

**MINUTES OF THE SCRUTINY REVIEW - HIGH INTENSITY USERS
TUESDAY, 18 DECEMBER 2007**

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

Also present: Tom Brown (Adult Services, LBH), Delia Thomas (Haringey TPCT), Lesley Prince and Paulette Blake (Community Alarm Service, LBH), Julie-Ann Philips (Alzheimers Society), Jennifer Strathearn (Age Concern), Professor Sue Procter (City University).

LC26. APOLOGIES FOR ABSENCE (IF ANY)

Apologies for absence were received from Councillors Hoban and Lister.

LC27. URGENT BUSINESS

None.

LC28. DECLARATIONS OF INTEREST

None.

LC29. MINUTES

AGREED:

That the minutes of the meeting of 20 November be approved.

LC30. TELECARE IN HARINGEY

The Panel received evidence from Lesley Prince and Paulette Blake from the Council's Community Alarm Service and David Souter from Tunstall

The Panel noted that the Service had been supporting elderly and vulnerable people in the Borough since the 1980's. This was 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 supported up to 4500 people within Haringey.

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 support individuals, such as occupational therapists, integrated care teams, home care agencies, Housing Association supported housing officers, district nurses, community matrons and GP's.

In Haringey, people were now considered for telecare as part of assessments that had been undertaken in response to referrals. The scheme aimed to;

- Reduce hospital admissions and readmissions
- Reduce dependence on care services and families
- Provide security in the home and enable greater independence.

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- Reduce anxiety
- Improve the quality of life for patients and informal carers
- Delay the move into long-term residential care.

The basic systems just involved a button that was carried around the neck and could be pushed by clients in the event of an emergency. This was connected to a telephone line and would alert relevant staff. There were also a range of other sensors such as ones that detected movement, flood, carbon monoxide, falls, property exit and epilepsy. The equipment was battery operated and did not require hard wiring. It provided a warning to the control room when batteries were low.

Door exit sensors were particularly effective for individuals with increasing dementia, which could be exacerbated when they were removed from home into residential care. The sensor monitored when the client left the home. If and when they did, a call was generated and received in the Control Room, where appropriate action was taken.

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

The basic cost to the client was £5.95 per week for the alarm on its own. Additional items were charged at 50p. per two items. Each local authority had its own way of charging. The service tried to keep the cost low and had taken advice on fair charging. In addition to direct benefits to the individual, the sensors could help give carers and relatives peace of mind.

The service had also set up a pilot scheme in partnership with Primary Care Trust involving the use of Vivatech Wrist Care. This entailed the individual wearing a wrist alarm, which sent wellness data via the internet to Vivatech. This was passed onto community matrons. Community matrons were able to assess a range a data including sleep patterns and well being, which was measured by the patient's circadian rhythm. As the patient's level of health improved, the patient was moved off wrist care and assessed by the Community Alarm service for Telecare products such as a pendant alarm, fall detector, medication dispenser etc.

The Panel noted that considerable savings could be made as a result of the use of the equipment. For example:

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

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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

The service was currently in the process of launching another tele health scheme called Doc@home. This was a portable device which was left in peoples homes for a minimum of 3 months. It could ask the patient specific questions about their health and take readings of blood oxygen levels, ECG, weight, pulse and blood pressure. The data could be monitored via the internet. If a patient's health was deteriorating, it could produce alerts that could be picked up and acted upon by community matrons. Doc@home could be used alongside a telecare alarm so that urgent emergency alerts could be made when necessary. Using the doc@home helped 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 had shown very good results and reduced hospital admissions. The scheme was being undertaken in partnership with the Primary Care Trust and was aimed particularly at high intensity users, such as people suffering with COPD. In addition to reducing the number of visits to the hospital, it also reduced anxiety. Doc@home had been tested in several EU countries as well as 15 PCTs. It was initially being used with 30 patients.

The range of Telecare installations had been publicised via the following:

- Road shows
- Demonstrations
- A fall detector pilot study with Housing Association residents
- Demonstrations to all teams within Adult Services and occupational Health teams in the Whittington and North Middlesex Hospitals

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- Attending events such as mental health, disability and carer's forums.
- An open day at the civic centre
- Smart leafleting, utilising the census to target where the pockets of elders reside in the community.
- Linking with Haringey Residential Housing Associations.

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

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

People generally adapted well to using telecare equipment. Clients were provided with guidance when the equipment was installed. The bulk of call-outs were false alarms but they were happy to receive them. Support staff were all fully trained and subject to Protection of Vulnerable People (POVA) checks. There was a strong care aspect to their work. The service was managed by the Adult Services Directorate. There was a feedback loop that enabled additional needs to be identified.

