Managing Vulnerable Frequent Service Users Project Overview and Analysis

April 2017

Introduction and Context

Commissioned by the Academic Health Science Network North East and North Cumbria (AHSN) and Northern England Clinical Networks (NECN), 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 Care Concordat amongst the remaining crisis care concordat areas in the North East and North 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.

Four crisis care concordat groups volunteered to take part in the process, Durham and Darlington, Northumberland, North Tyneside and Newcastle Gateshead, however due to time restrictions and apologies the Newcastle Gateshead event did not take place. The remaining three crisis care concordat groups 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 services.

This report represents an overview of the process and findings from the Crisis Care Concordat Groups who volunteered to be part of the project. Each of the participating crisis concordat groups received a more detailed report specific to their locality which included recommendations and associated actions.

Process

On 24 January 2017, the crisis care concordat leads were all sent a letter of invitation from the 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 could also be added by the concordat groups, i.e Street Triage, Social Care) 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 a senior person from each organisation to bring their data set to the Accelerated Learning Event, which took place over 2 days 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 plans, we assumed that the crisis care concordat groups 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.

Discussion with representatives of regional service user and carer networks was undertaken in the planning of this work in order to seek their input to the process and outcomes. During these discussions it was felt by all, including the representatives of the service user and carer networks, that due to the possible sharing of data that service user and carer representatives would not be present during the analysis of the data/information, however participation within the second part of the accelerated learning events was suggested via the crisis care concordat groups. A number of the crisis care concordat groups identified user involvement as a weakness as a direct result of this project and are taking steps to address this issue.

Learning from the Process

Overall the project was commissioned within a narrow time frame. The reasons for this were multiple and had an impact on the delivery of the project.

It was clear from discussions with the concordat groups that some felt unable to convene a group to consider the frequent service users within the timeframe. It was also clear that the meeting roster for many of the concordat groups varied significantly in that some met regularly whilst others did not, again this impacted on the concordat groups ability to engage with the project. In retrospect, a longer lead time with engagement with each of the

project groups may have improved engagement with the project. However for each of the concordat groups who did engage discussion took place at their regular meetings to highlight process and organisational engagement.

Following the first event it became clear that significant issues relating to information governance would have an impact on the project. Organisations had a range of responses to information sharing, some clear that they were able to do so, others unclear as to what information could be shared under what circumstances. This lack of clarity led to a reticence from some organisations to share patient identifiable information and taking a risk averse approach to the process, i.e. we are unclear therefore we will not. Unfortunately for some organisations this reticence only came to light on the day of the event itself, despite having had over a month to raise any issues prior. However, those organisations still demonstrated a willingness to participate and were able to discuss anonymised information regarding the characteristics of the frequent attenders to their service.

The clinicians in attendance highlighted that information sharing is an everyday part of their role, making referrals to specialist departments, letters to GP's, participation in conversations with colleagues, i.e. liaison psychiatry and integrated teams, and also that processes for multi-agency care planning and conversations were already in place for some who were classified as vulnerable adults, (Safeguarding or Multi-agency Risk Assessment Conference). However, this process has highlighted an anxiety at an organisational level regarding the sharing of information which will require further discussion and clarity. In particular, the introduction of the 2017-2019 CQUIN; Improving services for people with mental health needs who present to A&E will require significant development in terms of information sharing. We are aware of the work around information sharing across partner organisations and the development of information sharing protocols to support this, alongside new partnership working arrangements (i.e. High Impact Users of Services in Darlington) indeed the CQUIN clearly identifies the need for wide inclusion of partner organisations;

'Mental health and acute hospital providers, working together and, likely also with other partners (primary care, police, ambulance, substance misuse, social care, voluntary sector), to ensure that people presenting at A&E with primary or secondary mental health and/or underlying psychosocial needs have these needs met more effectively through an improved, integrated service offer, with the result that attendances at A&E are reduced'.

It is clear from the clinicians attending the events that this CQUIN is unlikely to be met if information sharing remains such a significant barrier and some level of regional support in addressing the issue may be helpful.

Learning from the Findings

Based on the findings from the three accelerated learning events, plus the original work that was done within the South Tees crisis concordat group, there are a number of issues which would seem to be shared across the concordat localities. Overall the number of women categorised as high frequency service users was almost double that of men, although the age range was very broad (17-93 years).

From two of the events there were 120 high frequency service users who were responsible for 5102 primary contacts with services (primary being the initial contact with services). Further analysis has also confirmed that the highest volume of service use correlates directly with those listed highest in the order of frequency, for example, the ten most frequent service users in one concordat area accounted for 80% of the overall contacts; and in one locality the Approved Mental Health Practitioner representative identified four individuals who were in receipt of 38 Mental Health Act assessments in a two-year period.

