The West Middlesex Frequent Attenders Programme

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Frequent attenders to WMUH Emergency Department (ED) had been highlighted as a significant issue. A retrospective review of the top ten attenders showed that the majority had multifactorial reasons for presentation including medical (87%), alcohol (31%), psychiatric (28%) and social (25%).

Less than 10% had a psychiatric complaint as their presenting feature. Early analysis of the patients suggests that offering a psychosocial assessment regardless of presenting complaint, is a key component in altering their patterns of attendance.

The West Middlesex Frequent Attenders model

Identification:
- Patient identified by senior ED clinician as a frequent attender.
- Proactive and reactive selection methods to be eligible for referral into the programme.
- Psychiatric morbidity is not a requirement.

Collaborative working:
- Full medical assessment by senior ED clinician
- Biopsychosocial assessment by a member of the Liaison Psychiatry Team

Care plan development:
- Care plans that are tailored to the individual's needs engaging relevant agencies are developed in collaboration with the patient.
- Care plans will be attached to the patient electronic records and automatically prints with their CAS card should the patient reattend.
- This alerts the ED to the care plan to be adhered to.
- GPs to receive copies.

Frequent attenders case conference:
- The care plans and progress of each patient in the programme is reviewed and adapted as necessary every two weeks.
- Chaired by Liaison Psychiatry Consultant with senior ED clinicians.
- Agencies eg, SS, LAS will be invited as required.

Review:
- Patients can be seen in the FA clinic for brief interventions, psychoeducation, engagement work etc.
- Monitoring of subsequent attendances.
- Modification of care plans and further action as necessary.

Case study

Patient A:
72-year-old patient with COPD, attended the ED (A&E) 479 times in four years.

Presenting complaints:
- COPD requiring O2 therapy but still smoking. Suffers with arthritis.
- New prescriptions requested on every attendance for inhalers and pain relief despite attending 3-4 times a week.
- Administers inhalers in the vicinity of his face, despite repeated attempts at educating him on correct technique. Spacers tried with no success.

Interventions:
- Bio-psycho-social assessment of his needs by a member of the Liaison Psychiatry Team.
- Capacity and neuropsychological assessment revealed deficits. Evidence of an anxiety disorder and mild cognitive impairment with some executive dysfunction.
- Social circumstances investigations revealed he was living as a lodger in a multi-occupancy house. Walls were blackened with smoke from cigarettes and incense sticks. Concerns of vulnerability to exploitation from other residents.

Outcome:
- Patient admitted to ward and case conference called which was attended by Social Services, LAS, ED, physicians and Liaison Psychiatry.
- Professionals agreed that his care needs were not being met by his current environment and patient agreed for placement in a nursing home.
- No attendances/admissions since intervention (approx 10 months)

Conclusion

Proactive multidisciplinary management of frequent attenders significantly reduces attendances, improves patient care and saves money.