Greater Peterborough Primary Care Partnership: Intensive case management

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Summary information

Target population
Initially (October 2004) our target population was older people aged 75 years or over who had experienced three or more hospital admissions in the preceding 12 months. This did not work as a target group and was quickly extended to include people aged 65 or over who had three or more identified risk factors (eligibility factors). We are now changing the target age group to include all adults, although older people, particularly those aged 75 years or over, are likely to be the majority user group.

Eligibility
We have adopted a set of eligibility conditions similar to the Castlefields model. This comprises a list of risk factors, including factors such as three or more long-term conditions, three or more admissions to hospital in the previous six months, three or more attendances at accident and emergency departments, five or more medications, 25 hours or more personal home care services provided, recent bereavement. If people have three or more of these risk factors then they are eligible for the service.

Size of service and persons served
Community matrons are advanced practice nurses providing clinical case management for patients with complex chronic conditions. They are part of the integrated community service and have the capacity to work with a maximum of 200 people at any one time. The capacity of the service is extending as we continue to roll out across the integrated teams. Greater Peterborough Primary Care Partnership (GPPCP) has 5.0 whole-time equivalent community matrons, working as part of integrated locality nursing and social care teams consisting of district nurses, community nurses, health care assistants and social care workers. In the first 15 months of operation of the service, community matrons have been involved with 400 people.

Our local target is to extend the service so that 1,000 individuals can benefit from intensive case management at any one time by the end of 2007 (based on the GPPCP patient base of 220,000).
Enrolment strategies
Case finding has been through local communications with practices, co-ordination with accident and emergency departments, and analysis of emergency admission data. We are just starting to use the King’s Fund predictive risk tool.

Services included within the programme
- Intensive case management by a community matron for a person living in his or her own home.
- Intensive case management by a member of the residential and nursing home team for a person living in a care home.
- Case management by a member of the community integrated services team.

Payment structure
All staff are employed by GPPCP. There are no additional payments.

General structure of the programme, care management responsibilities etc
Intensive case management (health care) and care management (social care) have been brought together through the GPPCP. Community matrons have a defined set of tasks and responsibilities in relation to people with complex chronic problems who are on the intensive case management programme. Once the person’s care and condition is stabilised, then responsibility may be transferred to a member of the integrated community team if that person could benefit from proactive support and holistic case management, with their whole care continuing to be co-ordinated through one named individual. The community matron can become re-involved at any time. The objectives are exactly the same and performance and outcomes are measured in the same way, whether a person’s care is managed by a community matron or by another member of the team. It is a whole team approach to intensive case management.

This is our way of maximising the use of community matrons and valuing the role played by district nurses, social care workers and others. It is a whole-service approach rather than a stand-alone case management programme. We view intensive case management as the core business of integrated community teams for the future.

Length of operation
- Started November 2004, with first group of users in December 2004
- Pause and Plan evaluation, September 2005
- Service model agreed, September 2005
- Second-stage implementation ongoing.

Programme goals
Initially strong focus on reducing emergency admissions, subsequently developed wider outcomes approach, including well-being, quality of life and maximising independence.

Initial cost savings
Independent evaluation by the Strategic Health Authority showed annual savings of £572,000 to date, based on admissions avoided. This was based on initial year 1 activity. As we extend the service, this is projected to rise to more than £1 million per annum.

One of the major challenges, to which we do not have the answer, is how to evaluate cause and effect and therefore quantify savings.

Programme description
Summary of objectives
- Reduced hospitalisation, especially unplanned hospital admissions
- Reduced crises for the individual and their carers, resulting in reduced contacts with primary care
- Improved confidence for the individual and carers in managing conditions
- More control for the individual over their own life and well-being
• Positive patient experience of well co-ordinated care from all those involved
• Improved quality of life and greater independence
• Improved support for carers.

**Where the service sits: stand alone or integrated?**

GPPCP is a fully integrated health and social care organisation. A section 31 [joint health and social care commissioning, provision and funding] agreement with Peterborough City Council covers all aspects of adult social care. We have integrated commissioning and service delivery arrangements. My post as Assistant Director, for example, holds responsibility for adult social care assessment and care management, direct provision of personal home care services, community nursing services and community allied health professional services. We have integrated nursing and social care teams within localities, linked to primary care practices, with a single line manager.

