REPORT

Item No:

SUBJECT:	High Resource Users
TO:	**Performance, Finance & Audit Committee**
Lead Officer for Report:	Director of Nursing, Health & Social Care Partnership
Author(s) of Report	Associate Nurse Director (Primary Care)
DATE:	5.8.19

1. PURPOSE OF REPORT

This paper is coming to the Performance, Finance & Audit Committee (PF&A) to provide an overview of the High Resource Users Project.

For approval	☐	For endorsement	☐	To note	☒

2. ROUTE TO THE BOARD

This paper has been:

Prepared	☒	Reviewed	☐	Endorsed	☐

By: Associate Director of Nursing and project leads. Updates on the project have been provided to the Strategic Leadership Team and the Primary Care Population Health Group.

3. RECOMMENDATIONS

3.1 The PFA is asked to note the findings of the High Resource Users project which was funded from IJB reserves as a work stream linked to unscheduled care.

3.2 The IJB is asked to note the development of an implementation plan to take forward the learning from the project.

4. VARIATIONS TO DIRECTIONS?

Yes	☐	No	☐	N/A	☒

5. BACKGROUND/SUMMARY OF KEY ISSUES

5.1 An analysis of high frequency Emergency Department (ED) attendees in Lanarkshire highlighted that over 40 % were also high attendees in the previous year (2014/2015 and 2015/2016). High rate ED attendees can be characterised as people who attend a health care facility between three and 12 times per year. It is also recognised that people in this category have greater rates of admission and a greater burden of chronic disease and that this group of people are often high intensity users of other health and social care services. (College of Emergency Medicine Best Practice Guidelines, 2014).

5.2 Frequent attendees are a small subpopulation of ED users who present to the department at a disproportionately high frequency. These patients often have complex medical and psychosocial needs, and utilise emergency services either for non-emergent care or upon reaching a crisis. It is also now recognised that these patients may fall into two distinct groups, those with a higher burden of alcohol and substance misuse and/or psychiatric illness and those with chronic disease. Whilst those within the first group have higher ED attendance, they tend to have lower acute admission rates compared to those with chronic long term conditions. Repeat analysis of ED attendance data confirms this.

5.3 Whilst EDs are able to manage these presentations acutely, the department is only able to provide episodic care on each independent visit and doesn't address the underlying cause. This same guideline also recommends that people who have been identified as high frequent attendees should have a multidisciplinary meeting and case management approach undertaken; including primary care, social care and ambulance service with a bespoke management plan developed to meet the person's needs.

5.4 Case management is recognised as the optimal method of managing these patients. It is a holistic model that provides continuity of care extending from hospital to the community, which ultimately aims to improve their overall social wellbeing and in turn, reduce the number of ED attendances/ admissions. This cohort of people have fluctuating chronic conditions often linked with anxiety/ psychological distress extending out with normal working hours therefore it is important that a review of all aspects of the persons service use, contributing factors and anticipatory care options are explored

5.5 Over the past six months H&SC North Lanarkshire has supported a project which offers an intensive proactive care management approach to people who experience high ED attendance. The benefits of this approach allows detailed analysis of each individual crisis which leads to individualised care plans being developed using a co-production approach, building on peoples assets whilst utilising wider community infrastructure.

5.6 Twenty-six individuals were identified as intensive users and a lead nurse and senior health improvement officer invited these people to participate in a person centred holistic review of intervention and support with appropriate multi-disciplinary discussion, further assessment and care management.

The findings were as follows;

- The cohort was made up of people deemed as 'Very Frequent Attenders' to ED.
- Initially 69% individuals of the cohort engaged with the project. This reduced to 58% (15 individuals when 2 individuals chose to opt out (& continued to present at ED) and 1 individual passed away.
- Of the 58% actively engaging with HRU Project, ALL are now engaged with other services.
- From Nov 2018 – March 2019 HRU Project completed 41 referrals to various agencies.