It was clear across the accelerated learning events that services were, with some notable exceptions, entirely reactive to high frequency service use. It was also clear that those attending the accelerated learning events felt that services were not providing a connected response and that overall future services should encompass the following:
- A more connected response
- A more proactive response

Which will
- Provide better outcomes for the individual
- Reduce demand on urgent and emergency care services

Within each of the accelerated learning events work was undertaken to identify sub-groups of frequent attenders who shared common characteristics. Across the concordat areas there were two clear shared sub-groups.

The first was a group of predominantly younger females, with multiple presentations at A&E, with a range of reasons for presentation (self-harm, medically unexplained symptoms), also associated with some level of alcohol misuse. This group were occasionally seen by psychiatric liaison services though most were not referred into such a service and were not connected with any other form of mental health service. The clinicians present felt that this group may be appropriate for a stepped-care personality disorder service, however a clear rationale and process for referral to liaison was also felt to be appropriate for this group.

The second group identified were predominantly male, older in their age range and presented with a complex dual diagnosis presentation. Although alcohol was a very common substance for this group, two of the concordat areas highlighted significant use of illicit substances. Of particular note to A&E, it was felt that this group often left before

treatment and that although multiple services were often involved there was a lack of connectivity around the planning of treatment and care and a significant lack of specialist alcohol and substance support for both hospital and community services.

Learning from the Recommendations

The recommendations from each of the learning events also shared some common themes, the first of which focused on developing multi-agency processes which would enable individual organisations to identify when a person was becoming a frequent user and initiate a multi-agency case planning meeting. A full list of the recommendations can be seen in Appendix 1.

There was also a clear recommendation to develop a business case for the commissioning of alcohol and substance misuse services, which would support both hospital-based and community services. This issue was relevant to both of the shared groups identified and there is anecdotal evidence to suggest that the diminishing resources for substance misuse work appear to be having a major impact on urgent and emergency care services. Public Health England are about to publish a review of their 2014 paper '*Alcohol Care in England's Hospitals: an opportunity not to be wasted*', which could present a significant opportunity for some joint work across the region.

At least two of the concordat groups discussed the development of a business case for a stepped-care personality disorder service, however there was also recognition that this kind of service may be more effectively delivered across a wider STP or provider footprint.

Also within the recommendations it was clear from those attending the accelerated learning events that there is a need for regional and sub-regional discussions regarding information sharing and the use of data to inform service commissioning and delivery. It was felt that a range of organisations could support this process, including clinical networks, AHSN and commissioning support organisations, alongside the information governance network.

In two of the concordat areas, NEAS identified a group of very high frequency users which often resulted in conveyance and a short attendance at A&E; in response to this NEAS are establishing a 'frequent user team' which may also provide an opportunity to consider proactive and connected responses for this group. A further issue identified was that NEAS data on frequent users only constitutes those contacts initiated from the patient's home, and that some of those frequent callers already have plans in place, for example to use a non-paramedic form of transport. However, should the same patient call from a public area this information is not recorded as part of the data set and also result in a standard response from NEAS. However, A&E record all patients brought in by ambulance and in theory could provide NEAS with useful additional data regarding those frequently conveyed

to hospital from any location, however the organisations do not currently share any of this information, which could have a positive impact on high frequency users and planned responses.

Summary and Recommendations

It is clear from the discussion across the events that there are a small number of people using crisis services very frequently.

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 and we believe this would make a significant contribution to both the quality and safety of care received by the individual as well as a reduction in the inappropriate use of urgent and emergency care services.

There is an identified desire from clinicians to provide a more connected response. The issue of multi organisation/disciplinary meetings to discuss vulnerable people was raised in each accelerated learning event. Systems such as MAPPA, alongside good practice such as the Northumbria Special and Emergency Care Hospital Cause for Concern Frequent Attenders meeting and the Durham & Darlington Liaison Service were used to highlight that such discussions already take place.

All the accelerated learning events raised the idea of an 'organisational flag' (i.e. a set number of attendances over a set time period) which would trigger such a meeting being agreed and establishing, or using existing, systems to allow that planned approach to providing care and intervention.

Clearly for this to happen would require organisational agreement, in particular around information governance, however the existence of similar processes and systems should provide a basis on which this could happen. Clearly there are vulnerable groups of people who share similar characteristics identified through this process who would benefit from such an approach.

There were also some gaps identified in this process, for example, participants agreed that a similar piece of work looking specifically at young people who frequently attend services would be helpful, as well as considering frequent attenders in primary care.

Recommendation 1

Hold a regional event to share and spread good practice would be of benefit across the concordat groups and their member organisations.

<u>Recommendation 2</u>

> Conduct similar projects to identify characteristics and recommendations for two further groups:
> 1) young people attending urgent and emergency care services
> 2) frequent attenders at primary care

<u>Recommendation 3</u>

> Develop an organisational 'toolkit' based on the frequent attender good practice in the region to support the spread of good practice.

