Waltham Forest
High Intensity User Service (HIU)

Health Scrutiny Committee
1 Introduction

The population of patients who are frequent attenders is heterogeneous. A UK Emergency Department study showed that 65% had Mental Health symptoms, 15% had significant alcohol problems, and 45% had Medically unexplained symptoms.\(^{(i)}\)

There is consistent evidence that the population of Frequent Attenders to a department do not constitute a stable cohort \(^{(ii)}\), the number of patients who attend frequently stays 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.

Patients known as "high impact users" (HIU) attend Whipps Cross Emergency Department (ED) very frequently, in some instances over 50 times per year each. Their ED use is associated with personal/health/housing/mental health crisis and staff report that this cohort consume large amounts of time and resources. Housing needs are often a key underlying factor resulting in repeat attendances.

In 2015/16 there were 147 Waltham Forest CCG patients that attended A&E (across sites) 10 or more times with a combined number of attendances of 3,383. The total costs of these combined attendances was £457,969 (average price per attendance of £135).

In 2016, the CCG piloted an innovative system-wide approach to this problem that aimed to reduce ED attendance, non-elective admissions and LAS conveyances through winter resilience planning. The service promoted integrated working and case management of patients from a whole system approach, for patients who may not meet criteria for care in other health care services.

Following this period, the service has seen an increase in demand. The CCG, working with the local authority, commissioned an expanded service from April 2018 as part of the Better Care Fund. The expanded team includes a care coordinator, a mental health nurse and an administrator. The caseload continued to increase and the team managed approximately 50 patients in 17/18.

2 Waltham Forest HIU Service

The "High Intensity User" group meet virtually every two-weeks. The group consists of; HIU Care Coordinator, Mental Health Nurse, London Ambulance Service, ED Consultant, Admissions Avoidance Team (AAT), Consultant, Liaison Psychiatry (PLS) and Social Care.

The group proactively managed those cases by:

- Making individual Patient Support Plans (PSPs)
- Crisis planning for alternatives to ED
- Housing and Social Support
- Using behavioural contracts in some instances when there are violent and aggressive patients
- Make onward referrals where appropriate e.g. CGL
- Initial assessment, plan of care, regular visit support utilising other community services to managed care effectively
- Review of care plan

The HIU Coordinator accepted patients onto the caseload from various referral routes, including case finding in the ED and referrals from GPs and the London Ambulance Service. The services does not have an exclusion criteria and can support some of our most vulnerable residents. There are often
examples of the team arranging to meet patients in public places where there is no home address or the address is not suitable.

3 Benefits

Health Benefits
- More coordinated patient centred care (case management)
- Improved patient concordance with care plans
- Improved patient education regarding available services

Quality Benefits
- Reduced pressure on A&E
- Reduced pressures on other associated services including NHS111, LAS, UCC
- Integrated working across urgent care system

Financial benefits
- Reduced A&E attendances

The care coordinator is the first point of care for London Ambulance Service (LAS) and other services when patients on their caseload are in crises. The Service works with all stakeholders including social services and Change Grow Live (CGL) to ensure the best care is provided to people at home and in the community.

Case Example;

14.08 – Patient has been flagged by LAS as a frequent caller after calling 15 times in July. HIU team accepted referral, the patient is known to Community Teams

11.09 – Patient calls LAS for social reasons, 97 years old, unable to leave the bedroom on the 1st floor of property. HIU coordination with Social Worker and family to move patient downstairs within own home.

09.10 – Calls to LAS has reduced and the patient is now calling Rapid Response Team. GP will be visiting her to discuss DNACPR wishes and future support needs.

Case example 2;

19.06 – Reported patient recently becoming addicted to codeine. Patient was on the street for the past 3 days requesting for medication from neighbours. HIU coordinator give the family access to CGL Service. Assessed by social worker last week and am awaiting feedback from them, findings may suggest needs a placement.

03.07 – Patient has been placed in accommodation temporarily, unable to return to home due to social issues, classified as ‘homeless’.

17.07 – Patient would like to go back home and is deemed to have capacity. Patient to be discharged back home with a care package. There was a meeting held with social services and the plan is to get access to a day centre to support the patient.
4 Results

Summary of findings after intervention:

- Overall 10+ Attendances reduced by 56% (1888)
- Waltham Forest service has been acknowledged as a model of best practice in North East London with local CCGs
- Some of the most prolific users have significantly reduced attendance to ED after intervention
- Patients placed in more appropriate accommodation to suit their change in support needs

Table One: High Impact User Activity 2015-16 vs 2017-18 at Whipps Cross Hospital.

<table>
<thead>
<tr>
<th>Patients with &gt;10 A&amp;E attendances</th>
<th>Maximum</th>
<th>Average</th>
<th>Totals</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16 People</td>
<td></td>
<td></td>
<td>147</td>
<td>£457,969</td>
</tr>
<tr>
<td>Attendances</td>
<td>159</td>
<td>23</td>
<td>3383</td>
<td></td>
</tr>
<tr>
<td>2017/18 People</td>
<td></td>
<td></td>
<td>107</td>
<td>£257,621</td>
</tr>
<tr>
<td>Attendances</td>
<td>41</td>
<td>14</td>
<td>1495</td>
<td></td>
</tr>
<tr>
<td>Variance</td>
<td>People</td>
<td></td>
<td>-40</td>
<td>£200,348</td>
</tr>
<tr>
<td>Attendances</td>
<td>-118</td>
<td>-9</td>
<td>-1888</td>
<td></td>
</tr>
</tbody>
</table>

The HIU service have formed strong partnerships across and beyond the hospital. Collaborative working with such a wide range of groups across acute trusts, primary care, mental health, housing, social care, the voluntary sector support very vulnerable patients is an example of how systems can work together to do what is best for the patient.