Ms. Thomas reported that wellness data could be of considerable benefit to health professionals. For example, sensors could detect whether people had had a restless night. Community matrons could access this data via the net and pick up the possibility of patients having a Urinary Tract Infection (UTI). It had therefore been of great benefit.

The service saved the NHS money by reducing the need for hospitalisation. The income that the team received did not cover the cost of providing the service. The service generated money from a range of sources, including Housing Associations and Supporting People. However, this did not cover all the costs and it was often challenging making up the shortfall. It was noted the service had a good relationship with the PCT. The PCT was currently in a relatively strong financial position and discussions were taking place on how financial resources from the TPCT could be used to support social care activities, such as this, undertaken by the Council that had the potential to make savings for the TPCT. The Panel noted that the cost could deter some people from having the equipment. People who were on certain benefits could get help with the cost. If people were referred, the service was free.

LC31. EVIDENCE FROM USER GROUPS AND ADVOCATES

The Panel received evidence from Jennifer Strathearn from Age Concern and Julie-Ann Philips from the Alzheimer's Society Haringey.

Age Concern

Ms. Strathearn reported that she was providing a new service on behalf of Age Concern, which involved acting as an advocate in cases where elderly patients from Haringey were subject to delayed or failed discharge. This covered situations where patients did not want to go to where they had been allocated or where they had been unable to find accommodation. Sometimes people could not afford care or found it hard to accept it. Local authorities were fined £120 per day unless for delayed discharges, unless they were the fault of the NHS. In addition, she could provide

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benefits advice. Advocacy was currently only available in hospital and was provided at both the North Middlesex and the Whittington.

Mr. Brown commented that it was known that there were gaps in this particular area. This was especially true of the Whittington Hospital, which had experienced problems with patients refusing to move out of the hospital. The service had been established using pooled budget money with the North Middlesex and the Whittington and services were commissioned jointly with them. The objective of the service was to try and assist in resolving difficult issues, where an impasse had been reached.

Ms. Strathearn reported that clients sometimes told advocates things that they had not mentioned before and which could make a difference. Older people were sometimes suspicious of professionals and were therefore likely to be more open with independent people. In addition to addressing delayed and failed discharges, advocates could also help to prevent readmission to hospital. For instance, preventative action could be taken to reduce the risk of falls. Older people sometimes found it hard to accept that life had changed following hospitalisation and could have the mistaken expectation that they would be able to continue their life as it had been before.

Referrals generally came from the Integrated Care and Discharge teams of each hospital. She normally just talked just to the patient but could also involve family members, if they were available. She frequently came across people who had no support at all and, in such circumstances, could provide practical help including benefits advice. She could also refer people onto other services, as appropriate.

Alzheimer's Society

Ms. Philips reported that the Alzheimer's Society was a small, national charity. They provided a number of services within Haringey including advocacy, a drop in facility and a café. There were approximately 1400 people in Haringey with dementia. Significant numbers were treated at St. Ann's. There was a high prevalence of vascular dementia within the Borough.

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

The Panel noted that the volume of people attending Accident and Emergency was such that it was often not possible to deal with anything other than the immediate issue. The North Middlesex Hospital did not currently have psychiatric cover for older people, which was a significant factor in the admission of a number of people to hospital. The lack of service meant that the issue was not being picked up. There had previously been an informal arrangement between the Mental Health Trust (MHT) and the hospital which the MHT had now decided to withdraw from. Formal arrangements were in place in other hospitals.

Ms. Philips commented that there was now a lot more awareness of dementia. Older people generally saw hospital as a safe place to go. Accident and emergency (A&E) was often seen as a safe haven. However, A&E took a long time to deal with people and, more often than not, did not have the full history of patients.

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Professor Proctor reported that hospitals frequently had several different case notes for the same person. The NHS suffered from poor information systems. Episodes rather than individuals tended to be the primary basis upon which record keeping was based. The problem was very difficult to resolve. Current systems were designed to react to rather than prevent ill health. A massive system change was needed. Mr Brown reported that efforts were being made 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. However, systems needed to be configured so that people did not end up in A&E in the first place.

MS Philips felt that there was a particular problem with out-of-hours care. People with dementia were particularly prone to wandering and other problems at night. She felt that provision of a 24 helpline and training on dementia for relevant health staff would assist. Medicines could assist in stabilising the condition and addressing challenging behaviour. There was a need for improved respite care. In addition, she felt that there was a need for better integrated day care and training for carers.

Mr Brown commented that the majority of respite care was provided for carers looking after people with dementia. £1/2 million was currently spent on such facilities. People with dementia were normally dealt with via mental health services at St. Ann's. However, there was a lack of medical facilities there. Most people needed both medical and care services.

