Frequent Attenders Initiative

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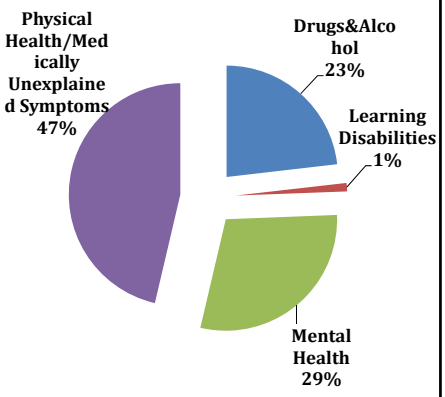
Who is a frequent attender?

- **There is no standard definition for an A&E frequent attender, generally it is considered to be someone who attends A&E three or more times in a year**

COMMON PRESENTATIONS

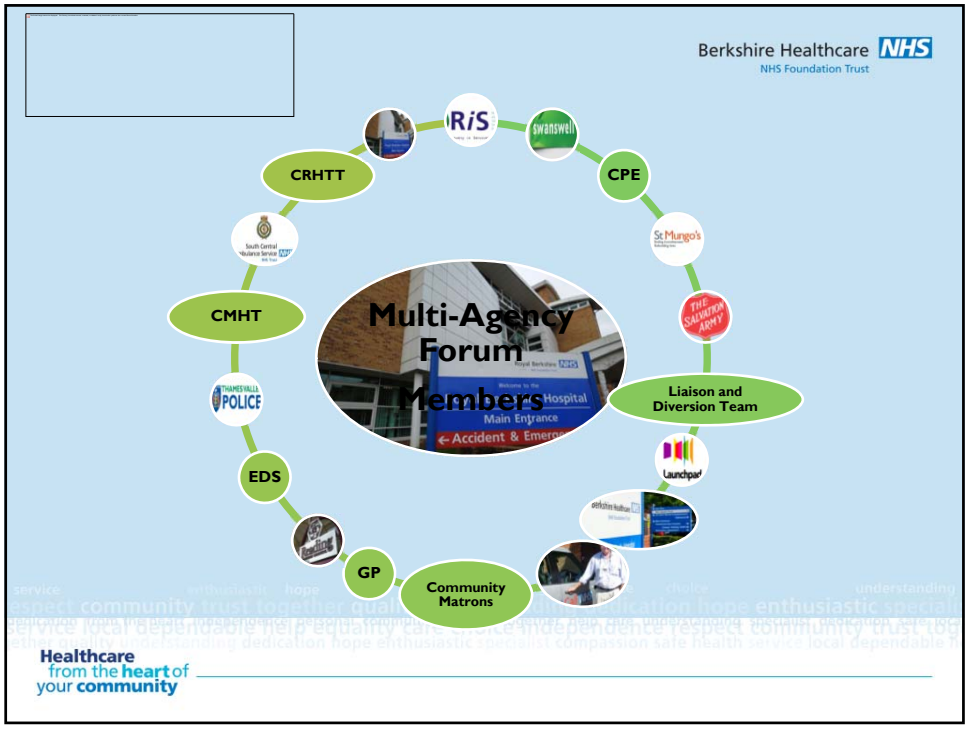
- Mental Health problems
- Learning Disabilities (or low IQ)
- Alcohol dependence
- Personality disorder
- Homelessness
- Long Term Health Conditions
- Medically unexplained symptoms



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

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

- **Create bespoke care management 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



Case example 1

74 visits in 24months

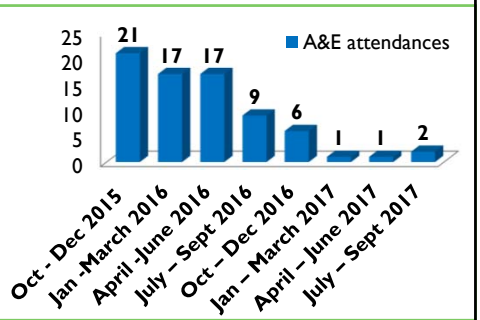
21 year old male, single and generally fit

Lives at home with his parents

Self presents after playing football with headaches, chest pains and ear problems.