Appendix 1: Recommendations & Actions from Accelerated Learning Events

Durham and Darlington Crisis Care Concordat

Sub-group 1

Sub-group 1 represented a group of predominantly younger females who presented very frequently to urgent and emergency care services. These presentations usually featured increased alcohol use, increased self-harm and or transient/significant trauma. Presentation at service was often characterised by increased police involvement. Participants described this group as possibly fitting some of the diagnostic criteria for sub-groups of personality disorder.

Recommendation 1

Extending/replicating the current integrated transition service model for LD for young people with mental health vulnerabilities.

Recommendation 2

Develop a business case for a personality disorder service for this group of presentations to minimise impact on urgent and emergency care and future presentations and individuals' mental health.

Recommendation 3

Develop a multi-disciplinary/multi-agency process (with agreed flags) to provide a co-ordinated response, ie MAPPA, MAREC model.

Recommendation 4

Repeat the process used for this project for young people with multiple presentations at urgent and emergency care services.

Sub-group 2

Sub-group 2 was described as predominantly male, aged between 30 and 50 years. Presentation was a combination of long-term mental health problems (extensively psychosis) coupled with entrenched substance misuse (in particular the use of amphetamines in Darlington). This sub-group was also often known to the criminal justice system and may present with increased levels of aggression.

Recommendation 1

> Explore a business case considering the development of a team utilising the principles of assertive outreach and the RADT model to proactively engage with this group.

Recommendation 2

> Explore the provision of a dual diagnosis practitioner that works into both in-patient and community settings to provide a proactive dual diagnostic response.

Recommendation 3

> Explore best practice from across the country for treatments and interventions for this group.

Recommendation 4

> Engage in more detailed analysis of this group and develop cost analysis across the pathway.

North Tyneside Crisis Care Concordat

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)

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.

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.

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.

Northumberland Crisis Care Concordat

Sub-group 1

Sub-group 1 described a group which were predominantly female, with ages ranging from late 30's – 60. This group was also characterised by high levels of contact with police and Initial Response Team (IRT) coupled with self-harming behaviour. Frequent contact with liaison services was also noted, however this group consistently failed to engage with mainstream services.

Recommendations

> - Visit each other's organisations to understand what we provide
> - Get high level agreement on sharing data about clients frequently using services
> - Pilot MDT approach to frequent service users
> - Look at triggers to set the planning process in place

Sub-group 2

Sub-group 2 again were predominantly female, with ages from late teens to early 20's. Presentations included self-harm and a high level of medically unexplained symptoms, ie. presentations to A&E which were not self-harm and individually would not seem significant, however the number of contacts across a range of presenting problems and symptoms, coupled with self-harm, are suggested of higher level need. This group, who are regarded as vulnerable, may also be open to mental health services, children & young people's or adult mental health services, and may well have been referred to the personality disorder hub.

Actions

- Understand each service's 'patient flows'
  - Arrange visits to critical hubs
  - Sub-group of crisis care concordat (data sharing)
  - Sub-group of crisis care concordat (problem solving)
- Widen the membership of the crisis care concordat
- Involve public health, safer communities + care + voluntary sector
- Feed this into wider system transformation work
- Transport – look at widening of transport options

Sub-group 3

This sub-group was mainly male and represented a very high use of ambulance service, with a mixed presentation of self-harm/alcohol/substance misuse issues. Often known to police this group also had very high attendance at A&E, although frequently left before treatment, alongside frequent assessment by psychiatric liaison services but with no onward engagement.

Recommendations

- Information Governance – each organisation take forward
- MDT regular monthly approach – ensure all organisations involved
  - Inform on service updates – are they being signposted correctly?
  - Involve patient in meetings/decision making = patient centred – patient sign-up
  - What does the person need
- Cost contacts

Sub-group 4

This sub-group was identified with very little gender differentiation and were characterised by frequent use of NEAS, but usually assistance only, and were not widely known to other services.

During discussion on the day it became clear that NEAS were working on this issue and had very recently established a frequent user group to consider the issues. This group highlighted the need for connectivity between the NEAS-led work and the other organisations represented within the crisis concordat.

It was therefore agreed not to discuss this group further.

Sub-group 5

Sub-group 5 represented a group with complex presentation, generally male, 30's – 50's, characterised by long-term significant mental health issues. This correlated either with current or previous use of the Mental Health Act and was characterised by multiple presentations to A&E, psychiatric liaison and mental health crisis services. It was not uncommon for this group to have multiple services involved directly in care provision.

Recommendations/Actions

- Share information across services – IG teams
- Red light re-referrals (past involvement of severe mental illness allowing short cut of referral process)
- Deep-dive – sub-group of Crisis Care Concordat to analyse this group – CCG to lead
- Develop tool to identify this group before discharge from services – NTW