Royal College of Emergency Medicine

Best Practice Guideline

Guidance for care of the child, family or young person who attends the Emergency Department frequently

MARCH 2026

Summary of recommendations

1. All Emergency Departments (EDs) should have a suitable system to record and display numbers of attendances for each patient in a year to allow staff to easily identify patients who attend frequently.

2. Children and young people who attend 3 or more times in a 2-week period should be reviewed by a senior Emergency Medicine and /or Paediatric clinician prior to discharge.

3. Children and young people who attend 6 or more times in a 12-month period should have their attendance reviewed by a senior clinician with consideration of onward referral to specialty or PHIU group.

4. All Emergency Departments should have a named senior clinician who is the point of contact for Paediatric high Intensity Users (PHIU).

5. All EDs seeing children and young people should develop a Paediatric High Intensity group or service.

6. Individual PHIU management plans need to be clear, agreed by all agencies involved in care and easily available for ED staff in and out of hours.

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Scope

This guideline covers best practice care of children, families and young people who attend the Emergency Department frequently, often known as High Intensity Users (HIU).

Reason for development

Paediatric patients who attend frequently have always been a concern and may signal a missed diagnosis, safeguarding concerns or a family that needs extra support. Services for adult HIU now exist in most systems, standards and models of care are emerging in the paediatric population. This guideline will outline actions that should occur in all systems and highlight different models of care.

Introduction

Children and young people make up nearly a quarter of Emergency Department (ED) attendances (2022/2023). Within the increasing numbers of children and young people attending are a group who are attending frequently and need a tailored approach to meet their varied healthcare needs. The Royal College of Emergency Medicine (RCEM) already has guidance for Frequent Attendance in the ED: Delivering Interventions and Services for HIU and this document will work alongside this framework. Paediatric practice is always 'the same but different,' the principles of managing frequent attendance in under 18-year-olds are similar to adult patients but there may be different drivers and concerns.

Who is attending frequently?

Within the paediatric population the highest attendance rates are amongst infants (<1 year old) closely followed by preschool children with a significant drop off in secondary school age and above. Infants commonly attend with febrile illnesses and as they grow and become more mobile, pre-schoolers come with more minor injuries. (1-3)

There is a paucity of published work on children and young people who attend Paediatric ED's frequently. Greenfield et al (4) in their literature review found no clear definition of frequent attendance but settled on more than 4-5 attendances per year. The group with the highest incidence of frequent attendance was under 5 years old (25.1% of UK frequent attendances) with frequent attendance as an infant predicting an ongoing pattern as a preschooler. Paediatric High Intensity Users (PHIU) of ED's were more likely to come from socially deprived areas and socially disadvantaged ethnic groups, have no primary care access, use ambulances more, have increased admission and investigation rates, were more at risk of non-accidental Injury (NAI) and have higher mortality rates (5).

The topic of frequent attendance is closely linked with 'non urgent attendances' (NUA) i.e. a problem or presentation that could potentially be safely managed elsewhere other than the

ED. Simpson et al (6) in a UK based retrospective study of ED attendances over 3 years in Yorkshire and Humber defined NUA as a first attendance with a problem which resulted in no treatment, onward referral or admission. Overall, 21.4% of attendances were deemed NUA with the peak age group <1 followed by under 5. Deprivation was linked to NUA and these children were more likely to not attend by ambulance and to attend out of hours.

How often is too often?

The factors that influence the frequency of attendance need consideration when deciding on thresholds for action. A child with complex needs and multiple long-term conditions is more likely to attend frequently with urgent care needs and will need a different threshold to a previously healthy non ambulant infant attending with a cluster of illnesses. We therefore recommend a two-tier approach:

Short term: 3 attendances in 2 weeks:

1st attendance: Assess by clinician
2nd attendance: In person review by senior decision maker (EM tier 4 - ST4/ equivalent or above or Senior Paediatrician) prior to discharge
3rd attendance: In person review by senior decision maker and consideration of extended observation and/or admission with input from Paediatric team

Long term: 6 attendances in a year:

Discuss with ED senior for review and onward referral or consider scheduling for discussion at high intensity user group.

EDs should ensure they have a suitable system to record and display number of attendances for each patient in a year to allow staff to easily identify frequent attenders.

The short-term trigger is there to catch and prevent an unappreciated illness or injury as well as a minor illness that is developing secondary complications. The National Child Mortality Database (NCMD) from 2023 identified 36% of deaths from infectious disease in childhood as having had ‘modifiable factors’ that contributed to death but if identified and treated differently could have prevented that tragic outcome. The NCMD have asked RCEM to look at barriers to accessing care and identifying a deteriorating child. The theme of multiple attendances prior a fatality due to sepsis is a recurring theme. Review of the previous attendances prior to the presentation meeting the short-term trigger threshold need not be exhaustive; themes can be identified from the electronic patient management system. This may occur during the triage process or when being seen by a clinician.

The long-term trigger over a calendar year looks for patterns in presentation, hitting the threshold should result in closer review of attendances. Any identified themes can be referred directly to a relevant service at that attendance or discussed at the Paediatric High Intensity User (PHIU) group

An ED attendance is an opportunity for a brief biopsychosocial assessment in young people such as the HEEADSSS assessment. In patients starting to attend frequently it may identify potential areas of concern to be addressed before they become more severe.

Paediatric High Intensity User group

Many departments will already have adult HIU services that will work within the ED and community to provide bespoke plans and management pathways for adult HIU. There is an opportunity to develop a parallel service with liaison with inpatient paediatric services, paediatric community teams, School Nurses and Health Visitors. CAMHS, young person's drug and alcohol services, children's social care, local violence reduction initiatives, youth workers and local police will also be important for older patients.