LC32. HIGH INTENSITY USERS - PRESENTATION FROM INDEPENDENT EXPERT ADVISER

The Panel received a presentation from Professor Sue Procter, from the City University, on key issues relating to high intensity users and interventions that have undertaken.

High intensity users tended to have one or more long term conditions (LTCs) plus complex social circumstances and/or additional mental health problems including anxiety and depression. Not all patients with one or more LTCs became high intensity service users. Those that did tended to make additional demands on A&E and out of hours services, including hospital admissions, and/or suffered from LTCs that had traditionally been managed by the NHS in isolation from social services (e.g. COPD, diabetes, heart failure).

High intensity users could be managed as part of a strategic response to LTCs, but tended to require additional demand management strategies such as;

- Anxiety management
- Out of hours and fluctuating support from social services in response to exacerbations of their condition
- Help to address complex social circumstances
- Containment strategies in order to prevent the patient bypassing planned care system

The Chronic Care Model identified the essential elements of a health care system that encouraged high quality chronic disease care. Strategic responses to high intensity were typically based on these. These elements were:

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- Community resources and policies
- Health care organisation prioritising chronic care
- Self-management support
- Delivery system design
- Decision support for to ensure integration of protocols and guidelines
- Clinical information such as
 - 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 role of the Community Matron was an important part of many strategies. Community Matrons typically took responsibility for about 50 older people with high levels needs and worked collaboratively with all professionals and care givers. They worked in partnership with GPs and members of the primary health care team. They worked with the patient to develop a personal care plan, kept in touch and regularly monitored the patient's condition. They performed a range of useful functions such as:

- Initiating action as required
- Updating medical records
- Mobilising multi-agency resources as required
- Educating care givers into when to alert services
- Generating additional support as required
- Maintaining responsibility for patient even if they are admitted to hospital
- Preparing relatives and patients for health outcomes
- Evaluating care packages with GP.

In respect of telemedicine, there was very little UK evidence so far. 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 very high intensity users. In addition, patients and families already experiencing high levels of stress may not welcome additional stress when technical problems are experienced with telemedicine.

On the whole, UK information systems were not joined up and this seemed to be the case in Haringey. Essential information such as District Nursing notes tended to be manual rather than electronic and therefore could not be interrogated. Existing information systems such as GP registers did not enable identification of current or potential VHIU. The PARR formula was a response to current deficiencies in routine data collection. The accuracy of its predictions was variable.

The single point of access was a way of providing a single point of information about the patient. It was designed to prevent the duplication that could occur when patients used multiple access points, such as A&E and out of hours GP services. It also enabled identification of the total population living with an LTC in order to plan

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services. A problem with current NHS information systems was that they gave information on episodes of care or incidence of a single disease not people.

In respect of the effectiveness of community matrons and case management, there was little evidence of it leading to a reduction in hospital admissions. However, other evidence showed that the approach was effective and that patients were benefiting from it by being alive and well, still living at home and avoiding hospital. Many trust boards were also pleased with local evidence showing that community matrons more than covered their costs in emergency admissions saved. It was also clear that they improved quality of life. There was always likely to be sufficient demand to fill hospital beds so significant savings were unlikely to be made. In addition, many studies were based on the US experience, which was not comparable to the UK due to structural differences.

One particular initiative that had been undertaken was the "virtual ward". This involved a network of virtual wards caring for the top 0.3% of a PCT's registered population ranked according to predicted risk of emergency hospital admission in the following year. Each ward had a capacity to care for 100 patients and was linked permanently with a group of GP practices. The clinical work of a virtual ward was led by a community matron. There was also a ward clerk and the telephone number for him/her the ward clerk was the sole point of contact for the entire virtual ward. Patients were cared for at different intensities according to need: of the 100 patients, 5 were reviewed daily, 35 weekly and 60 monthly. When a patient fell below the top 100 for the virtual ward's catchment area, discharge was considered. In the first two years following discharge the GP practice conducted quarterly rather than annual reviews.

Professor Procter briefly outlined the main principles of the report by Lord Darzi entitled "Healthcare for London – A Framework for Action". The report was based on the following principles of care:

- Fairness – equally available to all, taking full account of personal circumstances and diversity
- Personalised – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- Effective – focused on delivering outcomes for patients that are among the best in the world
- Safe – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

The Panel thanked Professor Procter for her presentation.

LC33. PROGRESS WITH REVIEW

It was noted that a meeting was in the process of being arranged with the Chief Executive of Camidoc. This would enable issues relating to our-of-hours care to be raised.

LC34. NEW ITEMS OF URGENT BUSINESS

None.

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LC35. DATE OF NEXT MEETING.

It was agreed that a meeting to agree appropriate conclusions and recommendations for the review would be arranged and that efforts would be made to ensure that Professor Procter was able to attend on order to feed in her expertise.

Cllr David Winkill

Chair

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