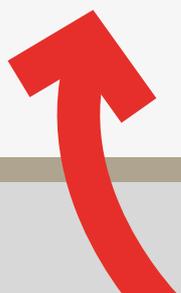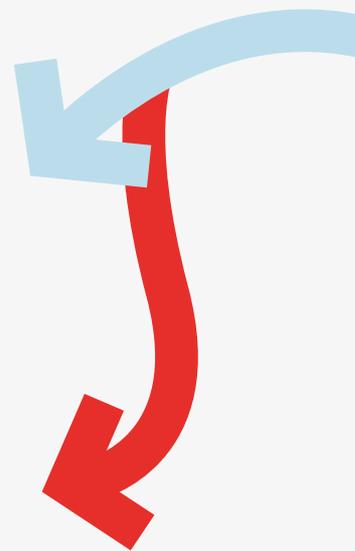**BritishRedCross**

Nowhere else to turn

Exploring high intensity use of Accident and Emergency services

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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 8).

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.

i Please see page 8 for the calculations behind this figure.

Contents

1.

About this report

1.1 Why explore high intensity use?

High intensity use of A&E is a significant challenge, not just in England but around the world, but it is one that the British Red Cross believes can be addressed.

We commissioned this research to shine a light on the issue of high intensity use and to bring together fresh insights from previously published literature and data, new data analysis conducted as part of this research and, crucially, the views of people who have experience of frequently attending A&E and the people who work most closely with them.

Our aim was to illustrate the scale of the issue but also to understand the drivers of high intensity use and to unpack what could be done to reduce the risk of people frequently attending A&E.

With reform to the structures of the NHS, the creation of Integrated Care Systems (ICSs)[2] and the commitment to move towards more personalised, integrated support in the NHS Long Term Plan, we believe there is a fresh opportunity for action in this area.

In bringing together services and funding across areas ICSs have an opportunity to take a lead in addressing high intensity use. ICSs have an explicit remit to go beyond addressing ill-health and to develop comprehensive strategies to proactively promote health and wellbeing. This approach could make a real difference to high intensity use, not just by improving access to the services and support that we know make a positive difference to people who frequently attend A&E, but also by working across sectors and across providers to fill the gaps in community-based support.

1.2 How we undertook this research

In January 2020 the British Red Cross commissioned The PSC (The Public Service Consultants) to conduct a mixed method research study on the high intensity use of A&E, with a focus on people with lived experience of frequently attending A&E services.

The research was focused on England, as – at the point of commissioning – HIU services were being rolled out across England only.

