British Red Cross

Nowhere else to turn

Exploring high intensity use of Accident and Emergency services

Summary report

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The power of kindness

Foreword
Mike Adamson, Chief executive at British Red Cross

People who frequently attend Accident and Emergency (A&E) are few in number, but their impact on health systems is significant. They make up less than one per cent of the population, but account for a significant proportion of all A&E attendances, ambulance journeys and hospital admissions. They cost the NHS at least £2.5bn per year (see page 4).

While it's easy to focus on where people end up, at the British Red Cross we know we make the most difference when we work with people to understand what has taken them there. The complex life histories, circumstances and service failures which have combined to leave someone with nowhere else to turn but A&E.

This report explores the profile and experiences of people who frequently attend A&E and considers what needs to be done to ensure that more people can be supported in the community, before they reach a crisis that leads to the door of the emergency department. It shows the clear link between high intensity use and wider inequalities. High intensity use is greatest in areas of deprivation, and across all age groups it is associated with issues such as homelessness, being out of work, mental health conditions, drug and alcohol problems, criminality, and loneliness and social isolation. And we know that people who attend A&E frequently are significantly more likely to die than people who don't attend so frequently.

Persistent attendances are distressing for patients and professionals alike. From our work across all of England's seven NHS regions supporting people who frequently attend A&E, we know that by the time people come through the doors of A&E they have often hit rock bottom, and don't know where else to turn. At the same time, A&E staff can feel frustrated and helpless – unable or unsure how to meet the complex combination of mental, physical and non-clinical needs that lead to attendance.

However, there are things we can do. We know from our own services that by working alongside people to understand the issues that are driving their attendance at A&E and by supporting them to find solutions within the community, we can bring down A&E attendance significantly.

The Covid-19 pandemic has exacerbated existing pressures on the health system and, as we go into winter, we know this pressure is only likely to grow. Now more than ever we need to ensure that wherever possible we are supporting people to access the help they need to manage their health and wellbeing in the community, avoiding distressing and costly admissions.

NHS reform, and particularly the creation of Integrated Care Systems, creates an opportunity for new thinking – supporting the shift away from competition between different parts of the system and towards a collaborative approach focused on keeping people healthy, rather than patching them up when things go wrong. We know that voluntary sector organisations, like the British Red Cross, have a critical role to play in these systems, getting alongside people and enabling them to access the support that they need, at the right time.

We want this research to bring fresh focus to the needs of people who frequently attend A&E, supporting the development of practical approaches that work better not only for those individuals, but all the people and organisations involved in supporting them.

At a glance

- 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 A&E attendances, 29 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

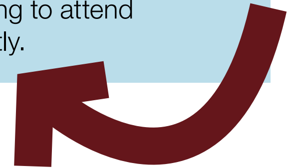
- High intensity use of A&E is closely associated with deprivation and inequalities
- The most common age groups to attend A&E frequently are those aged 20 to 29 and those aged over 70

- 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

- There are ways that we can better support people who frequently attend A&E so that they don't feel they have nowhere else to turn
- 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.



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 frequently attend A&E and those who are at risk of doing so.

We are calling 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 to turn but A&E.

We are calling for investment in VCSE 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.

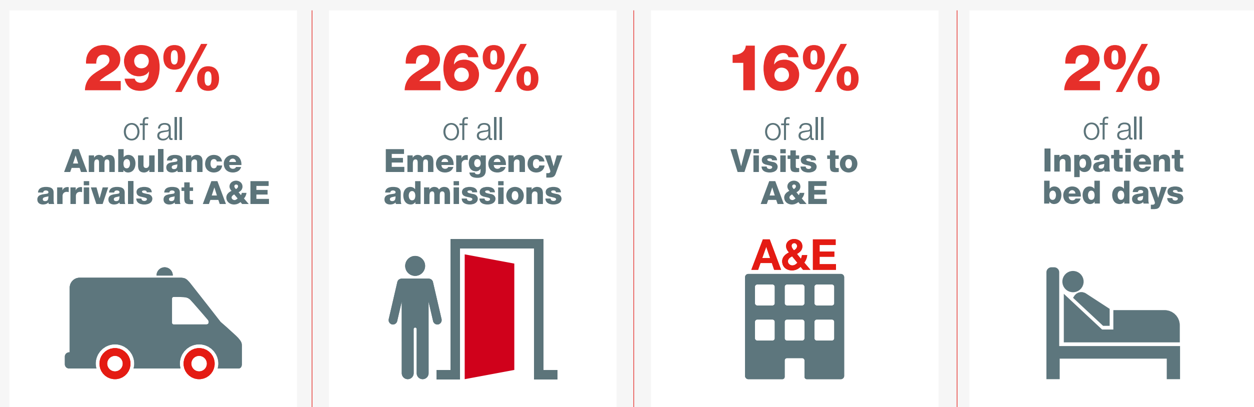
We are calling on the Prime Minister to commission a national cross-government strategy to reduce health inequalities.

