



Royal College *of*
Emergency Medicine

Best Practice Guideline

**Frequent Attendance in the
Emergency Department:
Delivering Interventions and
Services for High Intensity
Use**

March 2024

Summary of recommendations

- 1) Patients who attend the Emergency Department frequently should be treated with the same care and respect as other patients.
- 2) The terms Frequent Attendance or High Intensity Use (HIU) are preferable to 'Frequent Attenders' and 'High intensity Users' to avoid marginalisation of this cohort of patients.
- 3) EDs should have a named senior ED clinician who is responsible for co-ordinating the care of frequent attendance. EDs should also liaise as needed with other local EDs and services who are involved in care for this group of patients.
- 4) Care planning should be considered if a patient may benefit from a consistent bespoke approach. 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. Plans should involve the wider multidisciplinary team.
- 5) Some patients are difficult to engage or hard to reach. If, despite best efforts, a patient declines a care plan, and it is in their best interests to reduce harm, a care plan for clinician guidance remains appropriate.
- 6) Frequent attendance to EDs is a symptom of system-wide deficiency or unmet need in physical and mental healthcare as well as social care. Case management for this cohort may be helpful to identify gaps in local health and social care services as well as individual needs.
- 7) A 'de-medicalisation' approach to case management provides an opportunity for patient-centred holistic support. This type of HIU service was first introduced in the NHS Right Care model and can be delivered by non-clinical practitioners[†]. However, patients with regular acute medical presentations, such as DKA (Diabetic Ketoacidosis), will likely require a degree of medical involvement and guidance. In these cases, the aim should be collaboration between clinical and non-clinical teams.

[†] Nowhere else to turn. Exploring high intensity use of Accident and Emergency services. British Red Cross. 2021. <https://www.redcross.org.uk/-/media/documents/about-us/hiu-summary-report-final.pdf>

Contents

Summary of recommendations	2
Scope	4
Reason for development	4
Introduction	5
Background	5
Identifying patients with High Intensity Use of ED services	5
Management of Care	6
Management of Challenging Behaviour	6
Reducing attendances	6
Use of Individual Care Planning by Emergency Departments	6
1. ED Clinical Management Plan	7
2. Interdepartmental Clinical Management Plan	7
3. Specific Plans for Mental Health Patients	7
4. Multidisciplinary and Multiagency Care Plans	7
Bespoke Case Management	8
Evidence Based Practice	8
Other Considerations in Managing Frequent Attendance	9
Primary Care involvement	9
Management of patients with persistent physical symptoms or functional disorders	9
Information Governance	9
Evaluation of a HIU Service	9
Quantitative.....	10
Qualitative.....	10
Integrated Care System Involvement	10
Examples of HIU Programs	10
HIU Outpatient Clinics	10
Resources	11
Third sector involvement:.....	11
Other Resources.....	11
About this Document	12
Appendices	13
Appendix 1: Case study – “Philip’s story”	13
Appendix 2: Third Sector Involvement in Oxfordshire	15
Appendix 3: Example of patient profile data capture:	16
Appendix 4: Example of psychosocial assessment coproduced with patients and professionals	19
References	27

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.

There is no agreed definition for high intensity use and frequent attendance, but definitions may reflect frequency, impact, and complexity.

1. Frequency of attendance, which may vary locally and by service.
2. Impact; individuals who have a significant impact on ED resources, including medical and nursing needs, social needs, or challenging behaviour.
3. Complexity; individuals with complex medical conditions, mental health problems, chronic illness, or social situations that result in repeat ED attendances and/or admissions.

Reason for development

The number of patients frequently attending EDs as a result of unmet health and care needs, or with underlying vulnerabilities is rising. An ED visit is not always beneficial for these patients and may increase health care anxiety. Frequent attendance to the ED is often a reflection of a system wide deficiency of care for the most vulnerable members of society and this patient group has often been marginalised in the ED and other healthcare settings.

RCEM has previously cited five or more attendances in a year as reflecting HIU. However, there is significant variation in HIU services reflecting local differences in patient demographics, commissioning, and wider service engagement. What works, or indeed is possible, in one location will inevitably be different from another. Some EDs are best placed to host a HIU service, but other services may be based in the community. Nevertheless, EDs will continue to be a contact point for patients and are a partner (and safety net) in HIU work.

There are typically two aspects to HIU work: preventative and reactive. Preventative work aims to engage patients before they reach crisis point and present to the ED. In contrast, reactive work focuses on harm reduction and providing immediate care to patients once they present to the ED, as well as facilitating ongoing support. Improved care for patients with HIU should aim to shift care towards timely prevention, thereby reducing the need for reactive care.

