Managing Vulnerable Frequent Service Users
North Tyneside

April 2017

Introduction and context

Commissioned by the Academic Health Science Network North East and North Cumbria (AHSN) and Northern England Clinical Networks, the North of England Mental Health Development Unit (NEMHDU) has carried out a project looking to refine and spread the learning and best practice from a programme originally commissioned within the Tees Crisis Concordat amongst the remaining crisis concordat areas in the North East and Cumbria.

Part of this original programme focused on identifying and analysing vulnerable people who are frequent service users; this work became known locally as the Cohort 30 work stream as each organisation worked with their 30 most frequent users of services.

The project involved senior representatives from each of the participating organisations working together as those people identified as vulnerable frequent service users were categorised into five distinct groups and a range of actions and recommendations were put in place for each group.

Focused both on reducing demand on A&E, Ambulance, police and mental health crisis services as well as providing more proactive planned interventions for vulnerable people, the project made recommendations which included developing a proactive well-being and intervention service to reduce demand on emergency services, and better co-ordinating the responses from different services to manage people with complex needs.

The crisis concordat groups taking part in the process received support from NEMHDU to understand the patterns of behaviour of the frequent service users in their area and develop potential responses to better support those people and reduce demand on your services.

This report represents an overview of the process and findings from the North Tyneside Crisis Care Concordat Group.

Process

On 24 January 2017, the crisis care concordat leads were all sent a letter of invitation from the Strategic Clinical Networks to take part in the process, in which they were asked to identify a senior/appropriate individual from each of the following organisations/services (other relevant group members may also be added by the concordat groups, i.e Street Triage) to attend the Accelerated Learning Event:

- Police
- A&E
- NEAS
- Psychiatric Liaison
- Mental Health Trust Crisis Service.

Each organisation was asked to review their data from the most recent 12-month period available and identify:

- Name and Date of Birth of the 30 individuals (maximum) most frequently using their service
- What service/s that individual is using/accessing
- How often they are presenting and any patterns of service use
- Primary reason for contact
- Outcomes associated with contact

The identified senior person from each organisation would bring their data set to the Accelerated Learning Event, which took place over 2 days (17 March & 3 April 2017), where the group would:

a) cross reference the vulnerable frequent user lists across organisations
b) identify sub groups based on common characteristics
c) develop system improvement recommendations for each identified subgroup.

Based on past experience and information found in the crisis concordat action plan, we assumed that the concordat group would have existing information sharing protocols in place to support this process. The process was sent to all participating organisations alongside the latest information sharing policy guidance from the NHS.

Findings

On the morning of the first event several of the participating organisations had not fully completed their assurances around information governance and information sharing. Organisations had however brought anonymised lists of frequent users of services and it was decided to use these lists to facilitate discussions around sub-group characteristics. The following is a summary of those discussions.

Northumbria Specialist Emergency Care Hospital (NSECH)

NSECH identified 30 people responsible for 740 contacts and with an age range of 16-50 years. Gender split was 50/50 amongst this group and they identified the common presenting themes:

- Deliberate self-harm, predominantly female, clear pathway to liaison mental health services
- Anxiety or social issues
- Alcohol and alcohol misuse, predominantly male, often presenting in clusters e.g. several times within a few days and then no contact for a period of time. It was identified that this group of people often left before treatment.

- A range of medically unexplained symptoms including chest pain, abdominal pain and Gastro-Intestinal issues

Royal Victoria Infirmary (RVI)

The top 10 frequent flyers to ED between 01/03/2016 and 28/02/2016 made up 544 attendances. The majority of these (52%) were referred by the emergency services, followed by self-referrals (37%).
There are a significantly higher number of referrals from emergency services, in comparison to the weekly ED dashboard, only 25% of total ED attendances are referred from emergency services.
Referrals from the police are also noticeably higher at 6% compared to only 1% of referrals over the 12 week period on the ED dashboard.
Arrivals via ambulance are substantially higher in attendances for the top 10 frequent flyers with 54% of arrivals from an ambulance.
The highest proportion of frequent flyers are within the age band 31 – 45 (45%), followed by 16 to 30 (38%), then 16 – 30 (17%). The top ten frequent flyers are predominantly male, making up 79%.
There are three key themes shown throughout the diagnosis descriptions with 9 out of the top 10 attenders have several instances of mental health, alcohol or drug issues.

North East Ambulance Service (NEAS)

NEAS identified their 15 most frequent users of their services, 10 of whom have a mental health marker. They reported a 60/40 female to male split, with age ranges for their top 10 most frequent service users being:

Age	Number of service users
20 - 30	1
30 - 40	2
40 - 50	3
50+	4

It is worthy of note that NEAS only currently collate this data when an individual is conveyed from a home address, both the RVI and NSECH commented that they receive a high number of people conveyed from public places and that they record this data. NEAS also state that some high frequency users will not receive a paramedic response as an agreed care plan, however this would not be identified if an ambulance was called from a public place. It was agreed that sharing of this data between the organisations could provide a better more appropriate response.

