

MINUTES OF THE SCRUTINY REVIEW - HIGH INTENSITY USERS TUESDAY, 2 OCTOBER 2007

Councillors *Hoban, Mallett and Winskill (Chair)

* Member present

LC1. APOLOGIES FOR ABSENCE (IF ANY)

None received.

LC2. URGENT BUSINESS

None.

LC3. DECLARATIONS OF INTEREST

None.

LC4. SCOPE AND TERMS OF REFERENCE

The Panel noted the scope and terms of reference for the review that had been agreed by Overview and Scrutiny Committee. It was agreed that information would also be sought on how the statistics about which people were deemed to be most at risk from emergency admission (on which decisions were taken) were collected. In addition, Members felt that quality of life issues would also be considered and not just value for money.

In respect of independent expert advice, Members agreed that the possibility of commissioning some external input would be explored in order to provide an element of challenge and advice on possible lines of inquiry.

The Panel noted the definition of high intensity user that was used locally by Haringey Teaching Primary Care Trust (TPCT): "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 was made between people who just presented at Accident and Emergency and those who were actually admitted to hospital. "Ambulatory care sensitive" (high impact users with primary care sensitive conditions) was not a piece of terminology that was used.

In respect of mental health, it was noted that, although this was a long term condition, it was treated differently as a different range of services were required. There were now fewer patients going to Accident and Emergency now due to the emergency reception centre at St. Ann's Hospital and there were now systems in place to address the issue. It was agreed that the TPCT would be asked to provide relevant statistics in relation to mental health as well as information on the ethnicity of high impact users.

Members noted that thalassaemia and sickle cell were prevalent in Haringey due to the ethnic background of people in the Borough and felt that there should be consideration of these within the review. Gerry Taylor for the TPCT reported that there was a particular unit that dealt with this condition at the North Middlesex Hospital.

AGREED:

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1. That the provision of external expert advice for the Panel be investigated further, in consultation with the Chair.
2. That the issues of mental health, thalassaemia and sickle cell disease be considered as part of the review.
3. That the TPCT be requested to provide relevant and up to date statistical information on high intensity users, including people with mental health problems, within the Borough.

LC5. PROGRESS WITH REVIEW

Noted.

LC6. HIGH INTENSITY USERS

Gerry Taylor, Acting Director of Strategic Commissioning at Haringey TPCT, Delia Thomas, from the Integrated Care Team at the TPCT and Dr. Jyotindra Pandya MBE, a Tottenham GP and clinical director for the south east collaborative cluster of primary care practitioners provided an overview for the Panel on what was currently done to prevent the unnecessary hospitalisation of people with long terms and complex conditions.

Ms Taylor reported that Haringey practice was based on national guidance and strategy. This was generally based on the principle of helping people to support themselves. Haringey was currently on track to meet the national target to reduce emergency bed days by 5% by 2008 through improved care planning in primary care and community settings. The Community Matrons (CMs) scheme had been recommended as a particularly effective approach. Haringey's target was to have 21 matrons by 2008 and there were currently 14 posts established, of which 11 were filled.

One of their key roles was to identify very high intensity users and those most at risk from being admitted, as an emergency, to hospital. Some of the matrons were generic (4.25 posts) in their role whilst others specialised in a particular condition. They were based within each collaborative cluster. In identifying appropriate patients to work with, they liaised closely with local primary care practitioners. Before relevant patients were taken on, CM's had a discussion with the patient's GP in order to be appraised on their history. The patient was then visited. The CMs had more time to work with the patient than GPs. They undertook a range of functions, including reviewing medication and undertaking social and psychological assessments. They worked separately from the District Nurses. They worked intensively with patients at first and monitored them closely. Following this, they could taper down their involvement, if appropriate.

The CMs were employed directly by the TPCT. The scheme was intended to follow an evidence based approach. A pilot scheme had been set up initially using a telephone only contact with patients but this approach alone had been found not to be successful. CMs currently worked with a caseload of approximately 50 patients as this was felt an appropriate amount for them to handle. It was recognised that the level of service provided was not based on a complete picture of overall need/demand.

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The scheme was relatively new and had only been established locally in November 2006. It was possible that caseloads could grow once the scheme had developed further. The CMs had developed links with a wide range of organisations, including the Council's Adult Services, the community alarm scheme and the ambulance service. There was a specific CM network which allowed them to share expertise and knowledge. As it was a new service, it was currently being evaluated to ensure that it was effective. Current evidence was still unclear as to its overall effectiveness.

Patients who might benefit from the service were identified either from them having been admitted and discharged a number of times or by the CM identifying a need through looking at appropriate data and liaising with general practitioners. It was noted that data from Accident and Emergency was not always accurate. In particular, there was a different coding system that was based on a description of the condition. In some cases, conditions were not always immediately obvious. Information from Camidoc was not currently taken into consideration. The Panel noted that more people generally attended Accident and Emergency during the daytime than at night. In addition, patients might also use NHS Direct. Patients could use a range of facilities. There was a need to co-ordinate data from different sources.

The TPCT used the PARR (Patients at Risk from Rehospitalisation) predictive software which produced lists based on risk levels. CMs had access to this. Particular attention was paid to those patients with more than a 50% risk level. However, there were limitations in the usefulness of the data as in some cases patients had moved on or changed circumstances by the time that the figures came to light. However, this was not the only source of referrals as CMs also liaised with GPs. Members requested some more information about sources of data and how patients were chosen for the scheme.

Dr Pandya reported that all practices held disease registers and these could be referred to as well. Information on exactly how many people had been diagnosed as having particular conditions was therefore readily available. There was some element of risk in not admitting patients to hospital who were suffering from an episode of illness. The advent of practice based commissioning and collaborative clusters had helped considerably in improving services. There was some variability in the quality of practice and improvement might be facilitated by work being done across practices to bring everyone up to a uniformly high level.

The Panel noted that local hospitals had specific teams that also looked at high intensity users. There was a 1st Response team at the North Middlesex Hospital that referred cases to CMs. There was also a lead nurse at the Whittington Hospital, who also kept a "top 100" of their most prolific service users.

Part of the Primary Care Strategy involved developing further care pathways. There was particular emphasis on helping people to self manage their conditions through schemes such as the expert patient scheme and DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed). In addition, within each collaborative cluster, there were GP practices that had particular special interests. An integrated intermediate care and rehabilitation strategy had been agreed with the local authority and this also assisted with meeting the needs of people with long term conditions.

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The Panel requested up to date figures on high intensity users, including the conditions involved, total cost, and how this compared against other areas.

It was noted that TPCT spending on the scheme had not this year yet reached target levels but it was possible that they would be reached next year. However, potential savings from the scheme could mean that the service paid for itself. Current savings could be in the region of £1.5 million.

The vast majority of people greatly appreciated the new service. Only a tiny number of people had declined the service. Initially, some people were not enthusiastic about seeing a nurse instead of a doctor but once they had used the service the response was universally positive. The Panel requested information on the numbers of GPs that were utilising the service and engaging.

There was a particularly close working relationship with the Council's Adult Services. There was now a Single Assessment Process (SAP) and information could be shared. This helped to prevent the need for patients to repeatedly give out the same information. The computer systems used by the TPCT and Adult Services were not currently compatible and information sharing could be improved.

The Panel thanked Ms. Taylor, Ms. Thomas and Dr Pandya for their assistance.

LC7. NEW ITEMS OF URGENT BUSINESS

None.

LC8. DATE OF NEXT MEETING.

Tuesday 30 October at 6.30pm.

Cllr David Winskill

Chair