Summary of findings

About high intensity use of A&E

'High intensity use' of Accident and Emergency services (A&E) is defined as attending A&E more than five times in a year. Less than 1 per cent of England's population attends A&E at this frequency or more. However, this group accounts for a significant proportion of emergency service usage.

How those frequently attending A&E use services across the pathway



Based on their ambulance journeys, A&E attendances and inpatient stays, we estimate that this group of people cost the NHS £2.5 billion per year.[i]

Our research

Our report draws primarily on research undertaken by The Public Service Consultants (The PSC) for the British Red Cross. It encompasses:

- A review of existing literature around the high intensity use of A&E
- New analysis of a novel 6-year dataset covering hospitals in England encompassing information on 367,000 people who frequently attend A&E, as well as in-depth data for three hospital trusts
- Interviews with 14 people who frequently attend A&E and 17 professionals who work with them
- In-depth analysis of health data from North West London, undertaken by Imperial College Health Partners (ICHP) for the British Red Cross.[ii]

[i] Please see page 8 in the main report at redcross.org.uk/nowhere-to-turn for the calculations behind this figure.
[ii] British Red Cross (2021). 'A symptom of unmet need: Learning more about people who frequently attend Accident and Emergency services'. Retrieved from: redcross.org.uk/nowhere-to-turn

Our findings

The findings outlined in this report provide new insight into the characteristics, experiences and outcomes of people who frequently attend A&E and the factors that underlie their attendance.

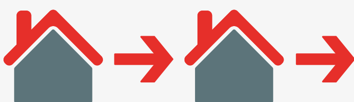
The term 'high intensity use' encompasses a range of different patterns of attendance at A&E, but our research reveals that:

- Most people (around three-quarters) who frequently attend A&E are in the lowest tier of high intensity use (attending five to nine times per year): 14 per cent attend between 10 and 15 times, and 8 per cent 16 times or more.
- While levels of use vary, there are some individuals who have gone to A&E more than 300 times in one year.
- By the eighth visit in a given year, a person has a 55 per cent chance of frequently attending for two years or longer. This probability reaches above 80 per cent by the 15th visit.
- Individuals who frequently attend A&E are significantly more likely to arrive by ambulance than the general population.
- Individuals who attend A&E frequently are more likely to attend at night than the general population.

We found a **clear link between high intensity use of A&E and wider health inequalities** with frequent attendance concentrated in the most deprived parts of the country, and people who frequently attend A&E more likely to be experiencing a range of other disadvantages.

A range of factors are correlated with higher levels of frequent attendance:

- **Demography** The most common age groups to attend A&E frequently are those aged 20 to 29 and those aged over 70. While some studies suggest that men are more likely to frequently attend A&E, our analyses found no conclusive evidence of such trends. Due to limited and poor-quality data, the relationship between ethnicity and the high intensity use of A&E is unclear and will require further research.
- **Geography** There is strong evidence showing that individuals who make frequent visits to A&E are most likely to live in areas that are deprived and urban. Older people frequently attending A&E are most likely to live in areas close to hospitals.



