Draft

The Management of High Impact Users of Healthcare

NHS Haringey has moved away from focusing on the numbers of community matrons in favour of reviewing the role of the community matron. We want to have a greater skill mix within the community matron service and provide more explicit pathways from the community matron service to and from other services.

As a result we have now introduced specialist case manager and community matron assistants for community matrons. These assistants facilitate better access to resources needed to more effectively manage patients in the community. Resources include rapid access to physiotherapy, occupational therapy, psychology, home care and equipment.

The role of community matrons in nursing and residential care homes has also provided considerable support and guidance. For example, offering specialist advice on applying the Gold Standard Framework as part of End of Life care planning and contributing to the development of improved access through the falls care pathway to the Integrated Therapy Team and London Ambulance Service.

The challenge of effectively managing high impact users is much wider than the community matron remit. It should not be seen in isolation to the need to prevent unnecessary admission, reduce the length of stay (LOS) for those patients who required admission, and prevent readmission within 28 days of discharge.

Those patients within the complex elderly speciality in 2008/09 who were readmitted within 28 days of discharge include 3245 spells in hospital for between two and ten days and 1993 spells of 11 days or more. It is clear to see why excess LOS and repeat admissions are of major concern to both health and social care in respect of quality of care and the impact of prolonged hospital stays on older people.

There are two main aspects to this problem - the ability of the hospitals to discharge patients in a timely fashion; and the ability and responsiveness of primary healthcare and social care to meet the needs of this patient group within the community setting.

To this end NHS Haringey has contracted CLINICENTA to provide Acute Home Care nursing and therapy support and the Stroke Care Pathway. This service help patients settle back home more quickly and the community matrons can also access the additional nursing and therapy support to prevent unnecessary admission occurring.

The increased in-reach to both North Middlesex University Hospital Trust and The Whittington Hospital Trust by the community matron team is also proving effective. We are able to apply advanced planning to effect appropriate and timely discharge and further investment is being considered to improve GP performance so that this too becomes more responsive and flexible.

The types of posts now provided in the community matron service include:

6 Generic Community Matrons with case manager
Specialist Community Matron for TB;
Specialist Community Matron for Older People;
Specialist Community Matron for Adults with Physical Disability;
Specialist Community Matron for Residential & Nursing Homes;
3 Specialist Community Nurse Assessors
Specialist HIV Nurse
Specialist Heart Failure Nurse
Specialist Diabetes Nurse
Specialist COPD Nurse and Physiotherapist
Specialist in Palliative Care
Specialist in Neurological Conditions
3 Specialist Safeguarding Nurses
CLINICENTA – Acute Home Care
CLINICENTA – Stroke care pathway
District Nursing Service

This further investment from NHS Haringey brings the total number of posts to 21 providing a more flexible and responsive community service which is working in better harmony with our Hospital Trust and social care partners.

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