The intensive case management service is part of integrated community services. Community matrons are part of the locality-based integrated community teams, with single-line management shared with the wider community nursing and adult social care services. It is not a specialist service but is the most intensive point of our continuum of care and support. Integration is critical to our model of care.

**Target population**

Adults with highly complex health and social care needs, who are at highest risk of loss of independence and/or unplanned hospitalisation, could benefit from proactive co-ordination of care, increased support and continuous review of their health and social care needs through one named individual. The initial target group is people aged 65 years or over, but this is now being extended to include younger adults.

Figure 1 illustrates the potential need for community matron services among adults over 18. It shows instability in the care of younger people, for example, a significant number of younger adults with only one long-term condition have had three medical admissions in a six-month period.

**Figure 1: Emergency admissions among PCT population by age group, February–August 2005**
Eligibility criteria and enrolment methods

People aged 65 years or over who meet three or more of the following criteria are identified as being most likely to benefit from the approach:

- people with three or more long term conditions
- people who have experienced 3 or more hospitalisations in the past 6 months (especially admissions with the same diagnosis)
- people who have attended accident and emergency departments three or more times in the past six months (especially for the same reasons)
- people who have had two or more non-environmental falls within the past two months
- people who have suffered a bereavement within the past year and are at risk of medical/social decline
- people who have been in hospital for more than four weeks in the past year
- people who have 25 hours or more personal home care per week
- people who fall into the top 3 per cent of frequent users of GP home visits
- people taking five or more medications.

Selection process

Case finding has proved time consuming and we have not yet got it right. We have been relying on local analysis of hospital data and referrals from GPs based on the eligibility criteria. We have also proactively searched GP patient lists. We have just started using the King’s Fund predictive risk tool that we hope will assist in highlighting those most likely to benefit in a consistent way.

Services offered include information, prevention advice and support, comprehensive assessment (across health and social care needs), treatment, review and monitoring.

The community matron has the following role.

- Undertake a full, detailed and advanced assessment of the needs of the person, incorporating nursing, emotional, environmental and social care needs.
- Review all input and address any gaps or causes for concern. This includes working with the individual, and all professionals, carers and relatives to understand all aspects of the person’s physical, emotional and social situation.
- Develop a personalised care plan with the person, carers, relatives and health and social care colleagues, based on the assessment of needs. The plan includes preventative measures and anticipates any future needs the person may have.
- Maintain regular contact with the person and monitor their condition regularly. This may be done by home visits or by telephone contact.
- Initiate action if required, such as ordering tests or prescribing.
- Update the person’s medical records, including medicines review, and inform other professionals about changes in condition.
- Liaise with other team members, other local colleagues and other agencies to mobilise resources as they are needed.
- Teach the person themselves and carers and relatives to recognise, as early as possible, subtle changes in the person’s condition that could lead to an acute deterioration in their health, and to call for help.
- Secure additional support as needed, for example, from home care, intermediate care, palliative care, or specialist medical/pharmaceutical input.
- Maintain contact with the person if she or he is admitted to hospital, liaising with ward staff to ensure integrated and consistent care, and a return home as soon as possible.

Carer involvement or input

Carers are fully included in the assessment and subsequent care plan. Input to the carer and consideration of their needs is viewed as being equally significant to the management of the individual’s long-term condition as an input to the individual themselves. Carer’s assessments are routinely offered to carers in their own right and links to carers’ support services made.
Patient-centred approach
The person is involved from the outset in agreeing to the delivery of the service, the assessment and the
production of the care plan for the individual. It is their care plan. Use of language and a focus on the person needs
from their perspective, and what works for them is key. Often problems could have been picked up and resolved by
better listening and communication.

Co-morbidities
The service works on the basis of having one named case manager for each person within the service. Initially this
is the community matron, with another member of the integrated team taking over this role once the person’s care
is stabilised and hence can be ‘stepped down’ to less intensive case management. Community matrons have
advanced training and access to other specialist advice as and when required. The principle of one case manager
is, we think, fundamental to the success of a service such as this. The case manager needs to have a breadth of
knowledge. It is often the lack of connection between what different professionals have said and done that causes
confusion, misunderstanding and potential crises in the delivery of care. One of the key benefits from the individual
patient perspective is the proactive and responsive relationship built up with that one key coordinator.