This guidance intends to change the way clinicians perceive patients who attend ED frequently, reduce the stigma associated with frequent attendance, and support clinicians in achieving the best possible care for this patient cohort.

Introduction

The overarching aim of High Intensity Use (HIU) services is to identify patients whose increased attendance frequency is indicative of vulnerability or unmet needs, consider new or escalating risks (for patients and staff), and work with other services to promote access of alternative care options. System-wide collaboration should seek to engage patients with appropriate scheduled care and other forms of support able to address their unique needs. Care planning should inform safe and quality care when patients come into contact with emergency services, including the avoidance of iatrogenic harm and a reduction in duplication of care.

Background

HIU is inconsistently defined but typically reflects a heterogenous population of patients whose attendance to ED is frequent and who have complex health and care needs. In this document we use the terms HIU and Frequent Attendance interchangeably.

Patients with who repeatedly attend healthcare settings reflect approximately 1-2% of people who use the ED each year. There is significant geographical and temporal variation. ED attendances at one trust² have tripled from 2003-2023 from 50,122 to 154,076 and the number of individuals has increased by a factor of 15 from 186 in 2003 to 2720 in 2023. 'Frequent attendance' to EDs is associated with frequent attendance of other health and social care facilities¹. This cohort tends to be of higher acuity, have greater rates of admission, and a greater burden of chronic disease, when compared to matched groups¹⁻³. For example, a UK ED study showed that 65% had mental health symptoms, 15% had significant alcohol problems, and 45% had medically unexplained symptoms⁴. Patients with multiple vulnerabilities (e.g. chronic mental health problems combined with social problems and alcohol/substance misuse) are more likely to have the highest intensity of ED use and may struggle to access other services. Mortality rates are markedly higher among patients with HIU relative to those with less frequent use⁵, partially reflecting a higher risk of death due to violent means and suicide.

HIU services are crucial in supporting vulnerable patients with complex physical and mental health needs. By developing links with physical, psychological, social support, and the third sector, these services can also benefit patients who attend less frequently. Individual EDs should decide on a feasible HIU definition with sufficient flexibility to include patients who may benefit from MDT intervention even if they do not fulfil a generic definition. EDs should consider including patients who; attend very frequently over a short period of time, escalate their frequency of attendance, or who present complex clinical challenges (even if they do not attend very frequently). HIU is often episodic, with declining service use as the crisis resolves. This means that evaluation of interventions for HIU should support investigation of a dynamic cohort of patients, including the use of qualitative data to capture clinician and patient experiences⁶⁻⁸.

Identifying patients with High Intensity Use of ED services

Departments should develop a mechanism for identifying frequent attendance. Identification by a data trawl or dashboard may be a good starting point. ED staff also tend to know this cohort well and may recognise triggers for attendance, ways to make patients safer or ways to rationalise their care.

Management of Care

Patients who attend the ED frequently should be treated with the same care and respect as other patients. ED clinicians should be aware of the higher mortality and morbidity of this group and speak out against the stigma that some of these patients attract.

EDs should have a named senior ED clinician who is responsible for co-ordinating the care of frequent attendance by acting as a point of contact for other services and evolving a strategy for managing care for this group. They should support access to GP, community matrons/district nurses, Liaison Psychiatry (LP), community mental health teams, security, police, third sector organisations, safeguarding teams, social prescribers, ambulance services, and any other relevant agencies.

Locally agreed processes should be followed: this may include routinely screening for mental health concerns, drug and alcohol use, safeguarding issues, social deprivation, and domestic abuse concerns to support appropriate specialist referrals. Consider creating a check list for identifying these issues for all patients in this cohort – this may form the basis of MDT discussions.

It is recommended that each department takes part in regularly scheduled meetings to discuss the patients who are attending frequently, and that these meetings should be multi-disciplinary.

Management of Challenging Behaviour

Given the increased prevalence of psychiatric disorders and alcohol misuse in this group of patients, challenging behaviour can be more common. These patients should not be criminalised via the criminal justice system for their frequent attendance to ED as this may be the only place where they feel able to receive care. However, staff should not be subjected to physical or verbal abuse in the delivery of care. Single or infrequent episodes should be managed according to locally agreed policies. Persistent episodes should be reported to the police and incident reporting should be encouraged. A care plan may be needed to highlight risks or triggers for aggression and identify ways to de-escalate that help this individual. The use of civil orders (e.g. 'Anti-social Behaviour Order', now termed 'Criminal Behavioural Order' (CBO)) raises complex medico-legal and ethical issues and should be avoided where possible.