Northumberland, Tyne & Wear NHS Trust (NTW) Liaison Services

Liaison services reported that 80% of those presenting to liaison services were previously known to either liaison or wider mental health services.

Northumbria Police

The police reported that they had a low number of people making frequent contact with services who had a mental health marker, they were all female, aged 18 - 53 years. They described one person making 149 contacts who was also known to mental health services. They reported 59 people who had been through street triage (93 contacts) and of those people, 12% went on to be detained under the Mental Health Act within 7 days.

North Tyneside Council

The Local Authority report 382 Mental Health Act assessments in the previous year, of which 59 had been through street triage.

North East Commissioning Support (NECS)

Colleagues at NECS had considered some data prior to the event and reported the following:

- 418 people identified with 7 or more attendances
- Of those, 132 had a mental health flag (31%)
- The top 2 attenders in North Tyneside attend NSECH and the RVI and were responsible for 49 or more attendances. One of these was identified as having a mental health issue, one of these was identified as having anxiety issues related to a medical condition.
- The top 16 people have attended 14 or more times
- The highest rate of attendance equalled the highest rate of admission
- 15 – 19 year olds represented the second biggest age group attending A&E
- Costs for those with 7 or more attendances plus 7 or more admissions was approximately £1.3 million.

During these discussions, three sub-groups and one issue was identified. The group then completed small group work on each of these, highlighting both additional information and ideas for service change/improvement, which are set out below.

During the time in between the events participants were asked to consider any areas of best practice they were aware of for the sub-groups identified and also encouraged to have conversations within their own organisations regarding possible improvements. At the

beginning of the second event participants were invited to add this information to the sub-groups identified and the following also includes a summary of those additions.

Sub-group 1

Sub-group 1 shared characteristics which were predominantly around self-harming behaviour. They tended to be younger and female and had very high attendances/contact with services. It was also identified that this group tended to have patterns or clusters of attendance.

Additional information:

- Risk assessment by non-health professional, responsibility stops
- Lack of engagement with services available
- Negative view of services available
- Wanting a solution – not onward referral
- Lack of data/sharing of information
- Lack of awareness from non-mental health referrers/contacts of available services
- Lack of community support
- No medical need
- Environmental issues/where they wait
- What's happening between clusters – how do we find this out?
- Aggressive/destructive/refuse treatment
- Attention-seeking behaviour

Ideas for service change/improvement:

- No definition of frequent flyer regionally + within services – need to agree what it is.
- Information sharing across all services: ?national ?regional
- Agreed response to flag – eg. Escalation of assessment with view to reduce transfers to ED; proactive rather than reactive response; ability for non-clinicians to access clinical prior to transfer - ?advanced paramedics, ?gatekeeping at ED
- Streaming at front door of ED by someone with mental health training (but only works for walk-ins)
- Need to have information on where they are when not in services (eg. Hospital admission, holiday, support in place + working etc)
- Move to self-care – menu of options for support
- Need info – why self-harming?
- Can 'on-call' resources across all services be better utilised if used together, eg. To support the above idea of having someone with MH training at front door.

Information identified at second event:

- Menu of services needed – what's available and how do you access (for all sub-groups)

- Alert codes – need to mean something on GP letters (for all sub-groups)
- Streaming to MH - ambulance and walk-in
- Regular attender files and plans held in ED – often after MDT (especially GP) discussion. Usually about sub-group 3 patients.

Sub-group 2

Sub-group 2 were identified as having very high use of A&E, predominantly coupled with a 'left before treatment' conclusion, alongside significant use of alcohol. There would seem to be patterns or clusters of attendance, with a background of possible police contact and social issues.

Additional information:

- Consistency/continuity of alcohol support services -– is provision of alcohol services variable across the locality– does the availability of an alcohol nurse impact on the pattern of presenting, ie. if there isn't one on duty so they can't get support they might come back.
- Age range = 15-20 years
- Phone support
- Risks associated with alcohol being only one part of presentation – labelling – underlying issues (medical/social) missed
- Trigger points – does anybody monitor them – look at attendances in clusters
- Not identified as mental health problem
- Do people use of ambulances as taxi or hospital as safe-haven – how are calls triaged re conveyance? Misuse of transport help patient get closer to home if, eg. missed bus or don't have taxi fare. Does this relate to police too?
- Have medical problem related to alcohol
- Lack of available data re patient at first contact, can't remove clinical risk (often present with high risk feature)
- Do people present in clusters due to other issues such as money/social
- Often don't engage with community services; no GP; chaotic. – Why – can we take services to the patient?