Prevention being encouraged in the management of the chronically ill
The initial assessment and information provision in a way that is understandable to the individual patient is the
critical element. We have found that people have often not been supported to understand the full implications of
their conditions or supported in finding coping mechanisms that work for them, even when they have already been
given written information. The open offer of support, encouragement to contact the matron and the reassurance
provided by having one person who knows about all aspects of your conditions and needs has proved very positive
for people. People are also offered support to forward plan and contingency plan, which is reassuring and
significantly improves quality of life in reducing anxiety.

Transitions between hospital and community care
The matron follows the person into hospital, liaises with hospital staff, contributes to case discussions and supports
the discharge out again. The person holds their own notes, which also go into hospital with them, and out again.

Environment and political context
GPPCP as an integrated organisation
As referred to earlier, GPPCP is a fully integrated organisation. This has allowed a joint health and social care
approach from the outset, and links the health and social care services and outcomes together. It is unlikely that we
would have adopted this model or afforded the development of the service the same priority if we had been two
separate organisations.

Current policy context – supports and barriers
The focus on intensive case management is very welcome. We intuitively believe this will have a highly beneficial
effect on the health and well-being of people, as well as reducing hospitalisation. However it is unfortunate that,
when first introduced into national policy it was not promoted, or widely understood, as a fully integrated service,
and was presented more as a specialist nursing service. The connections were not initially made with social care,
or with the fundamental issue of co-ordination of services. This was unhelpful, because it was seen as a specialist
enhanced clinical role, not as core business for community services.

The subsequent work on an integrated model counteracts this, but many people will not have read or absorbed
this. Whilst the recent White paper moves the service model further into one that is more integrated, there is now
work needed to undo the idea of the community matron service as a specialist nursing service that seems to have
been adopted in several areas. The White paper suggests single-line management teams (or networks) for health
and social care in the community. Single-line management may not be enough. If there is no joint ownership of the
resources or the ability to mobilise them, then single-line management in itself will not enable the delivery of an
integrated service that can meet all the needs. There is a real risk that social care will be seen as a secondary
partner in a health-led service, and the potential benefits that social care can bring may not always be realised.
Social care does have a different way of working and further work nationally on structures for service development may allow social care a more significant and influential role.

Commissioning a patient-led NHS and the separation of primary care trust ‘provider’ services, with a view to future market testing and contestability, brings a potential barrier to the development of such services. We consider one of the real benefits to be gained is the ability to consider the whole person, with the responsible person co-ordinating care having the skills, experience and authority to ensure all the needs are met. This really does suggest that those organisations which bring health and social care together as one will be able to be more successful; otherwise competing priorities and resource allocation are most likely to get in the way. However local authorities may now be very cautious in coming together with single-line management and pooled budget arrangements, if part of that team may change or be divided as early as 2008.

**Targets and standards for good practice**

The target for the Peterborough intensive case management service is to ‘avoid’ 350 emergency hospital admissions during 2005/06, and hence contribute to the overall organisational target to reduce emergency bed days. This is the first time we have set a target for the service; it is based on the assumption that the service will work with 350 people at some stage during 2005/06 and that each individual should have at least one less admission to hospital as a result of intensive case management intervention than they otherwise would have done. The service is currently actively working with around 180 people, and over the course of the whole year is likely to work with around 300 individuals. Whilst we do not yet have the end of year outturn for intensive case management, GPPCP has achieved a significant reduction in emergency bed days in 2005/06 compared with 2004/05.

**Performance reporting**

Currently our performance reporting is basic and lacks a wider outcome focus. We have designed a local database to capture performance and activity information. We are in the process of loading previous service information in relation to individuals for the 12-month period before commencing with the intensive case management service. We believe that it is necessary to undertake before, during and after analysis. However, the only information we currently have easily available for the preceding 12 months is hospital-based activity, so it is only a partial picture. We have a snapshot of impact on primary health care services and will need to develop this for the future. We are currently working on how to measure quality of life and independence outcomes, capturing a before, during and after assessment of such things as confidence and emotional well-being. We think there needs to be a straightforward way of doing this.