If a patient is known to attend multiple EDs (locally or nationally) then it is appropriate for clinicians to share care plans with the other department/s that the patient is attending. This is to ensure consistent care, reduce iatrogenic harm and guide staff on the best way to manage challenging behaviour compassionately.

Reducing attendances

A reduction in the absolute number of ED attendances (in isolation) is unlikely to be a helpful marker of effective intervention for this group. Instead, the focus should be on ensuring consistent care, reducing harm in ED, and collaborating with system partners to avoid high intensity use through proactive and preventative measures. This includes providing comprehensive background information (medical and social), previous community support, limiting harmful investigations and referring or signposting to more appropriate services. It is important for departments to tailor their approach to balance the needs of the patients known to them and available resources; both in terms of clinician time and finance/funding.

Use of Individual Care Planning by Emergency Departments

Due to the heterogeneity of the patients who frequently attend EDs, there is no "one size fits all" recommendation of what type of plan any department should be using in a given situation. It may be suitable for patients to switch between plan types during the course of their contact with a department. Whilst a bespoke and individual plan is the aspiration (if appropriate), it is recognised that many EDs in the UK do not have the resources to achieve this.

Approaches to care planning will be resource-dependent but should aim to identify individuals who may benefit from an ED care plan. Four approaches are outlined below.

1. ED Clinical Management Plan

This type of plan typically involves staff from the ED (only). It aims to give structure and boundaries to use of investigations and thresholds for admission for any individual patient – e.g. to ensure prompt and suitable analgesia, reduce iatrogenic harm to the patient through unnecessary and repetitive investigations, as well as reducing length of stay in the ED. It also benefits clinicians by providing background information on a patient and guiding their management. Patients will often be able to explain what approaches help or hinder when they attend.

2. Interdepartmental Clinical Management Plan

This type of plan aims to manage frequent attendance with a specific physical health complaint (e.g. cyclical vomiting, recurrent abdominal pain, or chest pain). ED clinicians should liaise with the relevant specialty team(s) to set guidance. This may include prescribing guidance as well as setting thresholds for investigations, admission, direct referral and follow up in specialist clinics. Involvement of specialist nurses is recommended for this group of patients.

Thorough background information (e.g. investigations, interventions, diagnoses) should be summarised clearly in the plan. Contact details of any involved specialty should be included. The ED clinician may need to attend a specialty team's MDT meeting to discuss the patient.

3. Specific Plans for Mental Health Patients

Many patients with frequent attendance will attend solely with mental ill health or at the point of crisis. This type of plan aims to identify and manage the risk of self-harm or absconding in patients with Mental Health problems, in some cases this may include a chaperone or special observation. The care plan can also highlight patterns of behaviour which indicate a patient is becoming more unwell and what may help to reduce their distress. Any risk to staff should be made clear in a care plan and/or as an alert on a patient's records.

All patients expressing suicidal ideation or those who have attended due to self-harm will benefit from a referral to Liaison Psychiatry (LP). The ED team should work closely with their LP colleagues to understand the patient's illness and diagnoses, including reviewing any existing admission avoidance or community care plans. Where possible, the details of these plans (including community support, key worker details, alcohol or substance misuse teams, and safeguarding concerns) should be incorporated into the ED plan for the patient.

There are some rare instances where the LP team may decide to not review the patient on each attendance; this should only be in exceptional circumstances and after careful consideration within the MDT (usually involving the community mental health team and the patient).

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.

4. Multidisciplinary and Multiagency Care Plans

This type of plan aims to include details of each of the clinicians and agencies providing care for patients with complex needs. The plan should include details of how each agency will respond to the patient when they attend the ED, including risk management and guidance on admission avoidance.

It may be appropriate to hold a one-off case conference, or a regular set of meetings, involving all necessary parties to create a full MDT plan for a given patient. MDT meetings often provide the ED staff with background information about how others are managing the patient, which can be useful

for care planning in the ED. Information sharing, and discussion of trigger points for attendance can identify issues that community teams can help with. Such meetings would typically include ED, Psychiatry, GP, Social Services, Alcohol Services, the Ambulance Service, security and possibly other third sector or emergency service organisations. Specialists such as chronic pain services may also be helpful to involve.

Consideration should be given to inviting the patient and or carers to a case conference where possible.