Ideas for service change/improvement:

- Evaluate alcohol team
- NEAS alcohol service/referral
- Booze bus/drunk tank
- Instead of concentrating on alcohol need to look at underlying problem
- Public Health Group
- MDT approach to managing patient – patient, social, housing, employment, health.
- Joint assessment between alcohol and liaison team
- MDT – sharing risk management/contingency planning

- Ability to provide delayed assessment, eg. when sober – or if have CBT not miss opportunity for intervention – requires cross service info sharing
- Can we develop a Need flag to recognise when people are becoming frequent
- Safeguarding issues/resource
- Follow up support for LBT if known to mental health services
- Should we have a GP letter to include brief summary of related attendances to flag concerns if LBT and not know to mental health
- Identify when peak times are to determine when a service is needed. Then provide a service accordingly.
- Don't bring people to A&E.

Information identified at second event:

- NEAS are getting a dedicated frequent calling team – new process – including a no send policy (for all sub-groups)
- NEAS fact file information: not aware of services accessed
- Working better with GP (in and out of hours service) (for all sub-groups)
- Police/NEAS already working to evaluate risk/need for ambulance
- Police/NEAS officer direct contact with clinician to assess risk – require ambulance and response (grade)
- PHE & NE drug and alcohol commissioning/strategic leads are about to start an audit/review of mental health within drug and alcohol treatment services.

Sub-group 3

The third sub-group were identified as those with very frequent attendances at A&E, with medically unexplained symptoms or multiple different low-grade presentations. These presentations may be seen as low-grade to emergency department staff, but psychiatry may view multiple presentations differently. However there was no obvious pathway to psychiatric liaison services, nor was there a pathway to social care.

Additional information:

- More MH referral needed in this group
- Is this group females mainly we have no data
- North Tyneside/Northumberland/Newcastle – mixed/complex pathways
- Over estimating symptoms
- Bouncing into services and between services
- Are MH issues being addressed?
- Continuity of care (lack of)
- What responsibility does the GP have?
- Suspect will also account for lots of outpatient appointments, investigations, GP referrals
- Police see as health issue
- Issue of delivery of health services – ED path of least resistance

- "Know what to say"
- How to risk stratify and who takes responsibility

Ideas for service change/improvement:

- Need community liaison
- GP education – consider MH as well as physical health – with support from MH colleagues to contain patients and end cycle of referral + ED presentation. There is a clinical network project looking at this.
- Co-ordinated service approach – one easy number to call
- Education 11+
- Wider links for GPs
- Specific MUPS clinics – eg, chronic pain – joint medical & psychological approach, eg. UHND & CDD liaison
- Frequent attenders clinics (community based) – ED refer to MH possibly liaison to manage patients proactively and work with ED, GP, CMHT etc to contain them – eg. Durham
- Need definition of frequent attender

Information identified at second event:

- Sunderland liaison team whole person care COPD pathway
  ↓ED attendances by 33%
  ↓Admissions by 43%
  Could we learn from this for this group?
- CDD local CQUIN 15/16
  25 patients
  Joint management plans ED & Liaison
  ↓no. of ED attendances by 386 (51%)
  ↓admissions by 170 (67%)
- CDD MUPS service – stepped care model
- CDD chronic pelvic pain clinic
  45% had complete symptom resolution
  25% still with CPP clinic
  All showed improvement, ↓attendances, admissions, investigations

Issue 1

During the first morning the group identified issues in terms of information sharing as highlighted earlier in this report. We agreed that as part of the group work we would explore this issue further, as detailed below.

Additional Information:

- Standardised data set

- Information sharing protocol
- MH risk flag on ED attendance – consistent, clarity
- Services not linked – different systems
- IG – consent/opt-out instead of opt-in? at GP?
- Generic alert
- Personalised system – shared database – medical history + social circumstances + any info flags on one system
- 'Overseeing organisation' to take responsibility
- 'Opt-out' patient authority
- NEAS data – only able to flag home addresses. If picked up elsewhere difficult to identify. Police can also use telephone numbers
- Capturing data for the whole of the patient journey
- Advice and guidance very quickly needed re IG & patient consent for info sharing and case management
- Ability to complete circle of patient journey – have to repeat whole assessment in ED each time.

