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Expansion of dedicated high intensity user services in East Warrington to provide more proactive care

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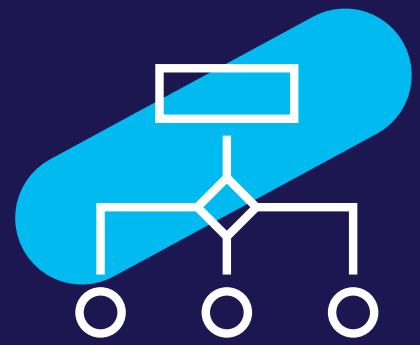
HIU summary of project scope

- Used the NHS England definition of patients reliant on unplanned care: analysed patients who had attended A&E 5 or more times in the last 12 months
- Identified all patients in the PCN who had any/all of 5+ read codes for A&E attendances between August 2020 and July 2021
  to define HIU cohort
- Compared this HIU cohort with all patients attending for care within the PCN
- Initial analysis focussed on demographic details and comorbidities of these patients



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- People who frequently attend A&E make up **less than one per cent of England's population** but account for more than 16 per cent of ambulance journeys, and 26 per cent of hospital admissions
- High intensity use of A&E costs the NHS at least £2.5bn per year

- High intensity use of A&E **closely associated with deprivation and inequalities**
- The most common age groups to attend A&E frequently are those **aged 20 to 29** and those aged **over 70**

- People who frequently attend A&E typically have **a range of physical and mental health conditions;** they are significantly more likely to be admitted to hospital than the average A&E user

- The key to addressing high intensity use of A&E is **identifying and addressing the practical, social and emotional issues** that can exacerbate people's physical and mental health conditions, and ensuring that people have timely and appropriate access to support in the community

- **High Intensity Use services already exist in many areas**.
- They make a significant difference – reducing attendance at A&E by up to 84 per cent in just three months

- People who attend A&E frequently **often make use of other health services frequently** too – for example frequent use of GP services can be an 'early warning sign' of high intensity use
- **Gaps in support in the community,** and restrictive eligibility criteria can lead to people starting to attend A&E frequently.

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Background and context

The recent AC CLEAR project (six sites) identified that HIU had x2.5~+ more GP appointments, 37 times+ more ED attendances and x33+ times more emergency admissions compared to other registered users

1. Analysis of data from August 2020 to July 2021 showed that 0.1%-0.4% of PCN registered patients were defined as HIUs, accounting for 65-289 of registered patients

2. GP appointments for the HIU cohort across the PCN ranged from 896 - 5350, equating to 0.8% - 1.4% of total GP appointments

3. HIUs accounted for up to 15.4% ED attendances and up to 20% of emergency admissions for all registered patients

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Summary of findings from HIU analysis

The analysis identified key metrics on the HIU cohort and the need for an HIU focused model of care to reduce the adverse impact on clinical capacity and other patient groups

Service encounter	Regis	East Lindsay	East Warrington	Hyde	Camden
No HIU cohort	289	82	144	228	147
Annual GP appointments	5350 (1.3%)	1170 (0.5%)	1410 (1.4%)	896 (0.8%)	1388 (1.3%)
Median GP appointments per HIU patient	17	33	7	34	8
Annual A&E attendances	1969 (12.6%)	570 (11%)	1001 (14%)	1577(15%)	1080 (15.4%)
Annual emergency admissions	433 (16.3%)	285 (5.2%)	130 (20.2%)	69 (8%)	18 (10.5%)
Median number of distinct medications per HIU patient	28	6	29	25	19
Total cost of HIU care	**£1.2m**	**£416,130**	**£520,390**	**£692,244**	**£495,132**