Groups may take different forms. Where links with paediatric orientated partner organisations already exist the setting up of a PHIU group should not duplicate existing work streams. Each department can work in any pattern that allows appropriate support and management of PHIU's. This may mean nominating a suitably qualified ED colleague to attend an existing forum featuring relevant agencies to represent the ED.

Management plans

Many PHIU patients reviewed by a senior clinician with onward referral or discussion with the PHIU group will benefit from a management plan. This may be to guide management in the ED or in inpatient or community settings as well. Where possible management plans should be discussed with the child or young person and their family or carers. Plans should be made with input from all agencies involved and should be easily available for ED staff to access.

Management by presentation:

Illness in infants and younger children

Healthy preschool children will normally have frequent self-limiting febrile illness. While they are more likely to attend than older children each attendance should be used as an opportunity to educate and support parents and care givers around self-management of these usually benign episodes. Parents are frequently burdened with 'fever phobia' and are bombarded with frightening and unrealistic health messages from many sources.

Infants and children who trigger either of the attendance thresholds should be referred to Health Visitor/ School Nursing services and sign posted to 'Healthier Together' online advice and education bundle (7).

Long term chronic health conditions

A small number of children with long term conditions will be HIUs, inpatient, community paediatric teams and ED teams will often know them very well. Some families may have 'open access' and bypass the ED entirely. Attendance to the ED should prompt discussion and/or review by the inpatient paediatric team.

Mental health

The number of attendances of children and young people with mental health needs tripled between 2010 and 2018 and continues to rise. Meeting the needs and keeping this vulnerable patient group safe is complex. When a young person triggers as a HIU the ED team should involve CAMHS to develop a tailored management plan for the patient and their family both in the community and for future ED attendances.

Social crisis

Teenagers and older children may present to the ED with a social emergency when care givers are no longer able to safely accommodate them at home or in another care environment. The young person frequently will have complex personal needs which may include mental health, neurodiversity, drugs and alcohol, chaotic family dynamics and being a looked after child. These situations are beyond the scope of this guideline. EDs should have locally agreed pathways for managing this circumstance that do not default to an admission to a ward when there are no active health issues.

Substance misuse

Young people frequently present to the ED with the effects of drug and alcohol use as well as injuries sustained while under their influence. Please refer to the RCEM Best practice guideline on Drug misuse and the Emergency Department. EDs should be aware of their local drug and alcohol services for young people.

Teenage injury and violence reduction

National crime statistics show a 20% increase in 10–17-year-olds being convicted of knife and offensive weapon offences over the last decade with estimates of 4% of young people ages 13-17 carrying a weapon in the last year. Emergency Departments are uniquely placed to help identify and refer young people to violence reduction services. Where these services exist locally, the Paediatric ED should build links and work alongside youth violence reduction teams.

Safeguarding

Repeated presentations can be a red flag in relation to non-accidental injury (NAI). Any patient flagging either the short- or long-term attendance boundaries should be reviewed to consider the risk that neglect or abuse is driving the attendances (8). PHIU include many groups vulnerable to child abuse in its various forms; the very young, the chronically ill, patients with mental health disorders and users of drugs and alcohol. ED teams should follow local protocols for the management of safeguarding concerns and seek a specialist opinion where doubt exists as to whether the pattern of attendances has abuse as a possible

cause. Please also refer to RCEM Best Practice Guideline: Detection and management of non-accidental injury in infants.

Fabricated or induced illness
Fabricated and induced illness (FII) is when parents or care givers exaggerate, fabricate, or induce symptoms in a well child. Signs include:

- symptoms that only occur with the parents or are witnessed only by the parent
- symptoms that do not fit any recognisable pattern
- multiple investigations are normal/negative
- the presentation changes once one set of symptoms have been fully investigated.

FII in a form of child abuse and is extremely rare but multiple attendances may flag short- and long-term triggers for attendance. Management of FII is multi-agency including inpatient paediatric teams, social care, and the police. ED teams who suspect this as a cause for a PHIU should refer to the inpatient paediatric team for review and investigation.

Parental health
Parenting is challenging and is even more difficult when a parent or care giver are themselves struggling with health-related problems. If it emerges that the parent or care givers health is contributing to their child flagging as a PHIU, then a non-judgemental and supportive conversation encouraging them to seek medical help via their GP or elsewhere can help them get the support they need. Social care can also help and a referral as a 'family in need' may be appropriate.

Summary

Identifying and acting when a child or young person is attending frequently is vitally important to prevent potentially imminent harm as well as facilitating tailored planning to help ED staff safely and effectively manage these often-vulnerable patients. ED teams need to work across hospital and community-based services to meet the needs of each individual child and young person consistently.

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Acknowledgements

RCEM Paediatric Emergency Medicine Professional Advisory Group, including members from RCPCH

RCEM Quality in Emergency Care Committee

Review

Further review usually within three years or sooner if important information becomes available.

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 reside with the treating clinician.

Research Recommendations

None

Audit standards

100% EDs should ensure they have a suitable system to record and display number of attendances for each patient in a year to allow staff to easily identify frequent attenders.

90% of children and young people who attend 3 or more times in a 2-week period are reviewed by a senior Emergency Medicine and /or Paediatric practitioner prior to discharge.

90% of children and young people who attend 6 or more times in a 12-month period have their attendance reviewed by a designated senior EM clinician or PHIU group.

Key words for search

High Intensity Use, Frequent attendance, High Intensity User, Frequent attender, Safeguarding, teenage violence reduction.

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7.Home :: Healthier Together

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