Frequent Attender, Care Enhanced (FACE) Team

6 Month Report (April-September 2013)

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10/12/2013

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**Commissioner Preface**

The FACE project was initiated from a multiagency stakeholder event which highlighted that there was a vulnerable group in society who were not receiving the services they required and in the process costing the health system financially through frequent and often inappropriate use of emergency services.

This project’s aim was to identify if by introducing a case management approach, these clients health outcomes and experience improved and reduced cost in emergency services. In the first year, the service has paid for itself in avoided cost despite the inevitable time taken during the early months to recruit staff, make the necessary contacts within partner agencies, embed processes and has demonstrated that through intervention this client group can have improved outcomes.

Due to the short length of the pilot, the long term impact of the FACE project was unclear. As a result the CCG agreed to extend the pilot for a further year.

With the transition to Clinical Commissioning Groups, access to patient identifiable data has been restricted so the financial impacts of the further 6 months covered within this report cannot be measured.

Despite this, we have been able to demonstrate the positive impact on service users and remain confident that without this service this client group will continue to increase their inappropriate usage of emergency services exponentially as has been the trend over the past four years. Therefore we recommend to the CCG that this service is substantively. We are also working with Peterborough and Borderline LCG to roll the model out into PSHFT.

Mental Health GP Leads Network, and Commissioning and Contracting Team

**Steering Group Recommendation**

The group strongly recommends that this service is substantively funded as the positive impacts for both service users and partners in relation to quality of care, improved partnership working and up-skilled workforce is crucial for this vulnerable client group during times of austerity.

FACE Steering Group
## Summary

| Referrals and Case Load | 52 cases taken on between April 2012 and March 2013.  
|                        | 32 cases taken on from April 2013 to October 2013  
|                        | The group have complex needs and present with chaotic and high risk behaviours and have a high mortality rate.  
|                        | 60% of caseload have harmful, hazardous or dependent drinking patterns; 21% have dual diagnosis; 31% have a personality disorder.  
|                        | The patient profile remains similar to the first year of the pilot, suggesting that this is an on going need.  |
| Admissions and Attendances | The CCG is unable to hold patient identifiable information, therefore the information presented below is for the first 12 months of the project;  
|                        | There was a 19% reduction in admissions  
|                        | There was a 45% reduction in attendances  
|                        | This equates to £246.1k avoided costs a year, approximately £6.7k per service user. As the team have seen more people this year we would expect this figure to be larger, an expected gross saving of £306k.  |
| Length of FACE pathway | Average of 10.1 weeks in the second year of project.  
|                        | Based on feedback from the first year the care pathway was extended to 8-12 weeks depending on need.  |
| Composition and capacity of the team | Funded for 5.1 WTE (4.0 WTE clinical roles).  
|                        | Almost always had vacancies for clinical staff  
|                        | Service currently delivering with 55% WTE the CCG have not paid for these vacancies and resources redeployed to other areas of need within the mental health service.  
|                        | Composition of the team has been reviewed to fill vacant posts.  
|                        | Since November 2012 the Band 6 CPN is currently Acting Team Leader, limiting clinical functionality.  
|                        | The Peer support worker post has been filled by a Support Time and Recovery Worker as of August 2013  
|                        | The current capacity of the team based upon clinical WTE in post is 65. The number of service users actually engaged by FACE by month 6 was 35. The team is on track to meet its full year goal.  |
| Service User Feedback | Those whom accessed FACE valued the support.  
|                        | Those surveyed, 8 weeks was too short a duration to have the necessary impact.  
|                        | There is a clear link between these respondents and a relapse into using emergency services. A longer term intervention from FACE may have prevented these relapses.  |
| Impacts on the Wider Economy | Decreased Section 136 Mental Health Act within police cells  
|                        | Ambulance service is experiencing a decrease in call outs from Frequent Attenders.  |
| Service Cost | The service has cost £129,285.70 for 2013/14, discussions are in progress with CPFT as to how this underspend might best be allocated within the local health system.  |
**Context**

“Frequent flyers’ costing NHS £2.3bn a year” (Guardian, 2006).

