Barts Health NHS
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Managing Frequent Attenders to the ED: Challenges, opportunities and lessons learnt

The Tower Hamlets Frequent Attenders Project

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Who are we?

- The project team behind **Tower Hamlets Frequent Attenders project**
- Commenced **March 2016** – running for 11 months
- We have secured funding until **March 2018**
- Involved in the **NHS CQUIN** consultation

- **Systemic, inter-agency model** of care following best practice guidance (2014) → 'supporting professionals to support patients'

→ bespoke care planning and inter-agency working (more on this later)

Why are you here today?

- Curiosity?
- Interest in this population?
- NHS CQUIN?
- Plans to set up your own FA project?
- You already have a project and are looking to other models for ideas?
- Nothing else interesting in the time slot?!

- We hope to touch on (most) of these

Outline: what to expect from today

1. Background: who are the 'frequent attenders' and why do they re-present to A&E?

- Some statistics from the literature
- Why are we talking about them- what makes them a priority?
- What feelings do they induce in staff?
- Local profile
- Our reflections – what are the 'common threads'?
- Evidence Base – how should we work with them?

2. Our project – what we do and how you can learn from us

- Challenges, lessons learnt and 'golden rules'
- Care planning
- Supporting other professionals
- (Anonymised) Case examples
- Conclusion
- Questions?

PART 1: Who are the 'Frequent Attenders'

….and *why* do they present to A&E?

Definitions: Frequent Attenders?

'Frequent Attenders' – sometimes called 'High Impact Users' (debate about stigma)

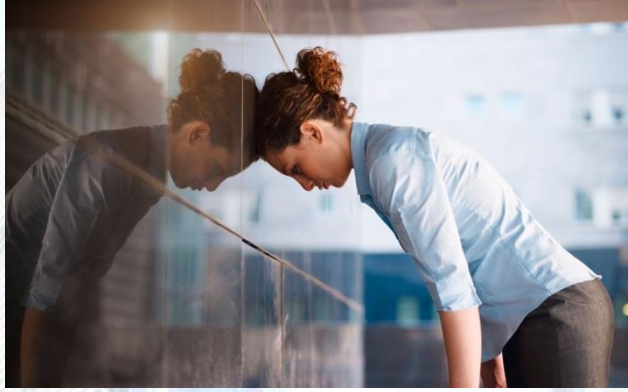
- **Definition:** small group of patients utilising disproportionate amount of healthcare resources
- Patterns noted in many Western countries
- Definition varies but usually:
  - >4 presentations a year
    - Locker et al (2007) – this frequency corresponds to *non-random* events
  - Top 10% of ED users

Our data

→ Broadly, FA = 10 times or more in one year

→ Small number 'very frequent' = 30 times or more

How are they perceived?



'Collective sigh'

- "Difficult"
- Labelled as a problem
- Make us feel hopeless, angry, burnt out
- Complex
- Time wasting
- Lonely

Who are they? (Literature)

- Aged between 20 and 55 years old
- More male than female
- Patients in their 40s are particularly over-represented
- More likely to arrive by ambulance or in police custody
- More likely to self-discharge from A&E
- Over 90% of FAs are registered with a GP
- Tend to be established in the UK
- Deprivation: 50% live in 20% most deprived areas, but 10% live in top 20% most affluent areas

Often vulnerable individuals: more likely to be of low SES, isolated, living alone, report chronic medical conditions and have a higher mortality rate

Health Service Journal

Common presentations

- Mental Health Reasons
- Learning Disabilities (or low IQ)
- Alcohol dependence
- Homeless
- Long Term Health Conditions
- Medically unexplained symptoms

→ Overlap (lots of comorbidities: e.g. MUS, 'Personality Disorder', homeless and long-term health conditions)- not uncommon to see all of the above in one patient