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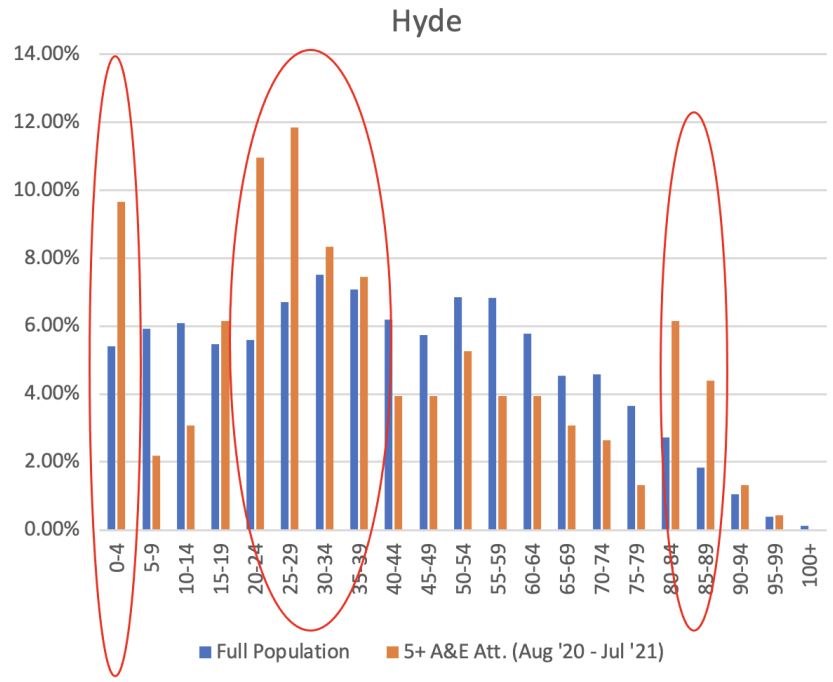
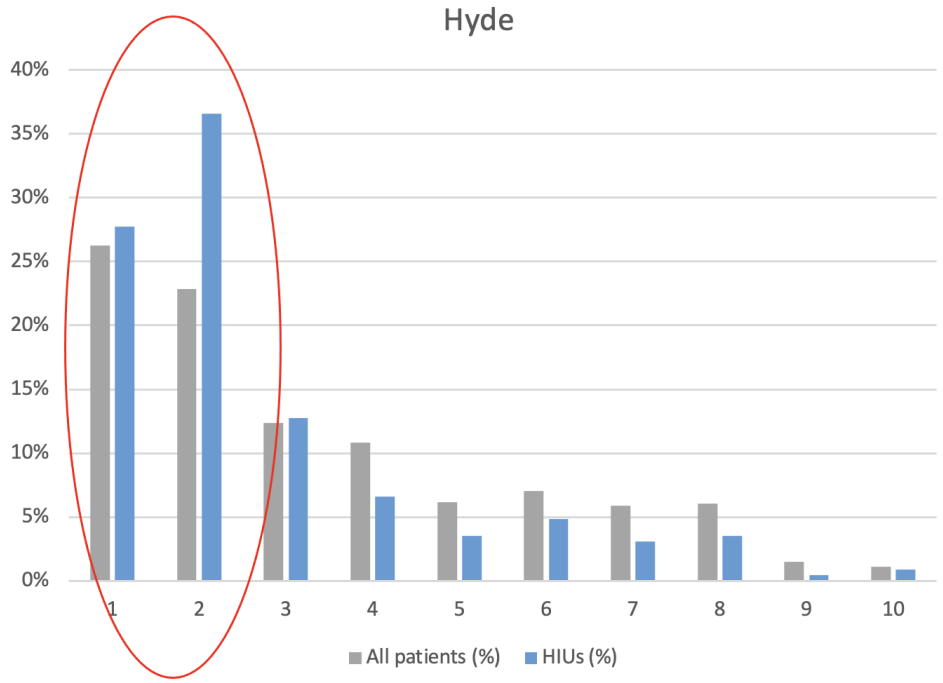
What do we know about the HIU cohort?

Age distribution



Indices of Multiple Deprivation



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There are three key areas for action

1

Putting in place appropriate non-clinical, specialist support

Ensure that High Intensity Use services are available in all areas, and that all health professionals are equipped to support people who are at risk of doing so.

** for integrated Care Systems to develop strategies for addressing high intensity use across their areas, ensuring that there is adequate provision to meet need in acute settings and across the health and care system, with a particular focus on areas of deprivation.*

2

Improving access to community – based support

Enabling more people to have their needs met in the community will help to ensure that they do not reach a point at which they have nowhere else to turn but A&E.

** investment in provision linked to social prescribing and other key services, such as community mental health as well as increased training and support for GPs and other health professionals to identify and respond to those at risk of high intensity use.*

3

Addressing health inequalities

Taking action on the wider determinants of health and recognising that high intensity use of A&E is a symptom of a wider set of disadvantages that require solutions far beyond the health and care system, will help people who are at risk of frequently attending A&E before their situation reaches crisis point.