- **Housing insecurity** People who attend A&E frequently are estimated to move homes at least 25 per cent more often than the general population.
- **Loneliness and social isolation** Both loneliness and social isolation have been associated with the high intensity use of A&E, with 22 per cent of people who frequently attend living alone (compared to 16 per cent of UK individuals).
- **Poor physical and mental health** Various indicators of general health status have been found to be associated with a higher frequency of A&E attendance. Broadly, poor physical health more than doubles the likelihood of the high intensity use of A&E. As well as being a direct driver of A&E attendance, mental health conditions were also identified as an underlying factor in high intensity use. For example, people with mental health conditions can often struggle to access appropriate support in the community for both mental and physical health issues, leading them to A&E as a last resort. Furthermore, some mental health conditions can exacerbate physical health conditions, and interrupt people's ability to manage their conditions independently.
- **Adverse childhood experiences and trauma** Many of those who frequently attend A&E have a history of trauma and / or adverse childhood experiences. These can have a lifelong impact on people's mental and physical health and on their relationships with professionals and services.

- **Criminality** Individuals with a criminal record or who have recently spent time in prison are more likely to attend A&E frequently.
- **Drug and alcohol issues** We also saw links between high intensity use of A&E and substance misuse issues. These were both a direct trigger for A&E attendance and impacted people's ability to access mainstream support in the community for other issues they may be facing.
- **Sudden crises or changes** In addition to the build-up of a variety of mental, physical or social factors, sometimes a sudden life change precipitates someone's high intensity use of A&E. Most commonly, crises include relationship breakdown, loss, or the sudden onset of physical symptoms.

"My GP wanted to blame it on anxiety and wanted me to just go away."

Case study: Alex, in his 20s

Before his regular visits to A&E, there was a period when Alex attended the GP "almost every other day" to seek help for his pain. He presented with multiple issues including trouble swallowing and chest pains. However, the GP insisted these were a physical side effect of his anxiety issues.

Although Alex asked to see a different doctor and get a second opinion from someone else, the GP declined and eventually limited Alex's appointments to once a month. Some of his visits involved confrontations, and on one occasion the police got involved. He started to feel "petrified" of going to the GP, and sought help elsewhere.

Alex's visits to A&E were triggered by his need to know why he was in pain.

> **"A&E couldn't do much more, because I know they're only there for emergencies."**

A&E would conduct blood tests but couldn't find a diagnosable problem. After being linked to a HIU service lead, he was helped to find another GP who provided him with some answers. The HIU service lead also supported Alex to manage his anxiety better, and to prevent it from manifesting as physical symptoms.

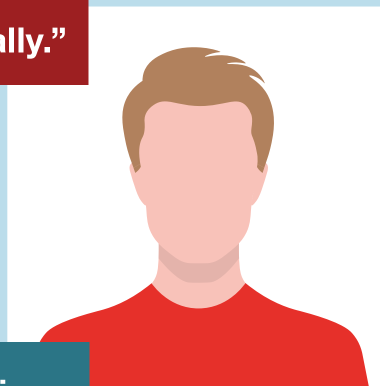
> **"I know there are better ways of dealing with things, better ways of dealing with chest pain and getting on the phone to 111. I have plans, whether it's taking antacids for the physical stuff, telling people when I feel low, or doing something else that can calm me down."**

Alex says one of the most helpful things his HIU service lead did was help him find a new GP.

He had previously felt dismissed and had his appointments limited by his former GP. This was at the root of his high intensity use.

> **"I would never have known what was wrong if I hadn't been helped to find someone that listens."**

"My GP had just fobbed me off really."



Alex

"I had to leave home really young and have been on my own quite a lot since."

"I was having chest pain and couldn't swallow. I just wanted to know what was wrong."

"I just wanted to know why I was in pain and couldn't eat."