Bespoke Case Management

Case management is a means of meeting individual experiences, needs and preferences of patients attending the ED. This will be in the context of what is appropriate and safe in terms of clinical care. 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. **The best outcomes result when patients are invited to be involved from the start.**

Some EDs have funding for a dedicated Frequent Attendance/HIU Service with staff and case workers (who may not be healthcare professionals) solely focused on working with individual patients or small groups of patients. Some services for patients with HIU are based in the community, they may be organised within local community health trusts, and some are successfully delivered by 3rd sector organisations. These professionals can consider all areas of the patient's life, including addressing issues such as homelessness, drug and alcohol misuse, unemployment etc. The case worker will liaise with providers such as primary care and community mental health teams. Using non-clinicians to provide in-depth support is a recognised model first applied by the NHS Right Care programme and now adopted by the Red Cross. It focuses on building a relationship with individuals who need stability and goes beyond the remit of hospital-based clinicians. For example, case workers may accompany patients to the job centre, or the Citizen's Advice Bureau, and to act as their advocate. Helping patients with non-medical issues such as housing, finances and getting back to work may help reduce their ill health and therefore ED attendances. HIU teams may need to liaise with "street outreach" and other specialist services for homeless people. ED based HIU teams should also aim to link with the newly emerging role of social prescribers within the Primary Care Network.

Evidence Based Practice

Ideally case management should be co-opted by the community physical and or mental health teams as the patient's attendances to the ED reduce. However, evidence of effectiveness of case management is lacking⁹⁻¹¹. 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 four RCTs of Case Management for frequently attending patients, two showed a modest relative risk reduction but small absolute risk reduction¹²⁻¹³ one showed a reduction that did not meet statistical significance¹⁴ and one that combined care plans which showed no difference¹⁵.

This is reflective of the complexity of issues that patients face, as well as the difficulty of defining case management as an intervention. For example, brief telephone-based engagement involves a degree of case work but is vastly different from community outreach programmes. It may also show that a short period of case management is not sufficient to change patients' lives and suggests patients need ongoing support. Indeed, case workers should not discontinue support abruptly, but rather identify suitable services able to provide long-term interventions. As a result, case work not only has immediate benefits, but can provide a 'holding service' while planning onwards referral.

Other Considerations in Managing Frequent Attendance

Primary Care involvement

Some patients who attend frequently have struggled to engage with primary care. Many 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.

Management of patients with persistent physical symptoms or functional disorders

A significant portion of patients with HIU attend with symptoms that are functional in origin – i.e., the problem is with the function of a system rather than an anatomically or biochemically identified abnormality. E.g., Exacerbation of irritable bowel syndrome, pain syndromes, inappropriate sinus tachycardia, or non-epileptic seizures. It is helpful if these patients are identified pro-actively and senior clinicians are involved early. Diagnosis should not just rest on exclusion of other conditions but on a positive diagnosis of a recognised syndrome and judicious use of investigations. Multiple investigations and referrals are unhelpful, instead the focus should be on validating symptoms, good explanation of the mechanisms involved and symptom management.

It is not uncommon for patients with these conditions to have experienced previous trauma or significant stress. Asking about this in a sensitive way can be helpful if followed by an explanation of how the body and mind interact, stressing how common this is in both functional and other conditions.

There is reasonable evidence for the interventions such as Cognitive Behavioural Therapy for patients with Somatic Symptom Disorder^{16,17}, so referral to IAPT (improving access to psychological therapies) or a psychologist should be considered. Self-help techniques such as mindfulness, yoga and breathing exercises have a place in reducing sympathetic drive and increasing parasympathetic activity.

HIU services would benefit from incorporating psychologists in their teams or collaborate with services able to access psychologists.

Information Governance

Professionals have a responsibility to share information about individuals in order to provide good care. To comply with General Data Protection Regulation 2016 an information sharing agreement should be set up. Information can be freely shared between health providers as they are all part of the care team for an individual. However, information shared with non-health providers should be with the permission of the individual or should be considered to be vital to be shared to prevent harm. It may also be helpful to share an ED or MDT care plan with neighbouring departments at other local Trusts, especially if it is known that the patient is also attending other departments frequently. Collaborative working should be encouraged between Trusts and agencies and Information Governance hurdles should be addressed and overcome so as not to hinder this.

Evaluation of a HIU Service

Evaluating the impact of a service set up to address ED frequent attendance is complex and should aim to capture impacts across the wider system, including the individual patient, the ED, and other closely related services, including nearby EDs and community-based services.

