MINUTES OF THE SCRUTINY REVIEW - HIGH INTENSITY USERS
MONDAY, 11 FEBRUARY 2008

Councillors: *Mallett and Winskill (Chair)

*Member present

Also present: Professor Sue Procter (City University and Adviser to the Panel) and Ms. G. Taylor and Ms. D. Thomas (Haringey Teaching Primary Care Trust).

LC36. APOLOGIES FOR ABSENCE (IF ANY)

Received from Councillor Hoban

LC37. URGENT BUSINESS

None.

LC38. DECLARATIONS OF INTEREST

None.

LC39. MINUTES

AGREED:

That the minutes of the meeting of 18 December 2007 be approved.

LC40. CONCLUSIONS AND RECOMMENDATIONS

The Panel, with the assistance of Professor Sue Procter and Gerry Taylor and Delia Thomas from Haringey TPCT, considered all the evidence that it had received during the course of the review.

It noted that there was a strong need for information to be collated across health and social services. At the moment, records tended to be episodic instead of patient centred. For instance, GPs were required to hold disease registers that contained information on patients with particular conditions rather then focussing primarily on the patients with them. It was not clear how many people were at high risk of admission to hospital and could therefore potentially benefit from appropriate interventions. Collaborative clusters were currently looking at ways that they could better identify people. GPs could potentially play a big part in addressing the issue.

It was recognised that there was limited scope for effective local action to address the shortcomings of information systems. However, there would still be some need for information systems to be developed locally in order to better join up services. It was felt that it was essential that that these were patient centred, rather then being episodic or disease based. In addition, it was felt that it was essential that Camidoc and other relevant providers were included in information sharing.

It was noted that a significant percentage of high impact users suffered from mental health conditions. It was therefore important that the Mental Health Trust was included within information sharing. In addition, there was currently a lack of psychiatric cover for older people at the North Middlesex Hospital due to a lack of

agreement between the TPCT and the Mental Health Trust on how this should be provided. It was felt important that this be resolved.

Ms Taylor reported that Haringey TPCT had not met the target of 21 for the number of Community Matrons posts that they were required to establish by March 2008. They were currently evaluating the effectiveness of community matrons as part of a stage process to expanding their numbers. Consideration was being given to increasing their numbers gradually. However, effective evaluation was complex. For example, people who had three emergency admissions in one year were generally less likely to have the same number of admissions in the following year irrespective of any intervention. Many evaluations that had been undertaken of community matrons were based on the US experience, which was not comparable to the UK due to different ways of working.

Information from up to 2006 on the effectiveness of Community Matrons had now been collected and was now being analysed. There had been a general decrease in the rate of hospital admission for older people and there was a need to look at data covering a longer period before reaching decisions.

It was noted that the TPCT was currently using alternative ways of providing case management to make good the shortfall in the numbers of community matrons. Targets for the number of people to be receiving case management had been met but the service had been provided by a range of different health professionals. GP collaborative clusters were considering how to identify appropriate patients. It was not possible to estimate the number of patients who were not getting a service but who may benefit from case management.

It was noted that some community matrons were carrying more then the recommended case load of 50. However, these were matrons who covered older people and a number of these cases were either not active or were for patients who were in residential care.

The Panel noted the evidence from Professor Procter that many PCT's were satisfied by the progress that community matrons had made so far in improving support for people with complex long term conditions. In addition, there was clear evidence that they helped to improve quality of life, which they felt should to be one of the key criteria for evaluating their effectiveness. The Panel was of the view that that the PCT should be looking at expanding their numbers up to target levels.

Professor Procter commented that admitting people to hospital was not without risk due to the danger of patients catching infections, such as C. Diff. and MRSA. There was also an increased risk of dementia due to the effects of institutionalisation. These risks were not necessarily taken into account by people, including health professionals. In addition, doctors who worked in Accident and Emergency were often at a junior level, likely to be unfamiliar with the patient and tended to request lots of tests on patients, which could clog up the system.

The wider availability of diagnostic equipment for GPs that would take place within improved primary care premises would greatly assist them. If primary care services were able to provide a wider range of services and were seen to be reliable and accessible, patients would be more likely to view then as safe places to go and more prepared to use them instead of hospitals.

It was felt that better integrated care between health and social care services was essential to improving support to patients. However, this needed to involve an element of financial integration between the TPCT and Adult Services. It was felt that a strategic evidence based approach should be adopted locally and should go beyond the merely aspirational and seek to make genuine progress towards joint working. It was felt that clearer definitions were required in order to ensure that there was 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 information systems.

In respect of telecare, it was noted that the TPCT paid for health professionals to have access to relevant data. The cost of renting the equipment had to be paid for by the patient and some people were very reluctant to pay. The service was not self financing and the Council had to find the funds to pay for it, which was not always easy. This acted as a disincentive for Adult Services to invest.

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.

It was noted that were a lack of patient groups across the Borough. In particular, the local diabetes group has ceased to exist. In addition, such groups that did exist appeared to be under funded. It was felt that some capacity building work needed to be undertaken by the TPCT to encourage and assist patients to develop support networks.

AGREED:

That, based on the above mentioned conclusions of the Panel, a draft final report for the Panel be produced and circulated to Members for final agreement.

LC41. EVALUATION

It being the concluding meeting of the review, participants were asked to provide feedback on the effectiveness of the review.

Members felt that they were much more aware of the issue now and the challenges that services faced. It was a very complex subject but they now felt that they now had a better understanding of it. The exercise had helped to highlight the key issues. They were satisfied by how the review had been administered and felt that there was no particular areas of relevance that had not been covered.

LC42. NEW ITEMS OF URGENT BUSINESS

None.

Cllr David Winskill

Chair