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?
‘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?

- Medical care
- Food, a hot drink
- Human contact
- Compassion
- Admission to wards
- Reassurance that they are safe
- Warmth
- Compassion
- Investigations – validation of suffering
- 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


Best practice Guidance (Royal College of Emergency Medicine, 2014)

→ 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

*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
A&E Attendances Pre: 319
A&E Attendances Post: 114
Bed days pre: 298
Bed days post: 120

Fewer Attendances
Ward Fewer Admissions
Fewer Bed Days

A&E Attendances
Admissions
Bed days

Apr-16  May-16  Jun-16  Jul-16  Aug-16  Sep-16  Oct-16  Nov-16  Dec-16
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)

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<th>A&amp;E Attendances pre-intervention</th>
<th>A&amp;E Attendances post-intervention</th>
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<td>22/05/2016 - 26/09/2016</td>
<td>26/09/2016 - 31/01/2017</td>
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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.

Intervention
- 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

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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**
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