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 24 months

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 24 MONTHS

60 year old female, divorcée 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

Feedback
- Has Bespoke Care plan in place
- Engagement with Community Mental Health Team, Crisis Resolution 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

Feedback
- Has Bespoke Care plan in place to help manage his attendances
- Engagement with Integrated Care System, Community 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 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)
“fabulous work, have definitely seen a reduction in attendances in some of our highest intensity users”

“Improved overall awareness of these patients, alleviates my frustration knowing they have robust community care plans and support in place”

“Tangible increase in communications, we are talking more about these complex patients”

“there has been a tangible or at least perceived reduction in frequent attenders”

“I have the reassurance that these patients are receiving holistic patient-centred, MDT care and co-ordination and I hope this continues”

“The biggest success for me has been the open channels of communication this project has developed”

**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?’

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

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