Examples of relevant metrics should aim to capture indicators relating to patient-level and ED-level measures over time of:

Quantitative

- ❖ Number of ED contacts.
- ❖ Length of ED stay.
- ❖ Number of radiological investigations.
- ❖ Number of patients who frequently attend as a metric to show wider system response of an HIU service.
- ❖ Use of other services including ambulance services.

Qualitative

- ❖ Patient and clinician satisfaction with the service and care planning.
- ❖ Self-reported health status, quality of life and wellbeing.
- ❖ Operational efficiency of the ED as a partner in the wider system (e.g. through involvement in MDTs, referral for preventative services and contributing to care plans that ensure harm and risk reduction in the ED).

Integrated Care System Involvement

Integrated Care System/ Boards are responsible for the commissioning and delivery of health and social care across organisational boundaries in a large geographic footprint. This puts them in the unique position of responding to the systemic gaps that lead to high use of urgent and emergency care. The ED HIU team can help identify those gaps. As a result, the wider HIU service has the potential of bringing about more far-reaching change than would be achieved by reducing the attendance frequency of a limited number of patients.

For ED HIU teams, involvement of the Integrated Care System/Board is a means of pooling resources and across a region. This may involve commissioning, but also includes data sharing. For example, a dashboard can be developed to identify regional high users, their pattern of healthcare seeking behaviour across Trust borders, use of radiological and other investigations (which may increase iatrogenic harm), and even drug-seeking tendencies. Collaborative working with other EDs is beneficial, as previously mentioned, in terms of gaining an understanding of the wider needs of local patients frequently attending EDs.

Examples of HIU Programs

NHS England's RightCare aims to support health and care systems to improve care quality, population health and system sustainability. Information on RightCare's methodology for change and guidance is available via: www.england.nhs.uk/rightcare

HIU Outpatient Clinics

In some parts of the UK, EDs can refer patients who attend frequently to specialist HIU clinics. These are staffed by a combination of trained staff including psychologists and LP team members who can look to address the issues and needs of the individual patient time away from the ED. This provides the opportunity for a full bio-psycho-social assessment, and referral onwards to other appropriate agencies if necessary, e.g. alcohol services, social services, housing, safeguarding etc.

Resources

- ❖ SHarED: Supporting 'high impact users' of emergency departments: <https://arc-w.nihr.ac.uk/publications/shared-supporting-high-impact-users-of-emergency-departments/> including the SHarED Implementation Guide: <https://www.healthinnowest.net/wp-content/uploads/2022/08/SHarED-Toolkit-v11.0.pdf>
- ❖ Whole Systems Integrated Care (WSIC) dashboard – example North West London ICB: <https://www.nwlondonicb.nhs.uk/professionals/whole-systems-integrated-care-wsic>
<https://www.england.nhs.uk/high-intensity-use-programme/>

Third sector involvement:

- ❖ MIND: <https://www.mind.org.uk/>
- ❖ Groundswell: <https://groundswell.org.uk/>
- ❖ SHOUT: <https://giveusashout.org/>
- ❖ Red cross: <https://www.redcross.org.uk/>
- ❖ Pathway: <https://www.pathway.org.uk/>

Other Resources

- ❖ Nowhere else to turn. Exploring high intensity use of Accident and Emergency services. British Red Cross. 2021. <https://www.redcross.org.uk/-/media/documents/about-us/hiu-summary-report-final.pdf>
- ❖ NHS HIU programme resource pack: <https://www.england.nhs.uk/publication/high-intensity-user-service-resource-pack-supporting-documents/>
- ❖ Homeless and Inclusion Health standards for commissioners and service providers: <https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final-1.pdf>
- ❖ For patients with functional neurological symptoms the website <http://www.neurosymptoms.org/> may be helpful for clinicians and patients. For pain syndromes <https://livewellwithpain.co.uk/> is recommended.

About this Document

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Endorsements

None

Review

This guideline was first published in June 2014.

Reviews are usually within three years or sooner if important information becomes available. Next review expected in March 2027.

July 2017 – First review

March 2024 – Second review

Declaration of Interests

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.

Research Recommendations

None

Audit standards

None

Key words for search

Frequent Attendance, High Intensity Use

Appendices

Appendix 1: Case study – “Philip’s story”

Philip is a 50-year-old male with poorly controlled type I DM. He had recurrent admissions for vomiting and DKA. In one year, Philip spent 143 days admitted in hospital in total, usually arriving by ambulance.

Admissions were cyclical and characterised by delayed ED attendance despite having days of vomiting at home. On attending ED Philip was very unwell, often confused, and unable to cooperate; dehydrated with poor IV access. Typically, Philip would spend approximately a week as inpatient and then discharged with repeat of cycle every 1- 2 weeks.

