CLEAR
Empowering staff to innovate care

CLEAR High Intensity User 2022

East Warrington Primary Care Network

Providing holistic, proactive, long term care for high intensity users of primary care

AT A GLANCE

CLEAR CHALLENGE

High intensity users taking up a disproportionate amount of GP and hospital time - 20% of PCN's unplanned hospital admissions and 14% of ED attendances

KEY CHANGES

A new multi-disciplinary model of proactive, coordinated, holistic care and support with primary and secondary care professionals collaborating and a dedicated out-of-hours team

FORECAST BENEFITS

Improved access to community-based support, better patient wellbeing and projected annual productivity savings of £122,466

THE CHALLENGE

East Warrington PCN had a higher than average percentage of high intensity users (HIUs) - patients who had attended the emergency department (ED) five or more times in 12 months.

The 144 patients, representing 0.4% of those registered with the PCN, accounted for 14% of ED attendances and 20% of unplanned hospital admissions. They had much higher levels of comorbidities than other patient groups and seven GP appointments on average compared with three for other patients. They were taking 29 distinct medications compared with seven for the general patient population.

WHAT WE DID

The CLEAR national team met the Integrated Care System HIU lead who takes an MDT approach for all ED referrals involving partner agencies. They interviewed key staff across the Cheshire and Merseyside Integrated Care System. Patients with more than five ED attendances between August 2020 - July 2021 were identified from PCN data and compared with all 20,000 patients needing care in the same period.

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CLEAR RECOMMENDATIONS

It was recognised that East Warrington PCN had already made good progress with integrated working with key strategic partners and a good MDT model for HIUs already existed in secondary care but there needed to be closer working between the service and the network.

The project team recommended that a primary care HIU lead should be appointed to support patients and a central hub created with easy access to clinical staff, with referrals from both the PCN and the acute trust. MDT meetings should be increased to weekly rather than monthly, an out-of-hours team for HIUs considered and access to health and social care teams improved.

The new model of care would have a dedicated team including advanced practitioners, care coordinators and health and social wellbeing coaches. Working with the secondary care team, they would proactively care for patients providing a range of services including regular medication reviews, psychological therapy and support with benefits, exercise and housing.

Creation of a new central hub with holistic integrated care and support would lead to a significant reduction in GP appointments, reduce the number of crisis points and improve wellbeing with projected annual productivity savings of £122,466

FORECAST IMPACT

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

The new measures would lead to significant reduction in GP appointments, ED attendances and hospital admissions for HIUs which cost £520,390 between August 2020 to July 2021.

The new model of care would involve estimated annual workforce costs of £73,442. There would be forecast annual productivity savings of £122,466 from a 25% reduction in GP appointments and a 40% reduction in ED attendances and emergency hospital admissions.