The following combined characteristics and groupings emerge when analysing the quantitative and qualitative data on the high intensity use of A&E:

Key characteristics by age group

	People aged between 20 and 39	**People aged between 40 and 59**	**People aged over 60**
Characteristics of high intensity use of A&E	- More likely to frequently attend at highest levels (16+ times per year) - More likely to attend frequently for multiple years	- Most likely to frequently attend at highest level (16+ times per year) - Most likely to attend frequently for multiple years	- Least likely to frequently attend at highest level (16+ times per year) - Least likely to attend frequently for multiple years
Other key characteristics	- More likely to live in deprived areas than older counterparts - More likely to live in urban areas - Elevated risk of mortality	- More likely to be men - High likelihood of homelessness and other socioeconomic issues - Alcohol dependency and other mental health conditions are common	- Highly likely to be diagnosed and admitted following A&E visit - Higher frequency of visits among those who live alone - More likely to live in rural areas

Health issues associated with high intensity use

The evidence shows that there is a strong relationship between poor physical and mental health and the high intensity use of A&E. People who frequently attend A&E often have a complex mix of mental and physical health issues.

Too often, frequent attendance can be stereotyped as ‘inappropriate’ use of A&E and even as a ‘cry for help’ but, in reality, many people who frequently attend have conditions that require hospital admission, such as dementia, heart failure, epilepsy or a mental health diagnosis.

> **“A person is a person at the end of the day. The reasons people attend A&E are actually quite logical.”**
> **HIU service lead**

People who frequently attend A&E are much more likely to be admitted than those who attend less frequently, and we have identified patterns in the conditions with which people whose use of A&E is high are commonly diagnosed. In our research exploring the high intensity use of A&E in North West London, we found that dementia, palliative care, heart failure, epilepsy, mental health, chronic obstructive pulmonary disease (COPD), learning disability and osteoporosis were common features in the long-term care records of people who attend A&E frequently. We also found that people who frequently attend in the area are 10 times more likely to have three or more medical conditions than to have no background medical history at all, with 51 per cent of people who frequently attend having at least one diagnosed condition, and 30 per cent having three or more (also known as multimorbidity).

> **“I’ve had lots of operations and it’s caused me a lot of pain. That’s on top of my chest infections and breathing problems.”**
> **George, in his 70s**

> **“I live with pain every day, it’s worse at night and in the cold.”**
> **Cathy, in her 70s**

Looking across the UK, the data also shows that people who attend A&E frequently have poorer outcomes than others who use A&E. The mortality rate for people aged 30 to 49 who are frequently attending A&E is **7.5 times higher** than this age group in the general population of people who attend A&E. The risk of mortality is highest among the younger members of this group.

"I needed medical attention, but I knew I didn't need to be in A&E."

Case study: Victoria, in her 20s

Victoria started attending A&E frequently after experiencing seizures. Victoria had never experienced them before, but they quickly became more and more frequent and violent, which led to injuries.

When the seizures were particularly bad, or when she'd sustained an injury as a result, Victoria or her partner would call an ambulance. By the time she arrived at A&E, the seizures would have stopped.

This led to Victoria being turned away without an explanation about the root cause of the seizures. She felt she was starting to be judged negatively for attending, often without what the staff recognised as a legitimate cause.

"Once I had to go to A&E with a head injury caused by something else, but they weren't really listening because they already thought certain things about me."

Victoria started to feel frustrated but was later identified by a HIU service lead named Tom:

"He put a letter through my door and said, 'What can we do to help you out?'"

Tom offered practical help for mitigating the effect of Victoria's seizures, like making household furniture adjustments so that the falls would be less dangerous. They also started to look into what might be causing the seizures:

"We're still not 100 per cent sure, but it could have been triggered by a trauma two years ago when I lost my daughter. He's put me in touch with a charity that helps with that. I haven't met them yet, but I didn't even know they existed before."

Victoria has only been to A&E twice in the last three months, but her falls are less severe, and her partner was also taught more about how to help her when she has a seizure. Now they know when it's necessary to call for an ambulance and when it's likely to be okay.

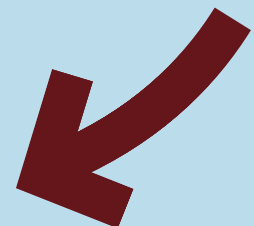
Victoria is being referred to a neurologist to try to get a diagnosis, but in the meantime the strategies put in place have begun to help. For other people in circumstances like hers, she said:

"It's important to make people aware that help is out there, even if you don't meet a certain criterion."

"By the time I got there I looked fine. The staff would just do basic observations, but they couldn't find the cause."