Philip was referred to the HIU Team for assessment including review of medical notes, contact speciality teams and GP, ward visits and a home visit. This assessment identified the following underlying drivers to attendances:

Mental health

- Philip was reviewed by Liaison psychiatry team on several occasions, low mood was identified, and treatment started.

Cognitive impairment

- There were no concerns regarding cognitive impairment although undiagnosed learning disability was considered and excluded.

Safeguarding (adult and child; patient has a child at school)

- Child safeguarding issues identified as a result of the HIU home visit. In addition, adult safeguarding concerns were identified including financial abuse from adult children. The forensic history of other co-habitants was a cause for concern and resulted in the escalation of the initial child safe-guarding concerns. Animal welfare issues were also raised.

Social problems: Benefits/ Housing/ Care needs

- Philip was supported in acquiring a freedom pass, which helped him to attend appointments. His benefits (PiP) were reviewed and subsequently enhanced and backdated. Access to legal aid was facilitated which first delayed (on health grounds) a warrant to evict Philip, and second appealed the decision to evict him. Direct working with housing, including joint home visits, resulted in rehousing Philip in a one-bedroom flat that was more appropriate for his health needs.

Substance misuse

- Substance misuse was not identified but Philip suffered as a result of the substance misuse of family members. He was a heavy smoker and has untreated dental caries.

Chronic/ unmet physical health needs

- Philip had not attended an endocrine outpatient appointment for the previous three years. The HIU team accompanied him to appointments and prompted attendances. The management of gastroparesis was inconsistent. This was improved by joint working with the endocrine team, acute medicine, and ED to create a gastroparesis pathway, including PEG tube and dietician referral. He had a history of poor engagement with community

teams and the GP. The education and vascular access team worked with Philip to improve access – this had previously been a challenge as Philip typically attended late, very dehydrated on background of poor IV access.

Poor nutrition

- Philip had no functioning oven/hob.

Outcomes

Philip was moved to a ground floor flat in easy access accommodation. With backdated benefits payments was able to purchase an oven/hob. He continues to receive ad hoc support from social prescriber regarding finances, and to need support and prompting regarding appointments. Regular review by pancreatic transplant team which has resulted in severe coronary artery disease being diagnosed and addressed. Philip report having a girlfriend and good relationships with his family and now attends the ED infrequently.

Appendix 2: Third Sector Involvement in Oxfordshire

Elmore Community Services is a charity providing high-quality mental health, complex needs, and domestic abuse services to vulnerable people. Since April 2020 Elmore's High Intensity Use Project has been commissioned to work alongside the Oxfordshire HIU Service to provide brief, community-based support to people who frequently attend hospital emergency departments or use emergency services.

The project is available to people aged 18+ living in Oxfordshire, who are patients of the Oxford University Hospitals NHS Foundation Trust Emergency Departments, and who the hospital-based High Intensity Use (HIU) Team feel would benefit from community-based support which they are unable to provide. The service criteria have been kept purposefully broad, due to a recognition that the project is aiming to support people with complex needs who do not fit easily into services.

The project provides intensive, proactive, practical, and emotional support which can last for up to 12 weeks, with further support possible over the next 12 weeks. Each patient is allocated a lead worker who meets with the individual on a weekly basis, or as often as needed, to help them to identify the goals they want support with and make progress towards achieving them.

The most common areas of support are:

- Improving mental and physical wellbeing and enabling recovery
- Building up confidence and self-esteem
- Providing support around housing, money, benefits, or debt
- Providing support and tools to prevent isolation and loneliness
- Acting as an advocate to ensure the patient's voice is heard
- Providing information and assistance to access employment, education, volunteering, or training opportunities
- Working alongside patients to help them learn or improve practical life skills
- Supporting patients in any contacts with the police and criminal justice system

Elmore's goal is to empower patients to stabilise their lives and access other longer-term, practical, and emotional support from specialist services to better manage their mental health and other presenting issues. One of the distinguishing features of Elmore's HIU Project is the ability to quickly take on a 'care co-ordination' role, pulling the different aspects of a person's care needs together, and supporting them to get back in control of their life.