- From 1st Nov 2018 – 30th April 2019 there was a decrease of 42 (23%) ED presentations at UHW
- Data identified that 48% of attendances (from this cohort of people) at ED could have been re-directed.

Individuals report that they have found their person-centred intervention beneficial:

"I feel that you are the only people who have listened to me."

"Knowing the support is there has helped me to stop using alcohol and drugs. I don't feel I need to go to hospital."

"I feel more able to cope. I don't feel alone anymore."

5.7 Key Themes emerging from the project were;

- Communication
- Lack of coordination of care
- Individuals needs do not correspond to existing services
- Transition support is critical to sustaining improved health and well-being outcomes

6. CONCLUSIONS

6.1 The HRU project has identified that a number of individuals who attended ED between 3 & 12 times a year benefit from a more individualised form of case management as they can have complex psychosocial conditions alongside chronic illness.

6.2 All the individuals in the cohort were also on the caseload of a variety of other health & social care services. The project has demonstrated that better case management will result in decreased attendances at ED and better outcomes for individuals.

6.3 The project is due to be completed in September 2019 and in advance of the end date, an implementation plan will be developed to take forward the learning from the project. Likely actions will be around building in 'trigger points' where patterns of behaviour are highlighted at an early stage which in turn will trigger the process for multi-disciplinary case management that is more tailored to the specific needs of the individual.

7. IMPLICATIONS

7.1 NATIONAL OUTCOMES

This project links to all 9 national outcomes.

7.2 ASSOCIATED MEASURE(S)

None

7.3 FINANCIAL

The project was completed within the agreed finding limit provided from reserves. No additional funding is being sought for the implementation plan.

Yes	☐	No	☐	N/A	☒

7.4 PEOPLE

7.5 INEQUALITIES

EQIA Completed:

Yes	☐	No	☐	N/A	☒

8. BACKGROUND PAPERS

None

9. APPENDICES

See attached graphic illustration of aims & objectives of projects.

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CHIEF OFFICER (or Depute)

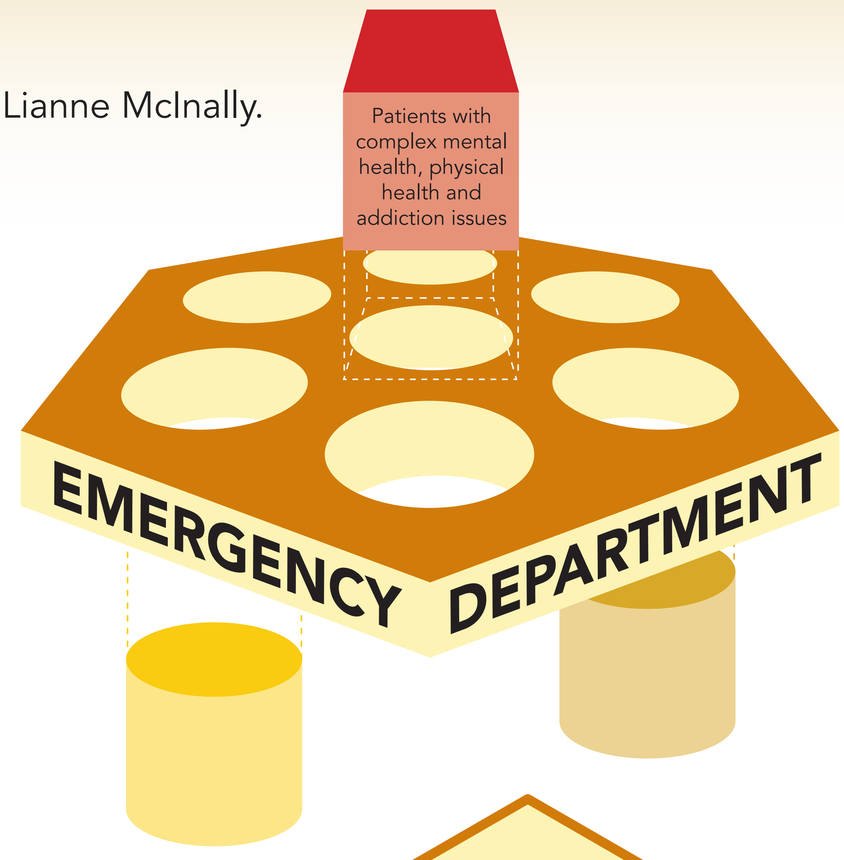
Members seeking further information about any aspect of this report, please contact Trudi Marshall on telephone number 01698 - 858118