→ Vulnerability and isolation

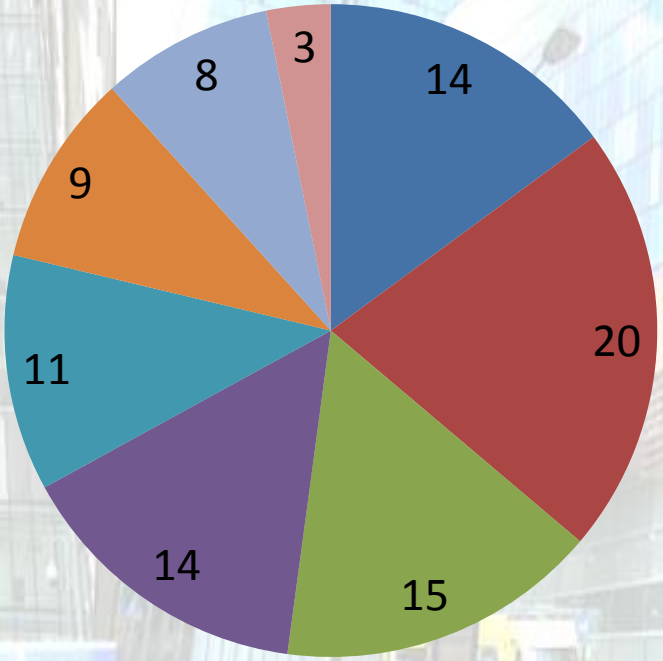
Local Community – East London

- Area with high deprivation and high wealth – high discrepancy
  - 40% of households in status of poverty (highest in U.K)
  - ↑ transient, immigrant & hostel population
  - Histories of trauma, separation, loss
  - High levels of homelessness and poverty
  - City workers with high stress and possible undiagnosed alcohol issues
- Cultural diversity
  - Beliefs around mental health of Bengali/Somalian population – somatisation of distress and vocabulary for emotions
  - Stigma/no language around mental health
  - ?Minimise this in assessments
- Trauma hospital and out of area patients – add complexity

Who are they? (our data)

- Benefit of subjective vs objective data

- Not mutually exclusive (many in separate groups)
- Does not discriminate between functional and organic symptoms – e.g. gastro. Not comprehensive.
- **Others- common but not captured:** health anxiety, drug-seeking, admission-seeking, diagnosis seeking, somatising distress/medically unexplained symptoms



Our reflections – common threads?

History of disrupted attachment relationships – difficulties feeling cared for by others (admission, medical care gives 'concrete' reassurance)

Difficult histories – struggles to regulate emotions without others

Traumatic histories and stigma around emotions – somatising distress (wanting diagnosis, 'physical illness' to validate emotional pain in less stigmatised narrative

Social isolation – loneliness and feeling excluded from society

Homelessness– need for food, shelter, social comfort → A&E is familiar, warm, has tea and sandwiches

Learning difficulties and difficulties coping– often people who struggle with the 'day to day' management of life – rent arrears, managing benefits – often end up on 'fringes' of homelessness. Especially difficult when managing illnesses with complex regiments (e.g. diabetes)

Dependent personality traits–linked with past

Sick role identity – often have/had illness → learned way to seek care, investment from others

What do people get in A&E?

SURROUNDED BY PEOPLE

MEDICAL CARE

FOOD, A HOT DRINK

REASSURANCE THAT THEY ARE SAFE

HUMAN CONTACT

COMPASSION

WARMTH

ADMISSION TO WARDS

INVESTIGATIONS – VALIDATION OF SUFFERING

CARE

MEDICATION/DRUGS

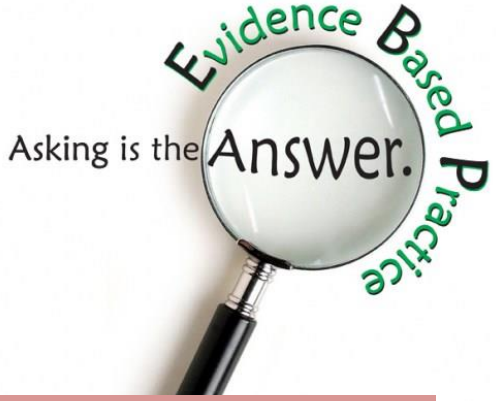
RELATIONSHIPS WITHOUT EXPECTATION OF ONGOING INVESTMENT

Why is this a priority?

High number of visits leads to concerns about appropriateness, especially with ED overcrowding

1. 'Red flag' for **vulnerability** - unmet needs (untreated mental health, poor care of physical health) – ethical mandate
2. Frequent use of EDs generates **high health care costs**
3. FAs more likely to have 'non-emergency' attendances – **contributes to overcrowding**, affects ED care, safety, risk
4. Now……**CQUIN:** now a mandatory national NHS target

So…how do we help?



