The Royal College of Emergency Medicine

Best Practice Guideline

Frequent Attenders in the Emergency Department

August 2017

Summary of recommendations

1. Patients who attend the Emergency Department frequently should be treated with the same care and respect as other patients.

2. Emergency Departments should have a method of identifying 'Frequent Attenders' to their department. This may consist of a data trawl or staff identifying patients who they think need input in the form of a care plan, liaison with specialties or case management.

3. Patients may benefit from a bespoke ED care plan. A plan may be used to give consistent care, improve analgesia, manage risk, or reduce unnecessary investigations.

4. Patients should be given the opportunity to be involved in the production of their care plans and be given a copy of the plan wherever possible.

5. Case management for Frequent Attenders may be helpful to identify unmet needs for patients and get other services involved in a patient's ongoing care.

6. Multidisciplinary case conferences are recommended to improve engagement with community services for some patients. They are also helpful to manage risk for certain patients with risky behaviour.

Scope

This guideline has been developed to provide advice to Emergency Department clinicians and managers regarding the management of patients who attend the ED frequently.

Reason for development

The proportion of patients attending ED who fit the definition of attending frequently has risen substantially. An ED visit is not always beneficial and over time becomes expensive.

NHS England has devised a CQUIN for 2017/18 and 2018/19 to try to reduce attendances for patients with predominantly mental health problems[i]. See position statement on this. (Insert link)

Background

The most commonly accepted definition for a "Frequent Attender" is a patient who comes to the ED 5 or more times per year.

Frequent Attenders make up a significant percentage of all attendances, rising in one trust cohort from 3.7% over to 9.3% in 15 years[ii]. Consistent findings from cohort studies show that 'frequent attenders' to Emergency Departments tend also to be frequent users of other health and social care facilities[iii]. Additionally, they tend to have a higher triage category, greater rates of admission, and a greater burden of chronic disease, when compared to matched groups.[iii, iv,v]

The population of patients who are frequent attenders is heterogenous. A UK ED study showed that 65% had Mental Health symptoms, 15% had significant alcohol problems, and 45% had Medically Unexplained symptoms.[vi]

Those with chronic mental health problems combined with social problems and alcohol tend to make up the very high frequency patients. They can be vulnerable and may struggle to access other services. Frequent Attenders were found to have double the mortality of non-frequent attenders[vii], and causes of death include violent means and suicide.

There is consistent evidence that the population of Frequent Attenders to a department do not constitute a stable cohort [viii],[ix]; The number of patients who attend frequently stays fairly static but patients come and go from this group. This makes measurement of attendances and any intervention problematic as patients tend to come to our attention whilst in crisis and then attendances drop off as the crisis resolves.

Management of attendances

Patients who attend the ED frequently should be treated with the same care and respect as other patients. They should be given analgesia promptly and triaged according to their need. ED clinicians should be aware of the high mortality and morbidity of this group of patients and speak out against the stigma that some of these patients attract.

Many frequent attenders are vulnerable and locally agreed processes should be followed. When reviewing frequent attenders always screen for drug and alcohol use, safeguarding issues, and domestic abuse concerns.

Given the increased prevalence of psychiatric and alcohol disorders in this group of patients, challenging behaviour can be more common in the 'frequent attender' population. While or repeated episodes should be managed according to the current NHS Protect advice[x], persistent episodes have in the past been managed by civil orders such as 'Anti-social Behaviour Orders' now replaced with an Injunction to Prevent Nuisance and Annoyance (IPNA). This is controversial and raises some complex medico-legal and ethical issues including as patient confidentiality.

Identifying Frequent Attenders

It is useful for departments to have a mechanism for identifying their frequent attenders. Identification by a data trawl may be a good starting point for this. ED staff also tend to know their population of Frequent Attenders well and may recognise triggers for attendance, ways to make patients safer or ways to rationalise their care.

Reducing attendances

Possible interventions to try to better meet this population's needs:

1. **ED Care Plans.**
   Care plans are invaluable for patients with complex long term conditions who present to the ED. They provide staff with background information, guidance on analgesia, investigations and in particular, what is *not* required. They should guide when onward referral is needed to inpatient specialties. Plans should be made with specialists who know the patient and ideally with input from the patient. Plans for patients with chronic pain exacerbations are very helpful for prompting appropriate analgesia to be administered early which may then prevent admission. These patients should be given a copy of their plan to bring with them when they attend the ED.

   Plans for patients with Medically Unexplained Symptoms have not been shown to reduce attendances but may reduce investigation and admissions for patients and can provide a consistent approach.