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Recommendation for 'model' HIU Service

3. Functional Support
Proactive enablement through dedicated therapy support

2. Clinical management
Proactive management of long-term health conditions and regular structured medication reviews

1.Care coordination
Dedicated care-coordinators to provide case management and continuity

4. Health/wellbeing psychological support
Health coaching and psychological support to help individuals to stay as healthy as possible in body and mind

5. Practical support
Personalised advice and support with benefits, budgeting and housing

6. Service Management
Data and administrative support to ensure the right people are benefiting from the service, and to monitor outcomes

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The HYDE matrix

Sites collaborated to develop a new model of care – captured in the 'HYDE Matrix' – which sets out the workforce requirement and activity mix needed to care well for the HIU segment, while reducing the cohort's demand on GP time, A&E admissions etc

Cohort	Number	Activity	Time/Frequency Required	Requirements	Driver	Measure	Impact	To whom
HIU Patients	228	Care coordination	60 minutes, bi-weekly for 12 weeks, then 30 minutes every 4 weeks	Dedicated care-coordinators, no clinical qualifications required. Good organisational skills, signposting and communication	Reducing unplanned activity, IIF	Unplanned activity monitoring, IIF	Improve case management, improve patient/carer experience, reduce unplanned activity	Patient, System
HIU Patients	228	Clinical management of LTC's	30 minutes, 3 x per year	Registered HCP with LTC knowledge and qualifications E.g. ANP/RN. Able to recognise and refer as indicated	QoF, IIF	Qof, IIF monitoring	Reduce complications, improve outcomes	Patient, System
HIU Patients	228	Structured Medication Review	30 minutes twice yearly	Registered HCP with expertise in medicines management and a prescribing qualification e.g. Clinical Pharmacist	QoF, IIF			
HIU Patients	228	Functional support - mobility, falls prevention, symptom management	30 minutes twice yearly	Registered HCP with expertise in mobility and functional support E.g. Physiotherapist, OT	Reducing unplanned activity, II			
HIU Patients	228	Health coaching	Course of sessions according to needs E.g. 60 minutes, bi-weekly for 12 weeks	No clinical qualifications required. Health promotion expertise and health coaching skills	IIF			
HIU Patients	228	Psychological support	Course of sessions/brief interventions	Registered psychological therapist	Reducing unplanned activity			
HIU Patients	228	Practical support and advice in relation to benefits, budgeting, housing etc	30 minutes annually + according to needs	No clinical qualifications required, knowledge and expertise in benefits and housing systems	Reducing unplanned activity			
HIU Patients	228	Administrative & Data support	30 minutes per patient per month	Administrative and organisational skills, Data interrogation skills, understanding of wider NHS systems, clinical and monitoring systems	All			

The HYDE matrix is a user-friendly articulation of a model of care that allows for cost effective and patient centric care of the HIU segment.

The CWIC tool (Cohort Workforce Impact Calculator) combines these workforce requirements with key metrics and patient care needs to drive workforce demand.

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East Warrington PCN – CLEAR High Intensity User

Planned, holistic care to improve the health and quality of life of HIUs

3 GP practices serving approx. 31,000

Data for 104,037 GP appointments over a 12-month period analysed

Data for all HIUs (5+ ED attendances in 12 months) compared with all patients needing PCN care

Annual saving of £122,466 from reduced GP appointments, ED attendances and hospital admissions

Challenge

The PCN had a higher than average percentage of high intensity users (HIUs) who were taking up a disproportionate amount of GP and hospital time. The 144 patients (0.6%) accounted for 14% of all the PCN's ED attendances and 20.2% of hospital admissions.

They had much higher levels of comorbidities and many more medications (29 on average). The cohort had seven GP appointments a year on average compared to three for the general patient population.

Recommendation

- **A new MDT model of care to proactively care for HIUs with long-term health conditions with a central hub with easy access to clinical staff with referrals from the PCN and acute trust. Working with current HIU service in Warrington**
- A primary care HIU lead appointed, MDT meetings increased and dedicated out of hours team.
- The new model to have a dedicated team including advanced practitioners, care coordinators and health and social wellbeing coaches who together provide a broad range of services including regular medication reviews, psychological therapy and support with benefits, budgeting, exercise and housing.

New model of care - dedicated MDT team

Role	Hours p/a	WTE	Cost
Advanced practitioner	864	0.5	£25,831
Clinical pharmacist	144	0.08	£3,893
Care coordinator	792	0.46	£11,532
Health/wellbeing coach	864	0.5	£15,024
MH practitioner	72	0.4	£1,646
Social prescriber	72	0.4	£1,194
Admin assistant	864	0.5	£14,322
TOTAL	**3,672**	**2.13**	**£73,442**

Impact – better quality of care at reduced cost

Holistic, proactive and co-ordinated care for HIUs will help to address health inequalities, improve access to community-based support and enhance the wellbeing of this vulnerable group of patients.

The new measures would lead to a significant reduction in GP appointments, ED attendances and hospital admissions which cost £520,390 between August 2020 to July 2021. If there was a 25% reduction in GP appointments and a 40% reduction in unplanned secondary care, there would be estimated annual saving of £122,466.