Link: <https://elmorecommunityservices.org.uk/high-intensity-user-project>

Appendix 3: Example of patient profile data capture:

Name:			
MRN Number:		NHS No.:	
Date allocated:			
Demographics			
Ethnicity:	Gender:	Age:	
Previous HIU involvement			
Known to HIU <input type="checkbox"/>	HIU plan in place <input type="checkbox"/>	HIU plan in-date <input type="checkbox"/>	Plan out-of-date <input type="checkbox"/>

HIU actions			
Timeline	Completed <input type="checkbox"/>		
Date of first contact:	Unable to contact <input type="checkbox"/>		
Psychosocial Assessment	Completed <input type="checkbox"/>	Declined <input type="checkbox"/>	Not indicated <input type="checkbox"/>
Date of assessment:			

Problem Types (select all that apply)			
Mental health <input type="checkbox"/>	Drugs and Alcohol <input type="checkbox"/>	Long term physical health conditions <input type="checkbox"/>	Housing need <input type="checkbox"/>
Social isolation <input type="checkbox"/>	Employment issues <input type="checkbox"/>	Self-harm <input type="checkbox"/>	Suicidality <input type="checkbox"/>
Trauma history <input type="checkbox"/>	Safeguarding concerns <input type="checkbox"/>	Learning disability <input type="checkbox"/>	Neurodevelopmental diagnosis <input type="checkbox"/>
Functional symptoms <input type="checkbox"/>	Chronic pain <input type="checkbox"/>	Financial concerns <input type="checkbox"/>	Other (specify):

Risks (select all that apply)			
Self-harm <input type="checkbox"/>	Suicide <input type="checkbox"/>	Inappropriate medication/drug prescribing <input type="checkbox"/>	Repeat of unnecessary investigations (e.g. CT scans) <input type="checkbox"/>
Inappropriate/unneeded hospital admission <input type="checkbox"/>	Homelessness <input type="checkbox"/>	Substance/alcohol abuse <input type="checkbox"/>	Domestic abuse <input type="checkbox"/>

Other safeguarding concerns (e.g. children, financial exploitation) <input type="checkbox"/>	Harm to others <input type="checkbox"/>	Other (specify):
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Services	Already involved?	Referral?	Liaison?
AMHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elmore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Connections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCPMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult Social Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Current care package? <input type="checkbox"/>		
Children's Social Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAMHS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning Point	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complex Needs Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talking Space Plus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SAFE!	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialist outpatient clinic – specify. (e.g. neurology, gynaecology, diabetes, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Contact details if useful:			

Hospital admission	
Previous admission to mental health hospital <input type="checkbox"/>	Date of last discharge:
Previous admission to acute hospital <input type="checkbox"/>	Date of last discharge:
Eligible for S117 After Care? <input type="checkbox"/>	

Patient centred goals (if helpful)	
Goals identified <input type="checkbox"/>	Details

MDT		
Arranged/requested <input type="checkbox"/>	Services involved:	Date:

HIU Plan		
Plan in place	Reviewed and remains relevant (please add comment on EPR) <input type="checkbox"/>	Date:
New or revised plan	Completed <input type="checkbox"/>	Date:
	Uploaded <input type="checkbox"/>	Date:
Plan shared with patient <input type="checkbox"/>	Plan shared with GP <input type="checkbox"/>	Plan shared with other services <input type="checkbox"/>

Appendix 4: Example of psychosocial assessment coproduced with patients and professionals

Date:

INDIVIDUAL PATIENT PROFILE AND CARE NEEDS ASSESSMENT

Name:	
DOB:	
NHS Number:	
Address: Mobile Tel Home Tel Ethnic category Religion Next of kin Relationship Tel No:	
GP Name Practice Name Address Tel No:	

We are asking these questions to understand individual situations and know how best to help patients. Additional information can be added on the last page with reference to the section and question.

1. Contact with healthcare and support services

a	When you attend the ED, do you find you attend with the same or similar symptoms/concerns each time? Please tell us more.
b	What other healthcare providers and/or support services do you have contact with? How often do you see them?
c	What else do you think could be done to better meet your needs?
d	Have you ever attended another emergency department in the last year and if so where? Why did you feel the need to attend an ED elsewhere?

2. <u>Care Plans</u>	
a	Do you know of any plans in place regarding your care? This could be with a specialist, ED or GP.
b	Are you familiar with the information contained in your care plan? Is there anything you would add/change? [This information will not necessarily result in a change but is merely asked to get your perception].

3. <u>Physical Wellbeing</u>	
a	Please list any previous and current medical problems.
b	Do you think you need further investigation by a medical professional? Are you concerned about any particular conditions?
c	Do you have any long-term physical conditions that affect your ability to perform daily activities? Please tell us briefly in what way you are affected. Is your mobility affected?
d	How does your physical health affect your mental wellbeing?
e	Has substance/drug use /dependence been a problem for you? Do you or have you ever had contact with any support services for this? If so, which service?
f	For use in female patients with chronic abdominal or pelvic pain (gain consent from the patient that information may be shared with the Gynaecology Pelvic Pain team): Do you suffer from heavy/painful periods? On sexual intercourse do you find that it is painful?