Improving Health and Wellbeing outcomes among high users of emergency departments

NHS Lanarkshire

Transformational Change

Claire Henry, Kelly McLean, Trudi Marshall, Jill Lockhart, Margot McLean, Elspeth Russell and Lianne McInally.



Problem

Evidence highlights a small population of individuals frequently utilise Emergency Departments (ED) to access care. These people often have complex mental health, physical health and addiction issues.

Whilst EDs and community based services respond to these presentations acutely, they often only provide episodic care and cannot address the underlying cause. It is recommended that people identified as intensive users of acute and community services have a person centred holistic review of intervention and support with appropriate multi-disciplinary discussion, further assessment and case management.

Aim

The purpose of the High Resource User project is to improve the health and wellbeing outcomes among high users of emergency department, with the improvement aim:

To reduce the ED attendances of the selected cohort at UHW ED by 10% by the end of March 2019.

Methodology

Baseline Data collated for 3 NHS Lanarkshire ED sites

1100 people identified as High Resource Users (June - Aug 2018)

University Hospital Wishaw identified as test site

26 individuals identified as intensive users

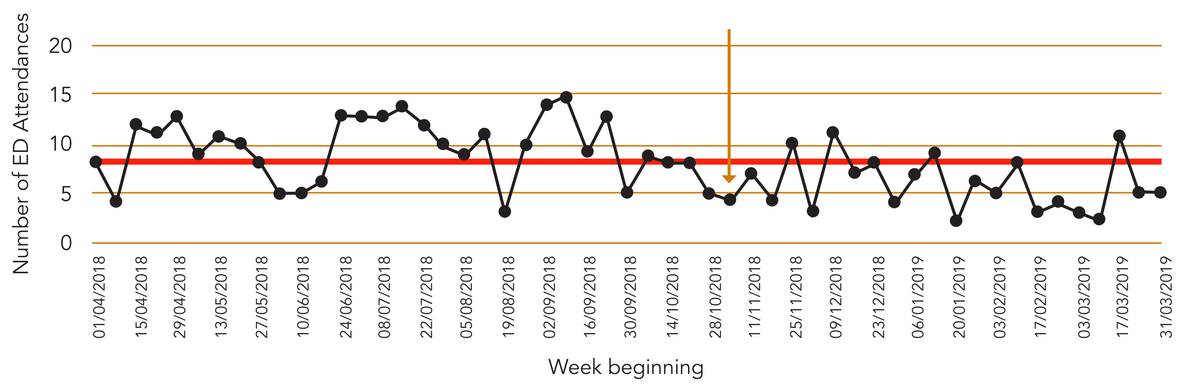
Lead Nurse and Senior Improvement Officer invited patients to participate in person centred holistic review of their care.

Testing new models of care with patients including:
Improve health and wellbeing outcomes;
Focus on prevention, anticipation and supported self management;
Redirection into appropriate services;
Support and encourage engagement throughout transition

Results

Transitional support is critical to sustaining improved outcomes for the individuals who frequently access ED.

Individual case reviews identify a 20% reduction in ED attendances between Nov 2018 - Mar 2019 for the selected cohort.