Victoria

"I was getting put into a box."



Experiences of health services

The majority of people who frequently attend A&E have engaged with other healthcare services before coming to A&E and most are registered with a GP.

However, they sometimes have atypical attendance patterns with GP and community services, which can emerge before their high intensity use of A&E, and some are dissatisfied with the support they have received from community-based services.

> **"I had a patient who had a lot going on in his life, and he was coming really frequently to get things off his chest. Luckily, I was a trainee and so had longer appointments, but it would be hard to help him with a 12-minute slot."**
> **GP**

> **"It's difficult to get communication with [my GP]. Half the time I don't bother."**
> **Zach, in his 30s**

> **"I didn't have the mental health support I'd had in prison. I was discharged and didn't know what to do with myself."**
> **Zach, in his 30s**

We found that people who frequently attend A&E services were often unable to access the support they needed within the community – with gaps in the support offered by GPs, in mental health services and in social care in particular.

Unfortunately, their experiences within A&E are also mixed. Of the individuals we spoke to who frequently used A&E, around half had positive experiences of A&E, but others had felt like they were not being listened to or were being dismissed.

Reducing high intensity use

While some people's high intensity use of A&E declines naturally after a year without the need for intervention, there are things that we can do to support people who frequently attend A&E to find other ways to manage their health conditions and address issues that cause them to reach crisis point.

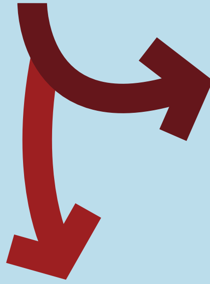
As part of 2019/20 NHS Operational Planning and Contracting Guidance, all health systems in England must implement a High Intensity Use service. These are person-centred non-clinical specialist services which offer holistic support to address the practical, social and emotional issues that may underlie people's frequent attendance at A&E. They also support them to identify community-based services that can help them to better manage their physical and mental health.

According to the latest guidance from NHS Right Care, services are now in place in more than 100 Clinical Commissioning Groups (CCGs). High Intensity Use services have been shown to be effective in reducing A&E attendances by between 38 and 84 per cent and non-elective admissions by between 24 and 84 per cent.

HIU services are often delivered by VCSE sector organisations, but some clinically-led models are delivered by NHS trusts and primary care providers. The British Red Cross delivers High Intensity Use services across all seven NHS regions and is recognised as a leading provider of HIU services. Our model has been expanded to also work with people who frequently use Mental Health Services (Liaison Psychiatry Services and Admissions) and Primary Care.

As well as receiving positive feedback from service users, professionals involved with our service users tell us they value the difference we make to their work, through the insight we are able to share to support service improvement and integration, and through the results we achieve with the people we work with.

British Red Cross High Intensity Use services



The British Red Cross is a leading provider of HIU services, delivering support across all seven NHS England regions and now developing services across the devolved nations.

We take a person-centred and strengths-based approach to identify unmet social needs that may be exacerbating physical or mental health conditions, leading the person to attend A&E.

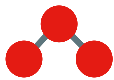
Our approach is de-medicalised and decriminalised. Everyone who is supported by HIU services gets a 'clean sheet', so that from the moment they accept support they can start to create a new narrative which no longer focusses on what is 'wrong with them' but rather what is 'right with them'.

Support is not time-limited and is based on what the individual needs.

The model encompasses:

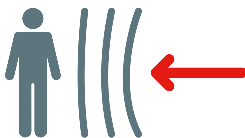
A complex casework approach Support is completely personalised, taking the form of health coaching and care coordination to help the individual in accessing the services and support that they need.

Connecting and listening British Red Cross staff need to understand the things that affect the individual – whether they are in the past or in the present. Unmet social needs are often the root cause of frequent attendance at A&E, exacerbating physical or mental health conditions and triggering relapse and crisis.



Joining the dots HIU services often act as the glue between clinical services for people who would otherwise fall through the gaps. For example, people with a dual diagnosis of mental health and substance misuse who do not meet the criteria for mental health services or drug and alcohol treatment.

