate of readmission.

The services that had previously been available to patients had been the usual ones;

- Out-patients (including out of hours)
- Day care (including out of hours)
- A&E
- In-patient beds

In addition, there had been services in the community, such as the George Marsh Centre, which provided:

- Genetic counselling
- Teaching
- Support groups
- Individual casework
- Drop in benefits / social services / housing session

Previous attempts to address frequent presenters had included counselling and case management. These had both been successful to some extent. However, the initiative that had worked best had proven to be the Home Care Outreach Nursing Team. The team worked with patients to help manage uncomplicated pain out of hospital.

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It took a multi agency, multi disciplinary approach, with the emphasis on providing continuity of care. There had been a steady increase in patient numbers and the service now had 1.5 staff and was currently dealing with 87 patients. There had been a 19% drop in admissions and a 32% drop in duration of admissions and satisfaction levels with the service were high. The service aimed to facilitate independence. The pain could be very frightening. She felt that it was probably not possible to avoid episodes but problems associated with them could be reduced.

Longer opening hours could help to improve the service and there was a need for more nurses. Dr. Yardumian was not sure that the service saved money but it was certainly a better quality service for patients that improved quality of life. More patients were managing more or less independently now and many patients just used the home care service and rarely admitted to hospital. However, there were nevertheless patients who continued to be admitted and used the home care service. A Community Matron was working with the small number of patients who were still being regularly admitted,

The service was 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 able to self manage their condition. It was now unusual for child to be hospitalised 'just' for pain management.

The hospital was now getting more patients from other Boroughs and this had enabled "critical mass" to be achieved. The model could also be considered for other long term conditions such as COPD and asthma. Members of the Panel would be very welcome to visit the George Marsh Centre.

The Whittington Hospital

Ms Harrington reported that the Whittington Hospital addressed the issue of high intensity users at both a strategic and specialist level. It worked together with key local partners to jointly address the issue. It had a Rapid Response team, whose role was to identify such vulnerable people and work with partners to avoid hospitalisation and, if this was not possible, to reduce the length of stay. This work involved social workers, occupational therapists and a nurse. This service was currently funded by Islington. There was also a close working relationship with Community Matrons and the matrons working within the hospital. In addition, there was also close liaison between discharge teams at the hospital and local authority social services departments.

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 was supported by clinical protocols to ensure safety and involved the triage nurse at Accident and Emergency identifying appropriate patients. The pilot was being fully evaluated by Islington PCT. Mr Brown commented that sometimes people went to Accident and Emergency due to lack of capacity in

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community provision and because services were not available to support people at night.

The Respiratory Team provided treatment, education and support to COPD patients to help them manage their condition more effectively. The Respiratory Early Discharge Service (REDS) helped patients admitted as an emergency to get home earlier and avoid readmission. This service was provided by a multi-disciplinary team of nurses, physiotherapists and doctors and worked in conjunction with primary care services in Islington and, to a limited extent, Haringey. The aim of the REDS team was 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 had an active pulmonary rehabilitation programme that worked with colleagues from leisure in both Islington and Haringey and involved Breathe Easy. The Trust also supported the Islington musculoskeletal (MSK) service in that their rheumatologist triages referrals and provided clinical support and supervision to the Islington MSK service.

The Trust was leading a new programme regarding self-management in Diabetes care with colleagues from both Haringey and Islington PCTs. It had 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 would 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 were 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.

The impact of case management schemes, such as the Community Matrons, was still unclear. Dramatic changes to activity were not being seen as yet but it needed to be emphasised that it was still a relatively new concept. The theory and practice had still not been properly assessed yet. However, improvements in practice occurred through evolution rather than revolution. She felt that improvements could also be achieved through joining up clinicians and professionals across patient pathways.

It was noted that there was an issue with people with low level dementia being admitted to hospital. Ms Harrington reported that the hospital was now actively screening new admissions for evidence of alcohol abuse and liaising with community services in Islington if appropriate.

One particular barrier to improved liaison between health and social care was the fact that IT systems were still incompatible. However, good progress was being made. It was essential that professionals had the necessary information to ensure that hospital discharges would be safe.

Adult Services

Mr Brown reported that, until recently, the focus of attention had been on getting people out of hospital. A lot of effort had been made in addressing this and progress had now been made. The government had allocated money put aside for fines for

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delayed discharges to social services departments. Haringey had used this money creatively and were investing in appropriate projects such as therapy, home care, advocacy and a rapid response scheme with the PCT. However, things were still at the embryonic stage. A five year strategy for integrated care services had been drafted. The intention was to have a single point of access to services that people could be referred to but which provided a multi disciplinary response and access to hospital beds if required. The position would be helped if it was possible for patients to have more treatments such as intravenous antibiotics at home, as happened in some other areas.

There were a range of networks available to identify vulnerable people and professionals generally knew who were the "frequent flyers" and staff made contact with GPs if there were sufficient concerns. There were particular issues with low level dementia and COPD. Services were not multi disciplinary at the moment. Agreement had been agreed so that people who are prone to falls could be referred to day hospital without having to refer via their GP. Not all GPs were helpful and the response in some cases was to assume that conditions were just the inevitable consequence of getting old. Relationships were, however, generally very good.

The Council provided services for 2500 older people including 600 people in care homes. They covered a wide spectrum of need. The Integrated Care Team had the necessary skills to keep many people at home. The team included a range of professionals, including social workers and nurses. There were considerable savings that could be made through reducing hospital admissions.

Whilst services were coordinated, they were not yet sufficiently integrated. Current arrangements had evolved in an ad hoc way rather than through a strategic approach. However, it appeared that the right people were being targeted and there was good dialogue between services. In particular, Community Matrons were working closely with Adult Services.

Keeping people out of hospital entailed additional costs for Adults Services. Discussions have been initiated with the TPCT on this issue and they were not unsympathetic to the issue. The advent of practice based commissioning and payments by result was making this more feasible. A number of local authorities were undertaking similar work in this area. A significant difference between the NHS and social services was that the NHS was free at the point of delivery, whilst services provided by social services were chargeable. Another key issue that needs addressing was that social care staff could not administer medicines and that offer this is a key factor in supporting people with long term conditions and can help reduce the need for emergency care.

The Panel thanked all the witnesses for attending.

LC15. NEW ITEMS OF URGENT BUSINESS

None.

LC16. DATE OF NEXT MEETING.

The Panel noted that efforts were being made to identify appropriate external expert advice and it was hoped to have resolved this by the next meeting.

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It was agreed that the following would be invited to give evidence to the next meeting:

- The Alzheimer's Association
- Age Concern
- Sickle Cell Support Group
- Community Matrons, *the* Expert Patients scheme, DESMOND.

It was noted that the next meeting would be on **Tuesday 20 November**.

Cllr David Winskill

Chair