In summer 2011 steps were taken to address the unmet needs of a specific cohort of service users in Cambridgeshire. This group, as also noted in other studies (see original business case, Appendix 2), frequently use Emergency Services (ambulance, A&E, police, fire and out-of-hours GP) in a manner deemed “inappropriate” (i.e. the service is unable to provide the care that the service user required).

This frequent attender cohort has a large overlap with Chronically Excluded Adults, identified by the MEAM coalition in 2009. Such co-morbidities act as blocks for entry into existing services. Emergency services are, to these service users, the only port in a storm. The Cabinet Office (2006) estimated that this cohort consists of 2-3% of the population.

A sample study of 88 frequent attenders showed a cost of approx. £18-24,000pa per service user prior to case management.

In 2011, the Urgent Care Network supported the creation of an intensive case management team (called the Frequent Attenders, Care Enhanced, or FACE team) to meet with this cohort of service users and facilitate their engagement with existing services. The team members have varied and complementary skill-sets, giving the greatest likelihood of a successful outcome for this highly complex and diverse group of service users.

Studies elsewhere in the UK and internationally (see original business case, attached) suggested that the case management approach could not only reduce inappropriate use of emergency services (by 30-40%) but also the cost-per-attendance (through a reduction of up to 40% in admissions per attendance).
Referral Source

Referrals are received from a number of services throughout Cambridgeshire. Referrals are more concentrated in Cambridge and make up 76% of all referrals for the region, with a much smaller number of referrals from Ely which we conclude is because the service is focused on acute sites.

The Face Team has found that engagement with Huntingdon has significantly increased from last year. However not all of the referrals have met the FACE criteria. This has highlighted a gap in services for patients frequently attending surgeries and the older population.
Profile of Service Users

The service user profile has become more defined during the second year of the project. The descriptions below are based upon the entire length of the project, comprising of the 84 service users taken on to the case load since 2012.

Males make up 53% and females make up 47% of the cohort, with the highest number of service users being between the ages of 33 and 52. 50% of service users classified as “very severe and complex, non-psychotic” using the HoNOS clustering tool. However it should be noted that the clustering tool is aimed at those who have a mental health diagnosis and does not accommodate those who are solely alcohol dependant.

“The real problem areas are those whose learnt behaviour is a bit more challenging and this is something we will find difficult to alter”

East Angela Ambulance Services

Needs

The needs of service users within the Frequent Attender cohort remain diverse. The Face Team has engaged 32 service users over the last six months. Of these 32 individuals 59% had some level of alcohol dependency and 31% had a Personality...
Disorder. These are similar numbers to those encountered in the first year of the project. This highlights that the need for this service is on-going.

The patient population seen by the FACE team has a high mortality rate. Since the FACE team has been in place seven service users have died. This is due to a variety of reasons which include:

- Physical ill health associated with alcohol dependence (four cases)
- Cerebrovascular Accident
- Methadone toxicity
- Cardiac complications/physical ill health

The reason for highlighting this within the report is to emphasise the complexity of needs for this high risk and vulnerable client group.

**Key Findings**

From the 1st April – 31st of October 2013, the FACE team had 64 referrals:

- 32 service users engaged with the team, 17 of whom were discharged by 31st October 2013;
- 30 service users either declined to engage or did not meet the criteria;
- 4 were re-referrals

*For the analyses below, a sample of service users were selected based on the data available at the time of report. Except where noted, the data used is for 37 of the discharged service users from year one—minimal data was available due to governance issues that arose when the commissioning group changed from a PCT to a CCG.*

**Attendance**

Inappropriate use of emergency services continued to follow the same pattern as found in the 9 month report (Appendix 2). Some services users’ attendance decreased whilst engaged by FACE, but not universally and a small number of consistently prolific attenders obscure the benefits seen in the remainder of the population. The average attendance levels dropped following discharge from FACE. Although some of those with more complex needs and ingrained behaviours returned to previous attendance levels. Whilst this was not predicted in the original business plan, it is not counter-intuitive—the short 8-12 week pathway is, for the majority of the cohort, the most intensive support they have had from any service. For those moderate attenders, attendances decreased post discharge, which delivers tangible improvements beyond their direct engagement with FACE.