	<p>Have you had any history of sexual abuse?</p> <p>Do you have any history of urinary tract infections, burning/stinging on passing urine?</p>
<p>4. <u>Psychological and emotional wellbeing</u></p>	
a	Do you have any diagnosed mental health conditions?
b	How does your mental health affect your physical health/symptoms?
c	Have you seen/are you seeing someone to help with your mental health (e.g. psychologist, counsellor, psychiatrist)? If so, who?
d	Are there particular situations which negatively affect you or your mental health?
e	Are there any triggers that could result in a mental health crisis for you?
f	What are the risks when you are feeling mentally in crisis?
g	Is there anything that may help you when you are experiencing a crisis?
h	This can be a hard question to answer, but have you ever thought about ending your own life? Have you ever taken action and attempted suicide? When did this happen? [ask about current plans, if appropriate]
<p><u>Screening questions for patients with no current mental health diagnosis – for completion with support worker or healthcare professional:</u></p> <p><u>Depression screening:</u></p> <p>During the last month, have you often been bothered by feeling down [depressed or hopeless]?</p> <p>During the last month, have you often been bothered by having little interest or pleasure in doing things?</p> <p>If a person answers 'yes' to either of the above questions, consider depression and discuss referral to GP for full assessment/appropriate onwards referral.</p>	

Anxiety screening (GAD-2):

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3

•If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and discuss referral to GP for full assessment/appropriate onwards referral.

•If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and discuss referral to GP for full assessment/appropriate onwards referral.

5. Home and social support

a	Are there people in your life who regularly offer you support, at home, friends, or family?
b	Where do you live (type of accommodation, council/rented/owned, etc.)?
c	Do you have any concerns about your housing situation? [Is your housing secure (won't be moved on) and affordable and fit for living in].
d	Do you have other carers/people who help you? [name individuals/agency]
e	Do you have dependents? If yes – document names/ages of children under 18?
f	If children are under 18, is someone with them now (i.e. when patient is in ED)
g	Do you have pets?
h	Do you have any hobbies/interests?

i	Are you a member of a spiritual, religious or faith-based organisation/community?
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6. <u>Financial Considerations</u> (make clear this information will not be shared with employer or school/university/college/council).	
a	Are you currently in employment? Do you have any concerns about this? [full –time /temporary, etc.]
b	Are you currently in education? Do you have financial concerns about this?
c	Do you currently receive benefits? If so, which type? (make clear sharing this information will not affect benefits)
d	Do you have any specific financial concerns (e.g. debt repayments, child care costs, food poverty, etc.), and are you receiving help around this?

7. <u>Additional Information (document relevant referrals)</u>	
a	Do you have any concerns about your or someone else’s safety e.g. domestic violence?
b	Are you or any of your family members in contact with social services?
c	Do we need to be aware of any specific cultural or religious considerations?
d	Have you been or are you currently involved with any legal proceedings on behalf of or against you? [clarify this is information is to understand stressors and improve care, and will not affect the proceedings]

Please provide any additional comments you think may help us understand your needs, e.g. personal concerns, aspects involving your physical and/or psychological wellbeing, and/or the care and support you receive in ED/the community.

Identify personalised goals to be achieved with the help of the HIU programme. These goals are to be discussed and agreed with the patients. If appropriate, ask the patient what is keeping them from realising these goals now.	
Goal	Description
<i>Let patient freely discuss goals before prompting with below</i>	
1.	Managing physical health and self-care
2.	Understanding your own condition and what you could do to help
3.	Managing mental health
4.	Overcoming social challenges (e.g. housing, substance abuse)
5.	Successful contact with other services
6.	Specific aspects regarding care in ED
7.	We've noticed that you come to the ED a lot ("What thoughts do you have about this; does this concern you?")

Ask about and discuss any concerns about sharing the above information with the patient. The aim is for it to be shared with individuals/organisations responsible for providing care. [Note: this section is not a 'request for consent', as relevant information may be shared in accordance with principle 7 of the Caldicott guidelines]:

Comments/observations from interviewer:

ACTION PLAN (for interviewer/clinician/HIU team to complete following the assessment):

ADDITIONAL INFORMATION:
PLEASE INDICATE THE SECTION AND QUESTION NUMBER

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