**Financial management**

**Payment mechanisms (capitation, fee for service, allocated budget)**

GPPCP invested in five new community matron posts to support this service; to date this is the sum total of new investment. The budget for the service is £200,000 per annum. Because we view this service as needing to be integrated, and being a significant part of core business for community health and social care teams for the future, we are not anticipating a requirement for significant additional investment. We believe this is about the modernisation of community health and social care teams, including a review of the interface between district nursing services and primary care. We can use existing skills and experience of community nurses and social care workers, however we are looking to invest in health care assistant posts to free up capacity in some of the nursing teams (in line with a newly agreed skill mix). This is about the refocusing of community services and positions this service as core business.

Co-operation and co-ordination across services is key to making this work, rather than significant new investment.

There is a challenge for commissioners in ensuring that services commissioned from primary care are delivered by primary care, and a challenge for community services in modernising and refocusing community health and social care.
Quality improvement

Process and outcome measures
We have not established separate mechanisms to measure quality apart from patient surveys and existing clinical governance and social care quality assurance activities. Currently we measure:

- the number of emergency admissions before and after intensive case management intervention
- the level of user and carer satisfaction with the service
- the degree to which the person feels more able to control his or her own lives
- the number of users admitted to care homes following intensive case management intervention
- any increase in adult social care provision as a result of intensive case management
- feedback from primary care regarding effectiveness of service.

Role of health and social care professionals

Mix of providers and team approach
Without a joint approach, there is a real risk of Case Management (Nursing) and Care Management (Social Work) trying to do very similar roles – resulting in both gaps and duplication. Our approach is as follows.

- In recognition of the health care expertise required to ensure the best care for the most vulnerable people, and to undertake the in-depth assessment required, we consider that community matrons should be nurse qualified.
- Community matrons need to work very closely with GPs and other members of the primary care team, in order to achieve the desired outcomes for individuals. Community matrons are represented on practice-based commissioning groups, as they are key contributors to designing pathways that prevent unnecessary hospital admission. A partnership approach is essential: community matrons provide the opportunity for intensive intervention that can be the key to better managed care and crisis avoidance but need to be working very closely with the medical practitioner. The relationship between the community matron and the GP is critical. The GP identifies possible patients and supports the community matron in changing the person’s care plan if needed. There has been strong support from some GPs, who work well together with community matrons, with positive feedback on the benefits perceived both for the individual and for the primary care team in terms of support in managing the person’s care. GPs responded best when they felt they had choice over who the community matron was, and where there were established relationships. GPs engagement with the wider development of the service seems to depend on how GPs view community nursing teams, and how much they have thought about the range of skills and experience that these teams have, or how they could be developed in the future. Where there have been ‘teething’ problems, perhaps because initial communications are not all they could be, some GPs have tended to disengage, rather than stepping up the support. There is a real challenge for some GPs in working as part of a wider team, and part of the challenge for all of us is to clarify and define expectations of community nursing services. There is a particular challenge for GPs in understanding what social care is all about. Intensive case management will only work if GPs are very much part of the team.
- Community matrons can transfer case responsibility to the integrated community teams, where people need continuing proactive management of their care but their condition has stabilised and they no longer need the level of intensive case management from a community matron. (Otherwise the service will block up and others’ skills will be underused).
- In the above circumstances, nurses and social care members of the integrated community teams can each fulfil the role of case manager as part of their existing role. They take responsibility for people when the community matron has stabilised their needs and a care plan is working successfully. If the needs most affecting the person’s continuing stability are nursing then a nurse can take the role of case manager; if the needs are primarily social/environmental then the social care worker would take the role of case manager.
- This is a challenge for all the professionals involved, as roles start to change, and professionals address issues and undertake activities previously outside their remit. This does link obviously with the single-assessment, person-centred approach.
- Within the integrated teams, each professional can call on a colleague for advice/input as required; additionally the community matron can become re-involved if necessary. The person’s needs continue to be actively monitored and reviewed by the case manager, with a view to maintaining independence, avoiding crises, and
avoiding unnecessary hospitalisation. This, in effect, is a less intensive level of case management; but over and above the existing service available.

- Co-ordination of care and care of the whole person is at the heart of both community nursing and social care, but increasingly over recent years there has not been the opportunity for this more in-depth work with individuals. It is now our challenge to find ways of this becoming a routine part of what this service does, in relation to the most vulnerable people, and better using the skills, knowledge and experience which team members already have.

- In addition it may be that the most appropriate case manager might be a specialist nurse or an allied health professional, depending on the particular needs of the person.