*Fig 3: Average Monthly Attendance and Admissions (n=37)*
Quality Outcomes

The WHOQoL-BREF, Chaos indicator, Recovery Star and HoNOS clusters were used to give an indication of service user’s quality of life. Although HoNOS Clustering is targeted towards those who have mental ill health and not specifically designed for those solely with alcohol related issues, it still provided assistance in developing care plans and measuring effectiveness of the service. Due to the chaotic nature of this client group, only a number of service users were able to complete the service user tools. However, where people did complete these forms, they showed a reduction in self-reported chaotic behaviour and an improvement in quality of life.

The HoNOS clustering tool was completed by a member of staff. 54% of service users in year one were clustered into the Non-Psychotic, very severe and complex category and 43% in year two were classified in this category. HoNOS clusters rarely changed over the course of engagement with FACE and this could reasonably be attributed to the short length of the case management pathway.
“Lifted my mental well-being state. Life was chaotic before and it’s more settled now.”

“I have a different outlook on life. It has totally changed the way I see things and how I live my life.”

“My life hasn’t changed by working with FACE”

“I’ve had my ups and downs, they’ve really helped me. Life has stayed pretty stable, bad patches are less. I feel supported.”

Length of Time in Pathway
The first year of the project saw an average pathway length of 69 days (9.8 weeks). The originally-proposed pathway length of 8 weeks was felt to be too short by service users, the team and some partner agencies due to the complexity of needs of this particular service user group.

The pathway was adjusted to range from 8-12 weeks. For this year the average length of time in the pathway became 71 days (10.1 weeks).

**Fig 4: Average Length of Pathway**

Explanations include:
- High overall complexity of the population of Frequent Attenders make an 8-12 care pathway appropriate, however due to the level of needs of this group there will always be those who remain past the 12 week pathway
- Some services are unable to respond to FACE referrals in a short space of time and as a result service users may remain under the team until such times that other services are able to do so.
  - Drug & Alcohol teams and mental health services sometimes have mutually exclusive criteria, which leaves a gap for some service users—occasionally the FACE team have to provide interventions in order to help service users meet the criteria of services.
  - The resource level for other teams is such that the FACE team have had to postpone discharge of a patient (and sometimes provide interventions in the meantime) while waiting for acceptance into the receiving team
  - Some service users have no care pathway available, for example younger adults with Korsakoff’s dementia who continue to drink.
- Changing capacity of the team over time:
  - Team has operated for long periods with vacancies in the drug/alcohol nurse/project worker and peer support worker posts (see below);

Service User Evaluation
The initial questionnaire has brought up a number of issues; a number of the respondents are known to mental health / alcohol and drugs services and yet feel the
need to access emergency services, mainly to feel safe and secure. Only a small minority made reference to needing hospital admission. There were several inferences to services needing to listen to the service user and be more flexible i.e. it could be explained that a person who feels that they need to be in hospital would keep presenting at hospital until they were admitted. One service user said that people did not believe how they felt and they would be discharged. Services being described as prescriptive and intimidating, being discharged from their CPN because of their alcohol use and perceiving themselves as a waste of time based on how they were treated, does not bode well for people having their needs met within the community. It could certainly explain people using emergency services as an alternative, particularly if A&E can offer the sanctuary of feeling safe.

The post intervention questionnaire responses demonstrate that the people who accessed the FACE team valued the support that they received from the service, but stated that 8 weeks was too short a duration to have the necessary impact on their mental well being and services received. There is a clear link between these respondents and a relapse into using emergency services. A longer term intervention from FACE may have prevented these relapses. Case management initially was to be provided through an 8-week pathway following the first engagement. During this period the team would develop and enhance relationships between service users and existing services, resulting in referrals and acceptance into those services. After nine months of the service, feedback from service users, stakeholders and partner agencies lead to a change in duration such that the FACE team would engage with service users for 8 to 12 weeks, dependent on individuals needs.