Intervention

1. **Informed GP of attendances**
2. **Client was presenting with Medically unexplained symptoms. Consents to accessing Community Psychological Medicine Service (CPMS) .Assessed and client accepted 12 sessions of therapy addressing health anxiety and developing coping strategies**
3. **Linked care CPMS, GP, A&E, Ambulance and PMS**



Feedback

- **Engaged well with Medically unexplained symptoms therapy in community (12 sessions)**
- **Has a Case Management Care Plan and Alert on health records**
- **Full time employment since September 2017 and has reduced his attendances significantly over last 24 months**

**Savings of £9798 A&E attendances (based on Kings Fund 2016 A&E attendances)*

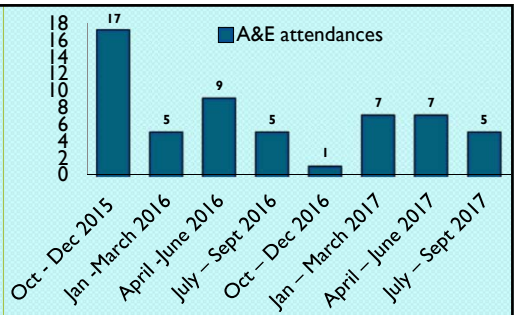
CASE EXAMPLE 2

56 VISITS IN 24MONTHS

60 year old female, divorcee with 2 supportive adult sons
Long history of depression, alcohol misuse and Type 2 diabetes
Presents with deteriorating mental health problems, self-harm and chest pains.
Contacts Ambulance 90% to attend A&E

Intervention

1. Informed GP of attendances
2. Open to Community Mental Health Team and Drug and alcohol services
3. Care co-ordinator heavily involved with input from D&A services
4. Support from her sons



Feedback

- Has Bespoke Care plan in place
- Engagement with Community Mental Health Team, Crisis Resolutaion Home Treatment Team, A&E, Ambulance, Thames Valley Police, SMART and Psychological Medicine Services

**Savings of £7392 A&E attendances (King Fund 2016)*

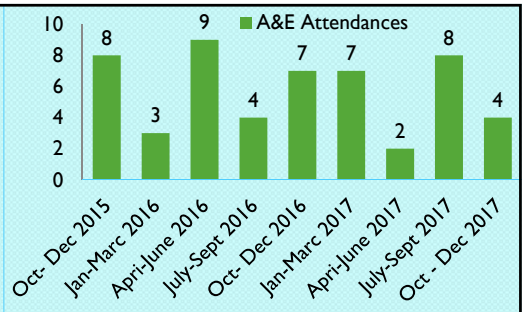
CASE EXAMPLE 3

52 VISITS IN 27 MONTHS

23 year old male, unemployed, lives at home with mum and younger sister
Depressive symptoms and suicidal thoughts, Insulin dependent diabetes, ADHD
Attends ED via SCAS, and presents with recurrent DKA and chest pains

Intervention

* Informed GP of attendances
* Involved Diabetes specialist clinic, community matrons, Community mental health team – psychological therapies
* Contacts CRHTT regularly for support and PMS
* Offered Psychology appointments but he has DNA'd



Feedback

- Has Bespoke Care plan in place to help manage his attendances
- Engagement with Intergrated Care System, Commmunity Mental Health Team, Crisis Resolution Home Treatment Team, A&E, SCAS, Diabetes Specialist Team, Community Matrons, Community Coaches and PMS