   Care plans for patients with Mental Health problems can be helpful in identifying and managing risk of self-harm or absconding. They may state if patients will or will not benefit from psychiatric assessment when they attend. They can also highlight patterns of behaviour which indicate a patient is becoming more unwell. Consideration should also be given to what can help reduce a patient's distress when they attend the ED and in some cases whether a chaperone or special observation is required. Any risk to staff should be made clear in a care plan and/or as an alert on a patient's records.

   Patients should be given the opportunity to review and contribute to their plan. They may be able to identify triggers for distress and importantly say what helps in these situations.

   The evidence for care plans reducing ED attendances is lacking - case series tend to show good results[xi],[xii] but studies with a control group showed no difference between groups[xiii]. [xiv]

Plans should however improve safety if used well and may perhaps reduce overall resources used such as investigations and referral to specialty.

See appendix 1 for example template of a ED management plan.

2. Case Management

Case management involves a detailed assessment of needs of the patient and liaison with providers such as primary care, community mental health, housing and social care to try to meet these needs. There are various models of care: some use Liaison Psychiatry teams to assess patients, others are based in hospital primary care liaison teams. Anecdotally helping patients with issues such as housing, finances and getting back to work can help reduce their ill health and therefore ED attendances.

Unfortunately, the evidence for the effectiveness of case management is lacking.[xv], [xvi]. Case series in the UK have shown marked reduction in attendances after case management but none have had a control group which would allow the effect to be properly quantified. Of 4 RCT of Case Management for frequent attenders, two showed a modest relative risk reduction but small absolute risk reduction[xvii], [xviii]one showed a reduction that did not meet statistical significance[xix] and one that combined care pans which showed no difference [xiii].

This is probably reflective of the complexity of issues that patients face. It may also show that a short period of case management is not sufficient to change patients' lives and suggests patients need long periods of ongoing support. A good example of this is the SIM project in the Isle of Wight ("Serenity Integrated Mentoring"). This project embedded a police mental health specialist within a community mental health team. A combination of compassion, discipline, perseverance and assertiveness reduced both ED attendance in individuals and overall 136 suite usage over 3 years [xx]. Even this evidence is limited due to the lack of control group.

3. MDT

Multi-Disciplinary Team conferences involving primary care, social care, and psychiatric teams can be useful. Information sharing, and discussion of trigger points for attendance can identify issues that community teams can help with. Specialists such as chronic pain services and drug and alcohol teams may also be helpful to involve. Consideration should be given to inviting the patient and or carers to a case conference where possible.

The focus of some MDT may be purely to manage risk and requires involvement of police, ambulances and Emergency Mental Health services.

An information sharing agreement should be set up so that information may be shared between health providers, police, housing agencies and social care.

4. Primary Care involvement.

Some who patients who attend frequently have struggled to engage with primary care. Others can be helped by a more assertive approach from their GP, for example a regular appointment with their GP which may pre-empt ED visits. Case management and care plans should involve GPs wherever possible.

5. Psychological therapy for patients with Medically Unexplained symptoms.

Patients who attend with Medically Unexplained Symptoms make up quite a large part of the Frequent Attender Population. Care should be taken as clearly important treatable diagnoses exist in this population. Junior clinicians however seeing these patients are more likely to request more tests and make referrals to make sure they do not miss a treatable condition. This approach is likely to encourage the patient to seek more tests and diagnoses.

It is helpful if these patients are identified as patients with Medically Unexplained Symptoms and clinicians focus on symptom management rather than diagnosis. Senior clinicians should be involved with these patients. A helpful approach is to acknowledge to the patient that their symptoms are definitely real and not imagined and can be due to changes in physiological pathways not actual disease.

For patients with neurological functional symptoms the website http://www.neurosymptoms.org/ may be helpful for clinicians and patients.

There is reasonable evidence for the interventions such as Cognitive Behavioural Therapy for patients with Medically Unexplained Symptoms[xxi], [xxii], so referral to IAPT (improving access to psychological therapies) or a psychologist should be considered.

Examples of Frequent Attender Programs

The West Middlesex Frequent Attender Program
http://www.rcpsych.ac.uk/pdf/The%20West%20Middlesex%20Frequent%20attenders%20programme.pdf

http://www.wlmht.nhs.uk/uncategorized/ae-programme-reduces-unnecessary-attendances/

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Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Key words for search

Frequent Attenders.

Appendix 1: Emergency Department Patient Specific Care Plan

Name:

Address:

D.O.B:

Hospital No:

Date of plan:

GP:

Care coordinator:

Consultant:

Reason for plan:

Problem list:

1. **1.**

Summary of previous attendances / Background:

Risk assessment – risk to self

Risk assessment – risk to others

ED plan

1. Every attendance should be assessed on its own merits
2.

Is the patient aware of the plan? Y/N

Plan developed by: **Plan discussed with:**

Appendix 2: Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

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