Ideas for service change/improvement:

- Make sure 'flags' can be reported on attendances to ED and shared between organisations
- Agreement to share data/information opening
- IG guidance
- Patient demographic check at point of contact and nhsnet account across organisations
- Use info for all health and wellbeing for sharing across organisations. Who would it apply to?
- Identify 12 months of frequent attenders – flag on system – all meet monthly and report on monthly data – deeper dive – action plan – to produce a personalised patient plan and to agree which organisation will take an overarching responsibility for patients to co-ordinate their care. How can the patient input into this process?
- Ability to link the person to the incident (for police)

Information identified at second event:

- Durham and Darlington A&E information sharing protocol for frequent attenders
- Northumbria frequent attender MDT (See appendix 1)

Link to the Darlington Liaison project and evaluation report can be found at the link below alongside other examples of best practice.

http://www.necn.nhs.uk/networks/mental-health-dementia-and-neurological-conditions-network/mental-health-dementia-and-neurological-conditions-network-groups/liaison-mental-health/

Recommendations and Actions

The main aim of the second event was to produce a set of recommendations and associated actions which the crisis care concordat group and its member organisations could take forward. In order to achieve this within the timescale participants were asked to prioritise from a full list of ideas generated. This prioritisation process highlighted a number of ideas and the top 4 were worked on by the participants who translated the idea into a recommendation and actions, which are set out below.

Recommendation 1

Original idea (Issue 1): "Agreement to share data/information opening"

The recommendation of this group is that organisations agree to share relevant information to ensure appropriate care is delivered to each individual, based on existing processes and systems such as MAPPA. (See appendix 2 for definition)

Actions

1. To understand the membership and geographical area of the Information Governance network identified by participants from NUTH
2. To identify existing information sharing agreements, eg. crisis concordat action plan
3. To identify who in each organisation would be responsible for signing off the agreement and meet to resolve the issues.
4. To clarify timescales – CQUIN Q1 2017/18
5. To estimate costs to system of not agreeing information sharing process – BUILD A CASE.

Recommendation 2

Original idea (sub-group 3): "Frequent attenders clinics (community based) – Emergency Department refer to Mental Health, possibly liaison to manage patients proactively and work with ED, GP, Community Mental Health Teams etc to contain them – eg. Durham"

We recommend the establishment of a frequent attenders' service within the Mental Health Liaison Team using the principles of the models currently in place in Durham, Sunderland and Darlington, but with a community focus.

The anticipated outcomes were identified as providing proactive management plans; reducing impact and attendances on emergency care; right place – first time; menu of services for providers; and reduced cost.

Actions

1. Identify project group
2. Identify frequent attenders from the MDT group and set terms of reference and standard data set
3. Identify any additional members of project group (stakeholders)
4. Develop business case to agree service specification and funding, including CCG discussion, steps and approval

Recommendation 3

Original idea (sub-group 2): "Don't bring people to A&E".

We recommend the development of a whole system approach to ensure that frequent attenders access the right service first time to offer maximum support in community to avoid an ED attendance.

The anticipated outcomes were identified as receiving appropriate care within a community setting; a menu of services to direct appropriately from providers; reduced service pressure on ED; directory of services updated to reflect current available services; and reduced service pressure on NEAS.

Actions

1. Review and update directory of services within A&E with detail
2. Check directory of services mental health pathway
3. Develop menu of services
4. Review access/referral criteria into available services

Recommendation 4

Original idea (issue 1): "Identify 12 months of frequent attenders – flag on system – all meet monthly and report on monthly data – deeper dive – action plan – to produce a personalised patient plan and to agree which organisation will take an overarching responsibility for patients to co-ordinate their care. How can the patient input into this process?"

The recommendation of this group is the development of a robust MDT within each acute trust in order to better support frequent attenders to ED. This will be informed by cross collation of information from NECS/CCGs regarding those attending multiple sites.

Actions

1. Identify who would be in MDT – breadth of members
2. Identify which patients should be referred into MDT and how
3. Agree how to share information coming from MDT
4. Share remit of existing MDT at Northumbria with concordat

5. It was recommended that 2 MDTs are established, 1 in each acute trust, and they then get together periodically as a larger group to review those patients who are accessing both trusts. This would be informed by the data NECS can provide and from services who cover both patches such as NEAS, NTW and Police

Additional recommendations

There were three further ideas regarded as priorities that were not considered within the second event and the crisis concordat may wish to consider whether they work on these separately. They were as follows:

- Original idea (sub-group 1): "Can 'on-call' resources across all services be better utilised if used together, eg. To support the above idea of having someone with MH training at front door."

- Original idea (sub-group 2): "MDT approach to managing patient – patient, social, housing, employment, health."

- Original idea (sub-group 3): "GP education – consider MH as well as physical health – with support from MH colleagues to contain patients and end cycle of referral + ED presentation. There is a clinical network project looking at this."

Summary

Throughout the process participants demonstrated a shared willingness and desire to provide a more connected and proactive service for vulnerable frequent users of their services.

The participants were able to identify some processes and systems already in place for some vulnerable adults which enabled multi-agency collaboration and planning on the provision of care which could be used as a model to develop such systems for the groups identified in this process.

Overall it was recognised that such collaboration is essential in providing high quality, safe and effective health and social care.

Though we recognise it may be difficult to implement the recommendations made by the participants, we believe this would make a significant contribution to both the quality and safety of care received by the individual and also to a reduction in the inappropriate use of urgent and emergency care services.