The team attempted to follow up service users at 3 month post discharge. This has been challenging and only a small number of service users have engaged with this process. The low numbers of responses are similar to the service user evaluation in terms of engagement with the feedback process.

A number of the challenges have been:
- Mobile & chaotic population
- Lack of perceived benefit by the service user.
- Service users failing to attend agreed post discharge appointments
- Vacant posts

**Feedback from other Services / Organisations**
Feedback from other organisations and services has been mainly positive, citing the FACE team’s engagement with services and service users as a reason for the reduction in pressure on those services from known frequent attenders.
The main positive themes emerging are that the team:

- Has the flexibility of approach to meet the needs of service users
- Can identify barriers to existing services that prevent people from engaging with the appropriate services
- Can highlight gaps in services
- Improves quality of life

<table>
<thead>
<tr>
<th>What works well</th>
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<tbody>
<tr>
<td>The service provides a net to catch our most vulnerable patients and prevents inappropriate use of services which are already very stretched.</td>
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<tr>
<td>I feel this is a useful group to address our patient population who frequently attend emergency services.</td>
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<tr>
<td>Significant impact on those with dual diagnoses, which highlights the chasm that exists where service users fall between services and how appropriate provisions of service can help service users quite significantly in a relatively short period of time.</td>
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<tr>
<td>Communications with the team is excellent especially as there always seems to be someone readily available to speak to.</td>
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<td>The multiagency meetings have a major positive impact on assessing, planning and joint working.</td>
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<tr>
<td>Intervention by the FACE team prevents further harm to the client and ensures better use of resources of the A+E department as well as the ambulance service.</td>
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<td>I am sure the data will show a reduction in attendances again, not always fully sustained but at least reduced.</td>
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<tr>
<th>What could be better</th>
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<tr>
<td>The entry criteria are too tight, there are others we would like to refer to the service such as primary care frequent attenders, children and older people.</td>
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<tr>
<td>There needs to be improved communication/feedback after the team have assessed patients.</td>
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<tr>
<td>Allow such individuals to be flagged up so that community services input can be better co-ordinated.</td>
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<tr>
<td>The team could benefit from having someone working directly with them as an expert in homelessness and also alcohol/drug misuse.</td>
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Feedback Provided by:
- Local GPs
- Addaction
- Liaison Psychiatry Services
- EEAST
- CUHFT
- Cambridgeshire and Peterborough Police
- HHT
- Gainsborough Trust
Gaps Identified in Service Delivery

Capacity of the Team

The FACE team has not been at full capacity for the whole of its existence thus far, with an average WTE of 55% of the planned establishment. In terms of clinical staff (i.e. excluding admin and managerial), this falls to 37%.

As shown by the graph below, this has affected the ability of the team to match the planned capacity. The short staffing, paired with the continued complexity of the client group has had a continued effect on the team’s ability to carry a full caseload.

The CCG had expected to fund the service to the cost of £270,080, due to the reduced capacity the service has only cost £129,285.70 for 2013/14 - discussions are in progress with CPFT as to how this underspend might best be allocated within the local health system.

Difficulty with Discharging and After Planning

The FACE team have had a number of challenges when discharging service users from our care. These include:

- Waiting times for service users referred into other organisations.
- Lack of care pathways for those with longer term needs eg Korsakoffs dementia.
Changes within other services leading to services users no longer meeting inclusion criteria e.g. Metropolitan floating support services.

Statutory services not being able to follow the care plan set up e.g.

- A service user was discharged from the acute inpatient ward at Fulbourn and refused to leave. This resulted in the police being called who then took the service user to be assessed by psychiatric liaison at Addenbrooke’s.