'Working in dim light' – virtually no robust evidence

Case management – most studied intervention model (Althaus et al (2011) – systematic review). Clear evidence psychological interventions in A&E do have a benefit

<u>Best practice Guidance (Royal College of Emergency Medicine, 2014)</u>

→ **Bespoke care plans for A&E** – ensure consistency, reduce staff anxiety, address reinforcing factors

→ **Inter-agency working –** address meaning of attendances; focus on 'unmet need', supporting breakdowns in systemic relationships

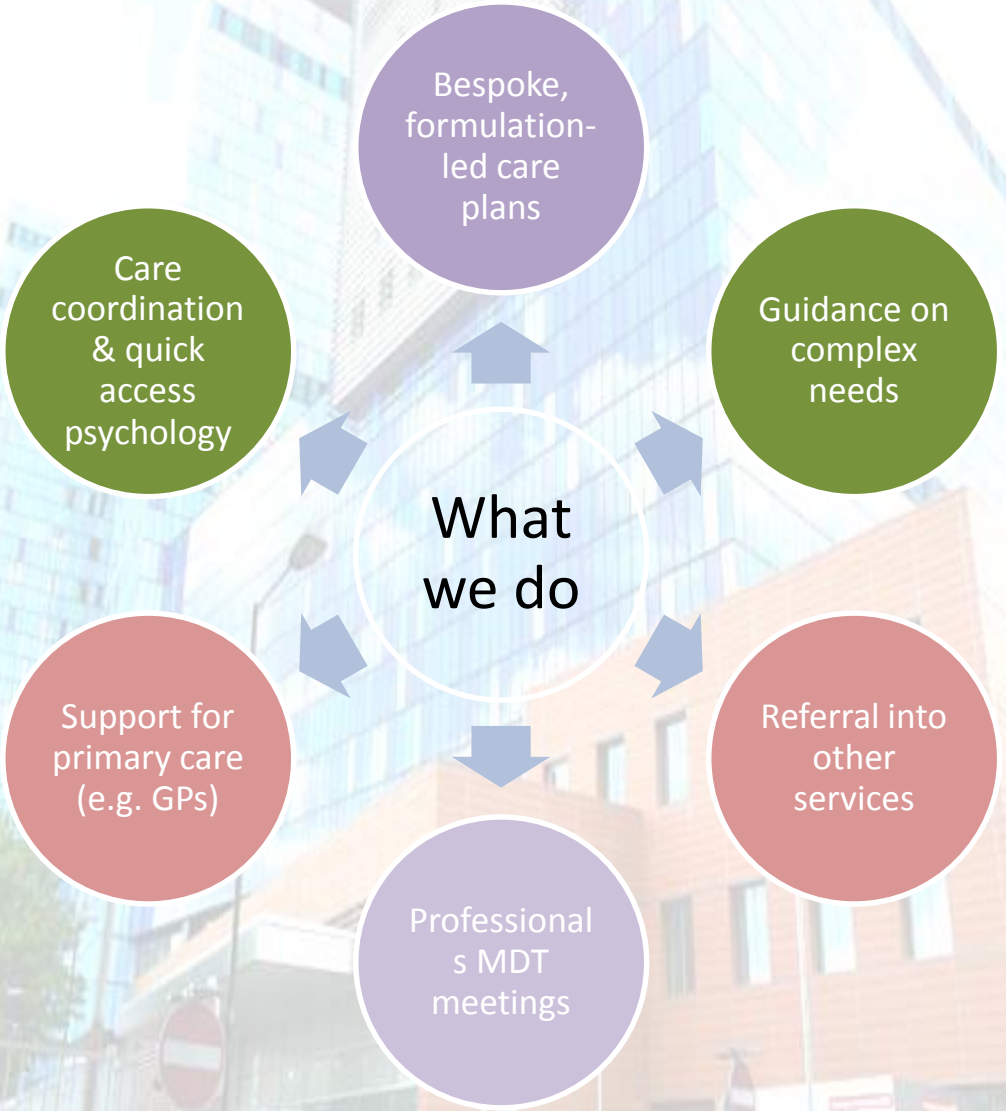
Part II: Our Project

What do we do?

….and what can you learn from our experience?

What do we do?