- The single-assessment process underpins the service, with nurses and social workers increasingly addressing the ‘whole’ needs of the person, and gaining knowledge and familiarity to break down the health and social care ‘divide’. Community matrons complete the overview assessment as the basis for their assessment, adding on specialist nursing components. We still have separate care plans for different services provided for the same person; we are currently working to develop an integrated care plan.

The role of the in-house personal home care services
We are currently in the process of refocusing GPPCP directly provided home care services (previously a social care service) so that a person who meets the criteria for intensive case management and who also has personal care needs or needs for ‘low level’ nursing/health care interventions will have this service delivered by an in-house team. Whilst we are in the early days of introduction of this part of the service we believe it offers an important extra element to successful complex case management – as it means a whole-team approach to delivering services for people who have the most complex needs, and who are at highest risk of a loss of independence and/or hospitalisation. The potential of clearly identified and linked personal home care services as an important arm of intensive case management may warrant further attention.

Professional and organisational input
Organisations Involved
The service is fully delivered by GPPCP community services, in conjunction with primary care. It is supported by Peterborough and Stamford hospitals NHS Foundation Trust through the provision of access to consultant advice and case support, and in the inclusion of community matrons as part of the wider teamwork with an individual in the event of hospitalisation.

Clinical advice and support is provided through a Care of the Elderly consultant. This has proved invaluable as a support to community matrons and a reference point if there are particular dilemmas.

Community matrons attend multi-disciplinary team meetings whilst any of their service users are inpatients. In these cases community matrons have often been able to support a quicker discharge because of the quality of knowledge about the individual that they bring with them, and the extra support they can give on discharge. There are also examples of a consultant changing treatment because of information provided by the community matron. The hospital teams have been very receptive and supportive, and see the community matrons as enablers for safer and quicker discharge for people with complex conditions.

In addition the hospital-based Transfer of Care team understand the role of community matrons and refer to them. Team members based in accident and emergency departments (to help prevent avoidable admission) are important sources of referral.

Physician involvement
GPs remain responsible for the medical care of individuals within the service and their support and involvement is critical to the success. Where GPs have positive experiences of using the service then they are proactive referrers and very happy to work as part of the wider team. This does need to be the universal approach and there remains a ‘heart and minds’ challenge.
At present the service is still young and community matrons work with allocated GP practices to promote the service and their use of it. Some GPs refer more than others but it would be unfair to consider this as resistance at this point. It is perhaps more of a communication and ‘selling’ issue. The database records practices and referrals information, it is our intention to use this information to target discussion with those that have not yet used the service, to ensure there is understanding and to share real examples of what can be achieved. There are undoubtedly still people who could benefit from the service who are not referred, however, given our relatively early stage of development this is to be expected.

Advice and clinical support is also offered to the community matrons through the GPPCP medical director on a formal basis and through a hospital consultant, also on a formal basis.

Other clinical involvement
As previously described this is an integrated team approach. We have agreed a fluid model of care. This addresses the question of how people move in and out of a community matron’s caseload. Without such movement the community matron’s caseload would become full, and remain full, very quickly. This model is reflected in Figure 2.

Figure 2: Model of care

Person identified by GP/hospital/other as meeting criteria for intensive case management

Community matrons work with people with highly complex needs until more stable

Ongoing, proactive support, intervention and review from other community-based health or social care practitioners where people have higher-level needs

70–80% of people with long-term conditions self-manage with appropriate advice, information, teaching and support from community-based practitioners.

Interface with intermediate care
There is risk of confusion between the aims of intensive case management and the aims of intermediate care. Intensive case management is not a time limited service, nor does it seek to intervene to avoid hospital admissions at the precise time of crisis (when a very high level input may be required to avoid that hospitalisation). It is a longer-term option with the focus on comprehensive and co-ordinated care to avoid the crises occurring, hence more of prevention approach. Community matrons, district nurses and social care staff will continue to need to refer to intermediate care for input if someone they are working with deteriorates and needs extra input to avoid a hospitalisation, or to support a discharge from hospital. Intermediate care will be needed to support intensive case management in such situations.
Communications/IT and data-analysis support for the service

Information sharing
Information sharing between community matrons, other team members, primary care and hospitals is mainly by telephone and letter. Community matrons enter information onto clinical systems where this is accessible, but information cannot currently be transferred electronically, nor is the patient record electronic, as yet.

The assessment and care plan is patient-held at present.