**Options Appraisal**
The FACE Steering Group has developed the following options for consideration:

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<tr>
<th>Option</th>
<th>Benefits</th>
<th>Risks</th>
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<tbody>
<tr>
<td>1 No Change – project to halt as of April 2014</td>
<td>Immediate reduction in funding for the team</td>
<td>Long-term costs of frequent attendance rising exponentially (Wong, 2011), and poorer patient experience.</td>
</tr>
<tr>
<td>2 Substantively commission the full service</td>
<td>Staff employed substantively, enable full recruitment due to stability of the service Relationships with other orgs. can develop long term Enable a wider group of people to be seen Ongoing avoided costs for the cohort (£1.25m pa.) Service reconfiguration to meet the recommendations highlighted within this report</td>
<td>Patient cohort composition could change We are unsure of the long term impact of the service due to the CCG being unable to hold patient identifiable information. Ongoing cost pressure (£275k pa.)</td>
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<tr>
<td>3 Substantively commission service at its current establishment</td>
<td>Staff employed substantively, enable full recruitment due to stability of the service Relationships with other orgs. can develop long term On-going avoided gross savings for the cohort (£306k pa.) Service reconfiguration to meet the recommendations highlighted within this report</td>
<td>Patient cohort composition could change We are unsure of the long term impact of the service due to the CCG being unable to hold patient identifiable information. On-going cost pressure (£130k pa.)</td>
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**Recommendation**
It is recommended that **Option 3** is approved in order to embed the service within the health economy and to develop a better understanding of the health needs and diversity of the patient cohort. We are unable to keep extending this service for short
periods of time as we are unable to recruit to the roles due to lack of stability of the service.

Once patient identifiable information is available, and we have a more substantial dataset and the long term benefits can be robustly validated, we would review the current service and staffing model and if appropriate return to CMET with an option appraisal.

Additionally, it is recommended that the service changes the way it functions slightly and reviews the issues below which have been highlighted during service delivery this year:

- Develop in conjunction with service users a suitable measure of quality outcome that they would be happy to complete as part of the service.
- Develop improved communication links with primary care via CONFER
- Develop improved mobile working due to the large geographical area that the team covers.

The service will also work in collaboration with the CCG to look at the following service developments:

- Review data to identify the volume of need in general practice in relation to frequent attenders
- Review service models for primary care frequent attenders services
- Review need for a service to meet the needs of children and young people
- Develop a business case for a Peterborough and Borderline service

**Impacts if the Service is Not Commissioned**

This report has highlighted that the client group using this service is extremely complex, high risk and vulnerable, which continue to present to the already stretched emergency services. The service is highly rated by service users and has demonstrated that it can reduce inappropriate usage of emergency services for this group and reduce cost to the health economy. Without this service we are confident that this client group would continue to increase their inappropriate usage of emergency services exponentially as has been the trend over the past four years. Moreover the client groups quality of life and health conditions would decrease.
Appendix 1 – Calculations

For 37 pts, PRE-engagement
# of attendances 12 months before = 646 (equivalent to 17.5 per s/user)
# of admissions 12 months before = 245 (equivalent to 6.6 per s/user)

Average cost per attendance before FACE engagement = £107.29
Average cost per admissions before FACE engagement = £1317.45

⇒ Total cost for the 37 pts before FACE = (646 * £107.29) + (245 * £1317.45) = £392.1k pa.

For 37 pts, POST-engagement
Attendances dropped by 45% and admissions by 19%

⇒ Extrapolating for 12 months:
  o # of attendances = 148 (equivalent to 6.6 per s/user)
  o # of admissions = 93 (equivalent to 2.5 per s/user)

Average cost per attendance after FACE = £97.81 (8.8% reduction)
Average cost per admissions after FACE = £1,414.10 (7.3% increase)

⇒ Total cost for the 37 pts after FACE = (148 * £97.81) + (93 * £1,414.10) = £146.0k pa.

Therefore for the 37 service users:
Expected annual savings = £392.1k - £146.0k = £246.1k
= £6.7k per service user pa.
## Appendix 2 – Associated Documents

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<thead>
<tr>
<th>Document Type</th>
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<tbody>
<tr>
<td>FACE Original Business Case</td>
<td>FACE Original Business Plan.doc</td>
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<tr>
<td>FACE Service User Evaluation Report</td>
<td>FACE s-user report April 2012-October 21</td>
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<tr>
<td>FACE Business Case 2013 9 month report 2012</td>
<td>130128_FACE Report 9 months FINA</td>
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<tr>
<td>FACE Service User Evaluation Report</td>
<td>FACE report November 2013.docx</td>
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