Advocating for the individual Our services either feed into or bring together multi-disciplinary forums to ensure that the people we are working with get what they need. By advocating for people who frequently attend A&E, our services help to change negative perceptions among health professionals, 'humanising' the individual and helping them, and the professionals they work with, to move forward together.



Building on people's strengths and creating resilience In many cases the services people need to manage their conditions already exist, however there are a range of practical and emotional barriers that can impede them in employing coping and self-management strategies. Our services help people to navigate the complexities of the health and care system, and help to bring down the barriers so that people can be heard, and can take control of their own wellbeing.

We carefully track the impact of our services by accessing data from health partners and undertaking regular evaluation of the outcomes and goals achieved by individuals as well as reductions in service use. For example, the British Red Cross HIU service in Stockport has achieved:

58 per cent reduction in A&E attendance

67 per cent reduction in non-elective admissions

71 per cent reduction in ambulance conveyances

This equates to a system saving of £432,000

The typical return on investment for our HIU services is between 250 and 400 per cent

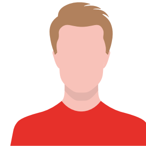
How High Intensity Use services identified solutions that worked

"My HIU service lead is a get-things-done kind of person."

Rupert, in his 70s

Rupert's HIU service lead helped him set up a new TV and mobile phone in his new home and took him shopping.

Having the 'basics' in place helps Rupert focus on things he cares about most. For instance, the mobile phone has helped with Rupert's feelings of loneliness.

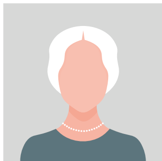


"I would never have known what was wrong if I hadn't been helped to find someone that listens."

Alex, in his 20s

Alex says one of the most helpful things his HIU service lead did was help him find a new GP.

He had previously felt dismissed and had his appointments limited by his former GP. This was at the root of his high intensity use.



"She's very helpful. She got me to a new private hospital very fast, and got a chair and toilet seat in the house."

Cathy, in her 70s

Cathy's HIU service lead was quick to help her make practical improvements in her life, which had a big impact.

After months of feeling stuck getting the same advice from A&E (that her physical problems and pain could not be alleviated), these quick fixes created a lot of relief.

"She's trying to get me to go outside more."

Amanda, in her 50s

Amanda was introduced to her HIU service lead at the end of a stay in hospital. She immediately received support to set up a bank account and monthly bill payments.

The support helped her feel less isolated as she lived alone and often struggled with the transition home.

Now that they have established a good relationship, the HIU service lead has started to encourage Amanda to engage with her local community.

Interviewees with experience of frequently attending A&E were recruited through a range of HIU services including those provided by organisations other than the British Red Cross. For more details see methodology.

> **"We humanise people that have been dehumanised a lot."**
>
> **HIU service lead**

Our experience shows that the following factors are critical to supporting people who frequently attend A&E:

Making a connection: HIU services work closely with people who frequently attend A&E to build trust and establish a connection. Listening to what really matters to people is at the heart of these services. Feeling heard is often the thing that people value the most. There are often a wide range of factors that contribute to an individual's regular use of A&E. Proactive, specialised outreach – rather than waiting for referrals – followed up with personalised support are vital.

Addressing the wider challenges: People who frequently attend A&E benefit from a range of social, emotional, and practical support. By learning what matters to people, services can better understand and address the day-to-day challenges they face in addition to their health conditions. HIU teams are often the glue between clinical services and are able to join up services involved in an individual's care, as well as identifying gaps in statutory or community provision.

Strength-based, holistic practice: HIU services stand out from other health and social care services because they are holistic, proactive, and the support is not time limited. Specialist teams are able to change the conversation and encourage the person to start focussing on what is right with them, building on their strengths. Enabling people to work on their hopes and dreams can be the key to building resilience, self-management and coping mechanisms.

While proactive, person-centred support for people who frequently attend A&E is vital, there is also a need for action to address the gaps in support and the wider inequalities that underlie high intensity use, so that we can prevent people getting to the point of attending frequently.

Time to act

With the NHS and social care under increased pressure as a consequence of the pandemic, the resulting backlog and ongoing seasonal pressures, now more than ever we need to address the issue of high intensity use of A&E and give people better, targeted help.