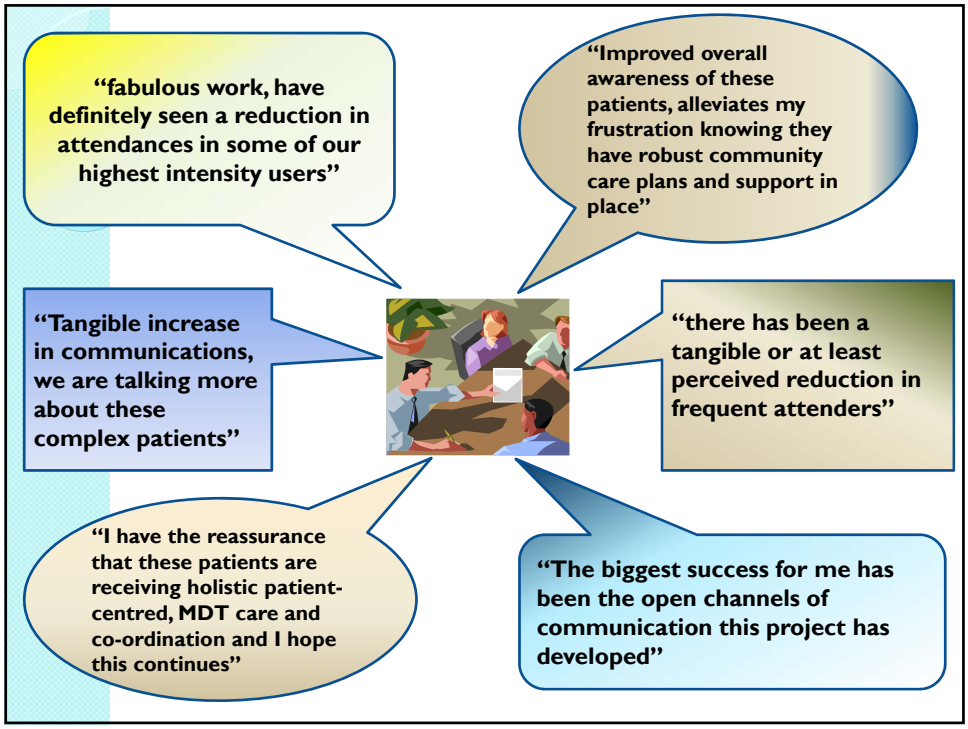
**Savings of £6864 A&E attendances*

Emergency Department Survey

- Are you aware of the frequent attenders initiative? Y/N
- Are you aware of the/any impact this initiative is having on the number of attendances by frequent attenders? Y/N
- Are you aware of the attached CQUIN to this initiative?
- Do you know who the frequent attenders leads/points of contact are in the Emergency Department? Y/N
- Do you know how to access frequent attenders care plans? Y/N

Qualitative feedback

1. Awareness (leads, contact points)
2. Awareness (frequent attenders project, supporting initiatives)
3. Impact (support, declining attendances, progress, meetings, EPR alerts)
4. Open forum (discussion, suggestions, comments)



Areas of development

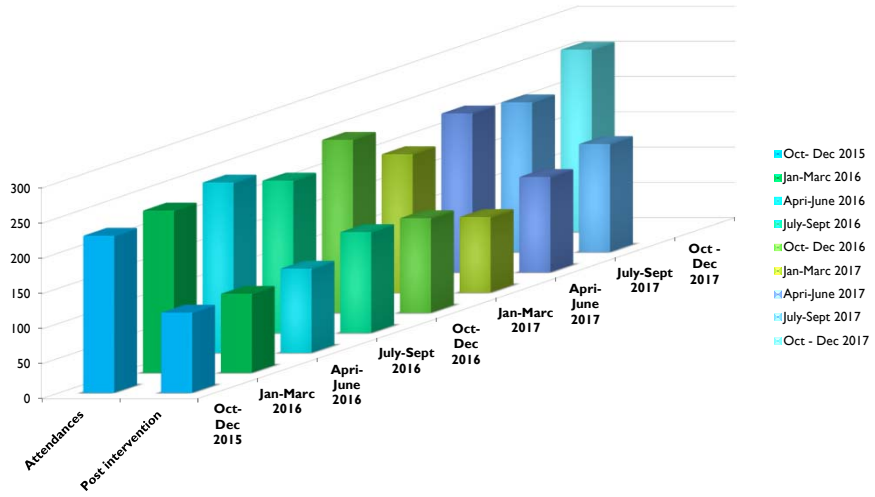
- Many were unaware of CQUIN
- Access to care plans on EPR could be made 'less clunky'
- Lack of clarity on how to access EPR care plans and alerts
- Some outdated printed care plans in patient's folders with duplicated work
- Lack of transparency on how to refer to MUS (medically unexplained symptoms) clinic or how to refer to community coaching
- Perceived lack of 'linking' between PMS-frequent attenders team-ED clinicians-community coaching

Suggestions for the future

- Success stories briefly relayed at Clinical Governance (CG) under KPI of re-attendance rate
- Double click star on EPR ideally, maximizing efficiency on how to access care plans as alert guidance is still perceived as being slightly vague
- Greater sharing of data regarding attendances at CG and ED team meetings
- 'Awareness and communication is excellent, but we should be aspiring to break the cycle and not just feed into it'
- 'Care plans could be more robust and direct with medical and non-medical suggestions; the need to be hard-nosed to restrict medication abuse by some of our frequent attenders for example; this takes time and effort and I'm not sure we have the time, energy or resources to enact this and deliver it safely?'

Berkshire Healthcare NHS
NHS Foundation Trust

Frequent attenders to RBH A&E
1st October 2015 - 31st December 2017



Acknowledgements

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