- **Research and formulation:** why is this person attending?
- **Bespoke care plans for A&E** medical and mental health staff
- **Inter-agency working**
- **Referral into other services** (what are the unmet needs?)
- **Support for primary care** (e.g. GPs)
- **Professionals MDT meetings:** recognising the impact on staff and importance of support after 'breakdowns' in systems



Our process

- Referred by A&E or highlighted in data
- Assistant Psychologist research: review of attendance and overview of care in detail
- Presentation at MDT FA meeting (fortnightly)- partners (expert psychiatrists, LAS, homeless team)
- Actions from MDT & interim flag on CRS
- Full care plan and action plan circulation
- Review date – MDT
- Discharge summary to all parties (GP etc.)
- Monthly review of attendance and if escalating process re-starts → 'top up' intervention

Key elements of the care plan

1. **Mental and physical health summary**
2. **Typical presentation to ED** (specifics- e.g. requesting MRI, complaining of pain
3. **Formulation** what is the meaning of their distress in the context of their past?
4. **Teams involved**
5. **Risk status**
6. **Triggers for attendance** e.g. argument with family, pain cold weather
7. **Clear recommendations for medical staff** e.g. senior to review if possible, do not CT unless clinically necessary, please see cardiac letter with summary
8. **Clear recommendations for mental health staff** e.g. avoid asking questions in 'box ticking' manor, devise clear care plan to take away
9. **Best practice guidance** e.g. on communicating with people with LD, on managing requests for investigations in medically unexplained symptoms

What they do

→ Ensure consistency of care
→ Addresses reinforcing factors
→ Reduces unnecessary investigations
→ Speeds up time in A&E
→ Contains staff anxiety
→ Promotes empathy and understanding

What they *don't do*

→ Care plans cannot address 'unmet needs' causing people to attend in the first place

(this is why we need inter-agency working and referral onwards)

Outcomes: does it work?

- Scepticism around complex patients – “too difficult to make a difference?”
- Data gathered: A&E attendances, inpatient admissions, bed days
- Post-engagement, there were 288 fewer A&E attendances
- There were 289 fewer bed days
- There were 30 fewer inpatient admissions

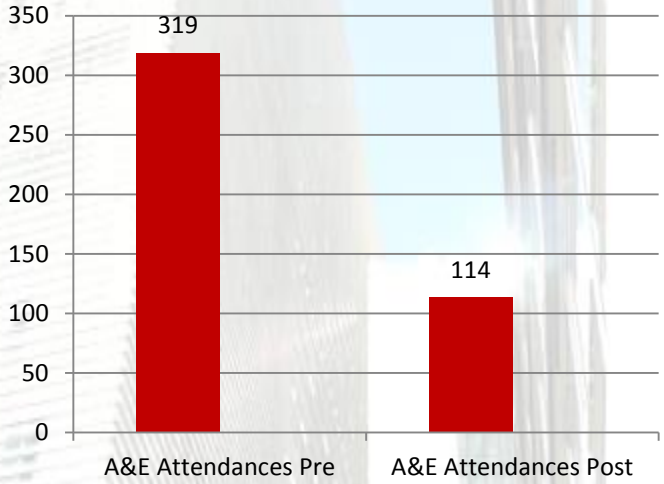
- 100% with care plan
- 69 through MDT
- 93 total

Estimated Cost Savings – 10 Months	
Estimated Gross Savings	~£115, 600
Total Costs	£19, 408
Estimated Net Savings	**~£135, 936**

*Average cost of A&E attendance is £138; average cost of inpatient day is £400

***Cost savings** and **benefit analysis** likely to **underestimate** financial and human resources impact

- Reductions in investigations in A&E (Band D →Band A)
- Reductions in time spent in A&E
- GP Attendances and use of other services
- ‘Containing function’ for staff anxiety


350
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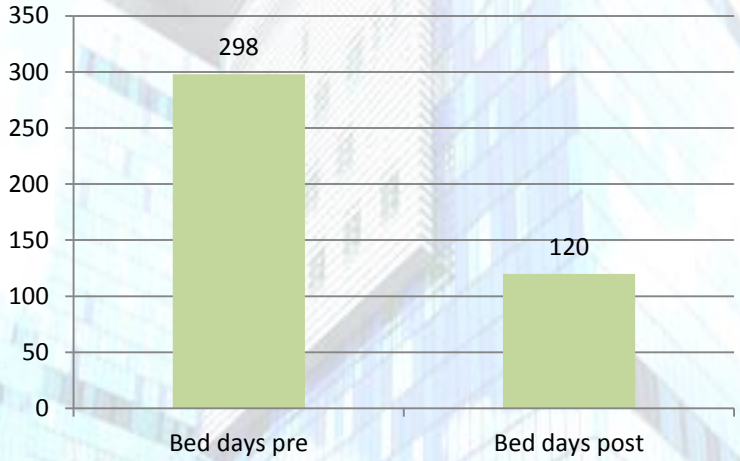
319
114
A&E Attendances Pre
A&E Attendances Post