Fortunately, there are fresh opportunities to do this with the creation of Integrated Care Systems (ICSs) enabling a new focus on bringing support together across organisational silos and investing to improve population health rather than to patch people up when problems arise.

Joining up action across the health and care system will be vital if we are to address high intensity use of A&E.

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 frequently attend A&E and those who are at risk of doing so.

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 to turn but A&E.

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. This will help people who are at risk of frequently attending A&E before their situation reaches crisis point.

We recommend the following actions:

To improve access to support for people who frequently attend A&E

Commissioners and leaders across acute settings should:

- Invest in specialist High Intensity Use services based on the holistic, non-clinical NHS Right Care model.
- Ensure that health and care professionals understand the complex issues that underlie high intensity use and treat those who frequently attend A&E with dignity.
- Ensure that people's needs are assessed holistically, including through the provision of non-clinical support in line with the Department of Health and Social Care's hospital discharge policy.

Integrated Care System leaders should:

- Agree a commissioning strategy for addressing high intensity use, including ensuring equitable access to High Intensity Use services for those in greatest need.
- Work with the VCSE sector to tap into their skills and expertise in delivering non-clinical support that complements clinical activity.
- Consider how data can be shared and analysed across the system, including with the VCSE sector, to ensure that people who frequently attend A&E, or those who are at risk of high intensity use, can be identified and appropriate preventative support can be provided.
- Equip health professionals in the community, including GPs, to identify escalating patterns of behaviour or known triggers for high intensity use and to have access to appropriate referral pathways that provide proactive intervention.

NHS England and NHS Improvement and the Department of Health and Social Care should:

- Update guidance on the development of High Intensity Use services to reflect new NHS structures, including ensuring that Integrated Care Systems develop strategies for high intensity use across their areas.
- Incentivise improved recording of patient data and information-sharing regimes between emergency departments, community health and non-clinical services.
- Agree a consistent set of national measures to evaluate the impact of High Intensity Use services and to build the evidence to support investment.

To ensure more people can access support in the community before they reach crisis point

Integrated Care System leaders should:

- Bring together leaders across health, social care and the VCSE sector to identify gaps in current community-based provision and to develop commissioning and funding strategies to address these.
- Invest in the capacity of the VCSE sector to deliver support linked to social prescribing, particularly in deprived communities where capacity is often weakest, to ensure that people are able to access holistic support in the community, before their needs escalate, and as a 'step down' from High Intensity Use services.
- Invest in non-clinical community schemes and activities, including homelessness support, housing, support to self-manage long-term conditions and practical and emotional support focussed on growing people's independence and connecting them to their communities.
- Invest in the rollout of multi-agency, integrated health and care teams, focussed on ensuring people's holistic needs can be met in the community, prioritising areas with the highest rates of emergency admissions.

The Department for Health and Social Care and NHS England and NHS Improvement should:

- Continue to roll out personalised care so that all health and care professionals base their interactions with people on 'what matters to them'.
- Ensure the community mental health framework for adults and older adults is appropriately funded and rolled out across England.
- Ensure that increased investment in social care is used to improve access and quality, particularly in the most disadvantaged communities and for at-risk groups.

To address the health inequalities that underlie high intensity use of A&E

Integrated Care System leaders should:

- Ensure that the links between high intensity use of A&E and inequalities and deprivation are understood in developing population health management strategies.
- Work with partners across sectors to address the wider determinants of health.

The Prime Minister should:

- Commission a national cross-government strategy to reduce health inequalities, which recognises the need for action across departments to address the wider determinants of health.

The Department of Health should work across Government and particularly with HM Treasury to:

- Reverse cuts to the public health grant and commit to maintaining its value as a proportion of total health spending.
- Review NHS England and NHS Improvement's allocation formula so that it meets the needs of health and care providers and communities in the most deprived areas.
- Strengthen the Health and Care Bill's duties to include a specific requirement to reduce inequalities between patients' experiences of healthcare services (in addition to access and outcomes), and require Integrated Care Boards to develop systems to identify and monitor disparities in health outcomes, access and patient experience.

For the full report visit:
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