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High Intensity User Lead

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Introduction

- The HIU Programme supports people who frequently attend A&E and aims to reduce admissions to emergency departments and the burden on emergency services and other NHS resources.
- HIU clients regularly call an ambulance or attend A&E when they feel they have nowhere else to go. These are often vulnerable people, who may be experiencing a combination of physical health conditions, substance misuse, depression, anxiety, abuse, financial problems, or homelessness.
- Very often, A&E is not the most appropriate and sustainable care option for these clients.
- The HIU Programme aims to connect with frequent users of NHS resources and adopts a supportive, non-medical and a social coaching approach to patient care instead.
- The Programme strives to connect patients with community based services and organisations to better suit their needs.

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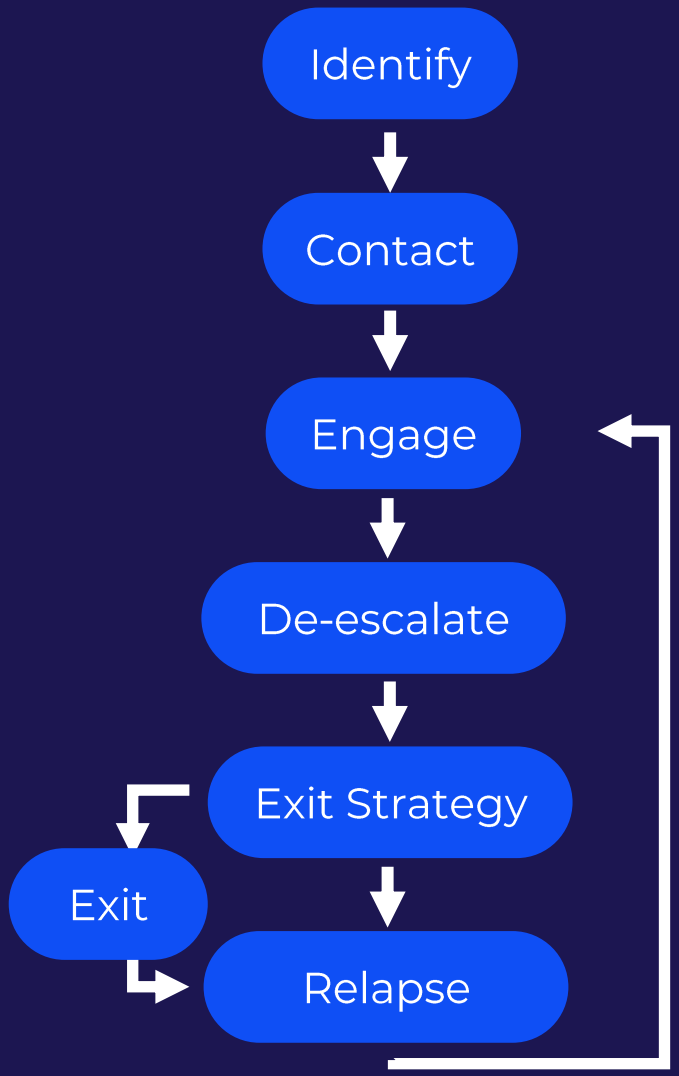
How it Works



List of most regular attendees at A&E identified by analysis of A&E data systems. Additional high risk clients may be selected (minimum 5 attendances per quarter).

Clients are contacted by phone followed up by home visit to build a genuine human connection. Focus on the clients perception of the issues and de-medicalise their needs to uncover the 'real' issues.

Supported referrals + signposting plus creative + motivational coaching work completed with the client to engage client with community services, community projects, friends and/or family.

De-escalation service offered by the project: phone contact with HIU leads to provide immediate access to listening support related to social, emotional, financial or family issues.

Once client has engaged with suitable support services / community contacts and feels a fresh sense of purpose and connection, the service will be tactfully withdrawn at an appropriate pace.

Clients may return to old behaviours and relapse into regular attendance. Clients are encouraged to re-contact with HIU leads at this point or they will be picked up again through the A&E data.

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Relationships we have developed in Warrington

- Pathways to Recovery
- Welfare Rights
- CAB
- Silverline, Samaritans, Give Us A Shout, Crisis Line
- Housing
- Local community based groups
- Warrington Council
- Debt management
- MIND
- Counselling Services
- Foodbank
- Police, NWAS, District Nurses, Parole Officers etc.
- Warrington Wellbeing
- RASAC, Women's Centre, refuges etc.
- Adult Safeguarding Team
- Sensory Assessment Team
- Mental Health Assessment Team & Outreach Team, CORE 24
- WVA
- Library, Care UK
- DWP
- Job Centre Plus
- GP's & Practice Managers

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Finally

- Thank you for giving us the opportunity to attend & present to you all today.

- Please feel free to ask us any questions that you may have.

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Questions?

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Next session today

International: a conversation on the healthcare challenges on either side of the pond

23/03/23

15:00-16:00pm

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