350
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250
200
150
100
50
0
298
120
Bed days pre
Bed days post


50
0
-50
-100
-150
-200
-250
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
A&E Attendances
Admissions
Bed days

Case study 1:

- Middle- aged gentleman with 20+ yrs frequent attending pattern. Challenging behaviour (racism, verbal abuse), alcohol dependence, MH issues (self-harm, auditory hallucinations), cognitive concerns, forensic history, social issues (homelessness). Distressing for staff.

Intervention

- Support for hostel
- Expert guidance on management of challenging behaviour for A&E
- Liaison with probation officer & forensic services
- Referral for assessment of Alcohol Related Brain Injury
- COPD care plan with ARCARE
- Joined up working with primary care (GP: 1. conversations around A&E use, 2. shift to community medical management – inhalers, vitamins etc.)
- 'Home triage' plan with London Ambulance Service
- Expert care plan for hostel keyworkers during transition period (ABC chart, behavioural reinforcement principles, communication)

A&E Attendances pre-intervention	A&E Attendances post-intervention
22/05/2016 - 26/09/2016	26/09/2016 - 31/01/2017
72	15

Total saving for A&E: £7, 866

Case study 2:

- Gentleman w/ resolved history of drug addiction. Began attending A&E when relationship broke down with district nursing (DN). Issues: case list rather than stable relationship, variable appts. Difficulties waiting, appts. clashing with methadone (which he can't do without) meant often marked as DNA. Situation reached dire straits.: admitted w/severe infection after passers-by found collapsed with wound oozing. Trust in services at all time low; pain, embarrassment, hopelessness. Suicidal ideation – "I will put my leg under a train", heading for amputation. This would have been catastrophic – unlikely to manage demands of post-amputation rehab.

<u>Intervention</u>

- Escalation to senior District Nursing management
- Psychological formulation to explain behaviour and promote empathy
- Referral to DN clinic with set appointments instead of home visits
- Practical contingency plan, common sense approach –
- e.g. appointments after methadone
- Referral to 'Groundswell' for keyworker escort to
- accompany to appointments
- Care plan with hostel – reminding him well in advance
- Care coordination – central point for communication
- Crisis prevention planning around Christmas, holidays etc.
- "How to engage me" care plan with workers who know him

Total saving for A&E: £690
Cost of leg amputation:~£12,000 for the procedure alone**.** Cost of 2X weekly rehabilitation for 12 months is **£1, 092** per person **(NICE, 2012)**

****Rapid recognition prevented escalation in A&E attendances

A&E Attendances pre-intervention	A&E Attendances post-intervention
06/11/2016 - 12/12/2016	12/12/2016 - 31/01/2017
6	1

Challenges

- Information governance
- Objective cost data
- Capacity and resources
- Dealing with fluctuating and chronic patterns of attendance
- Community support
- Buy-in from the acute & mental health trust

Lessons learned

- Importance of objective and timely data
- Inter agency and MDT working – consultation process integral
- Compassion and seeing the person – the value of psychological formulation and the bigger picture
- Resources that can prioritise
- Picking your cohort
- Access to interventions

Our golden rules

Do:

- Info governance early on
- Establish partners and MDT
- Think about your cohort and intervention access
- Be realistic about what you can achieve
- Protect time
- Embedding flags in to practice and IT system
- Think about what ED need early on
- Problem solve creatively

Don't:

- Think you will stop everyone from coming
- Don't lose focus on the priority
- Oversell the project and be clear about clinical responsibility
- Expect immediate results
- Lose hope

Conclusions

- In our experience…hugely positive and beneficial work
- Involves offering a service to the most vulnerable
- Satisfying as a clinician
- Supporting staff to support others
- Rewarding but challenging