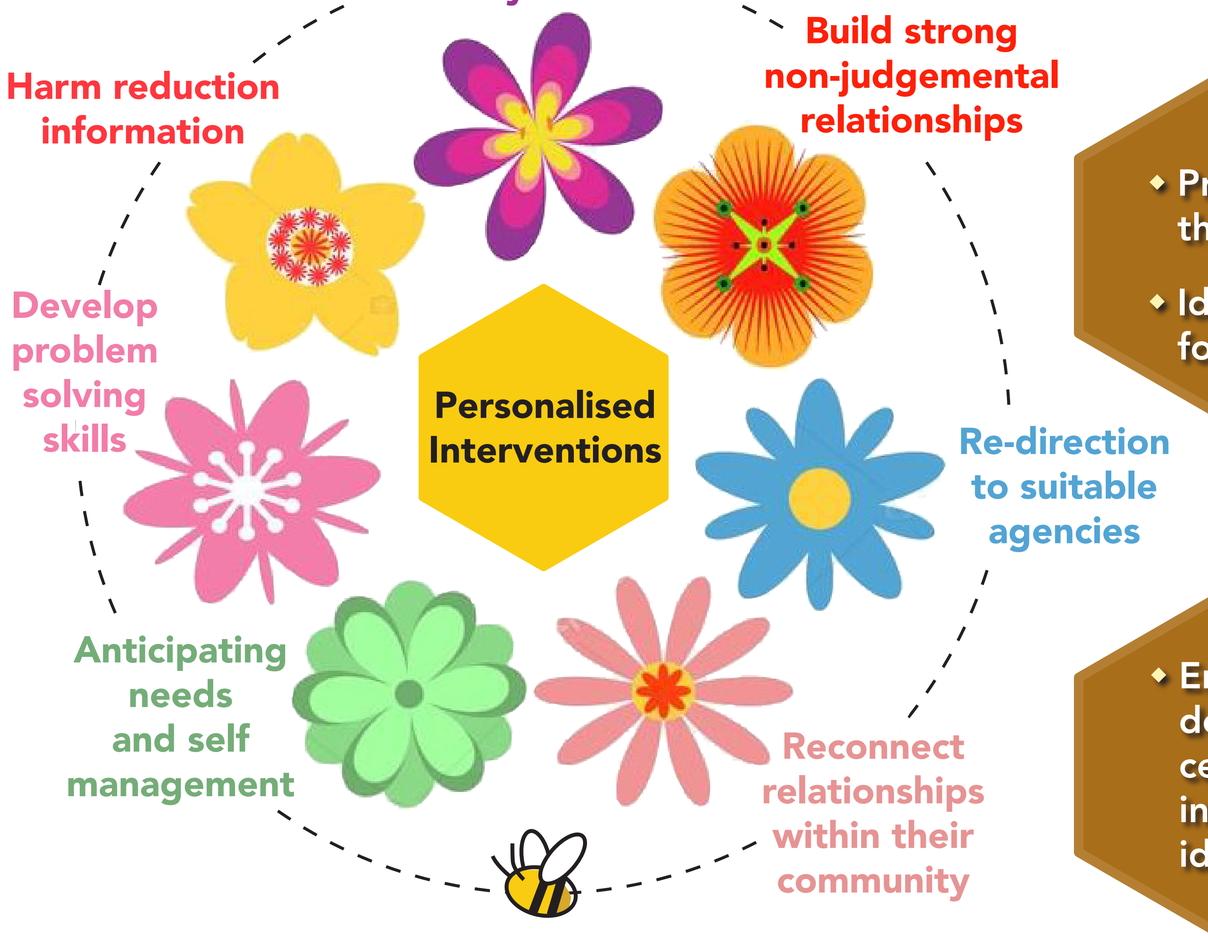


UHW Number of High Resource Attendances at ED

Weekly number of attendances

Median

Individuals report that they have found their person centred reviews beneficial:



What happens next?

- Present our findings to the HRU Project Board
- Identify areas for improvement
- Promote communication via MDT approach to provide wrap around care
- Encourage the development of patient centred pathways for individuals who are identified as high resource users