Outputs and evaluation of outcomes

Primary measures of success
- reduction in unplanned admissions to hospital
- reduction in unplanned use of primary care services
- control over day to day life/quality of life (individual and carer)
- confidence in maintaining care at home/independence (individual and carer)
- overall physical and emotional well-being.

Monitoring
Monitoring of outputs and outcomes is still underdeveloped. We currently only monitor emergency admissions – before, during and after the service is delivered. We do not yet have an easy way of measuring impact on primary care interventions.

We have many individual pieces of feedback in relation to health and well-being/independence effects, and have introduced a feedback process for users of the service and carers. However we do not have any comparison that can clearly demonstrate what life was like before, and it is hard therefore to draw conclusions about effectiveness of the service. We are currently working on this.

Evaluation
Norfolk, Suffolk and Cambridgeshire Strategic Health Authority undertook an initial pause and plan review of the service after nine months’ operation, so that we could learn lessons and confirm our plans for the way forward. This included validation of impact in relation to emergency admissions for people using the service. However the evaluation could not prove, and we still do not know, whether any improvement (i.e. reduction) was in fact due to the establishment of this service. By the same time other variables could affect the care for those individuals and it is impossible to assert, with certainty, what would have happened without the service.

Preliminary results
With the proviso above, the review nevertheless suggested that there had been a reduction in emergency admissions as a result of the service.

Figure 3 shows fewer admissions to hospital that contributes to the national target of a 5 per cent reduction of medical inpatient bed days. Pre- and post-intervention data was available for an initial group of 81 patients who were eligible for community matron care. For the 81 patients, admissions totalled 344 before the service commenced. After the community matrons became involved, only 58 admissions occurred for the same group of patients over a comparable period.
Each admission to hospital cost approximately £2,000; hence the reduction in admissions is estimated to have saved £572,000 for this group alone. (Source: NCS Review Report, November 2005.)

As always, it is dangerous to claim too much when other factors may well be relevant. It does however suggest that the introduction of the service has had a positive (i.e. downward) impact on hospitalisation. Early results are therefore very promising but it is early days, and we are therefore cautiously optimistic.

Figure 4 illustrates impact on primary care. This is based on records for one practice only over 6 months from May to October 2005.

**Figure 4: Impact on primary care activity, May–October 2005**
The data suggests that the community matron has a wider impact. Reductions can also be observed in GP visits and medication costs.

The data also shows that the intervention of the community matron revealed previously non-diagnosed problems, an important element of improving care and outcomes.

**Impact on individual patients and carers: issues of well-being/quality of life/independence**

The following feedback was received from users of the service.

‘I feel so much better since I have had someone who I can contact.’

‘I already feel better after your phone call yesterday and both my wife and I now feel someone cares about us.’

‘I am a whittler and do get anxious and nobody seemed to listen to me until you contacted me.’

‘You are better than a doctor.’

‘You always do what you say you will do and do not let me down.’

‘Thank you for visiting me in hospital, it shows you care.’

Carer’s anecdotes include the following.

‘What a good service.’

‘About time.’

**Cross-cutting themes: key factors**

**External environment**

- Integrated organisation, pooled budgets, single management
- Support from primary care
- Support from hospitals, need to ensure loss of income does not become a disincentive.

**Essential components**

- Integrated health and social care approach.
- Buy in and involvement of wider community health services; this is not a stand-alone specialism.
- The service potentially changes the way professionals work, training implications, and management implications.
- Improved understanding and measurement of outcomes.
- Links with personal home care services potentially very important.

**Financial incentives and return on investment**

- Redesign of community services arguably limits the need for large-scale investment, specific to this service.

**Targeting and case mix**

- Need to be absolutely clear that we do not apply this intensive approach to those with less complex needs, and support the lowest level of intervention possible.
- Risk of dependence and service being available only to a few.
- More simple case management is sufficient in the vast majority of cases.

**Role of physicians**

- Close working relationship with GPs and GP support critical.
- Support from GPPCP medical director also important.
- Support from hospital doctors/consultants is also critical; the link with the Care of the Elderly consultant is a reliable source of support and expertise. The co-operation of a range of hospital physicians in working with the community matron as part of the extended team is also important; without this it would have been impossible for some treatment to be changed, and difficult to achieve the reduction in length of stay where emergency (or other) admissions have been necessary.