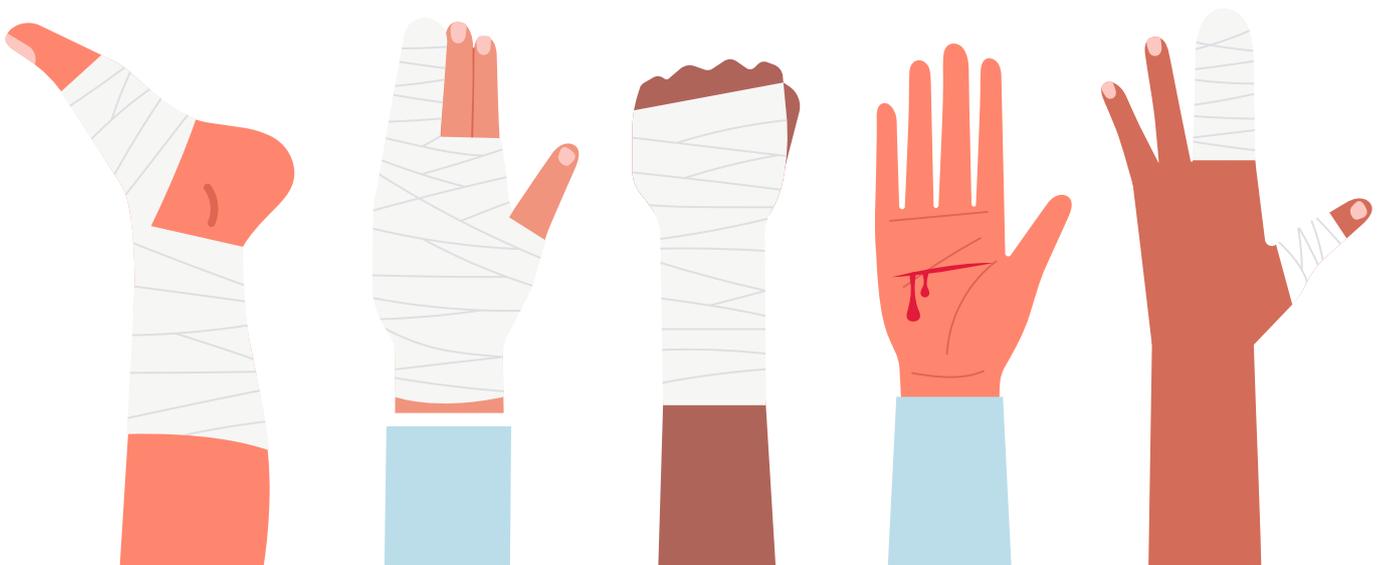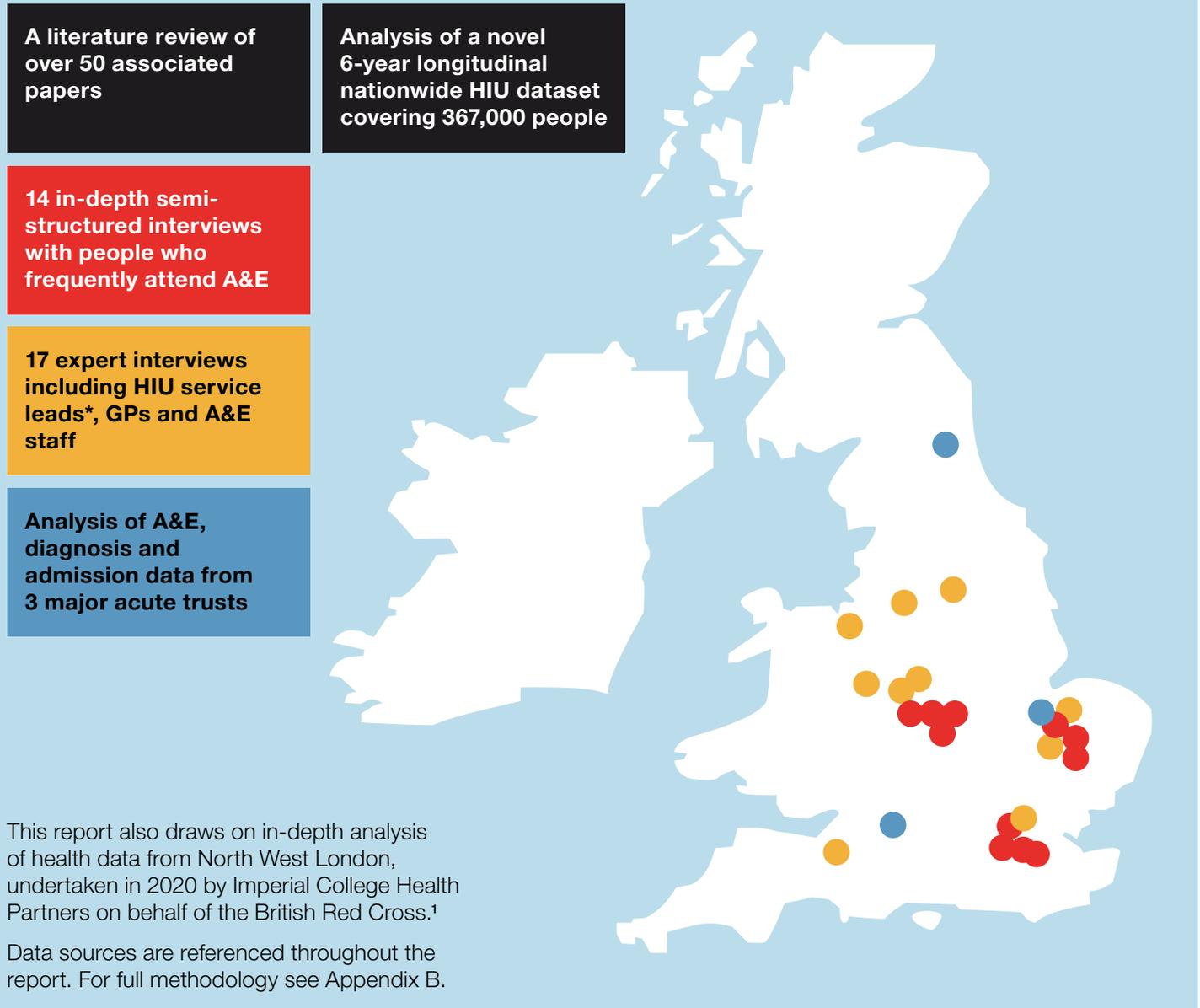Our research aimed to explore the following questions:

?

What are the demographic characteristics of people attending A&E regularly?

What triggers high intensity use of A&E services?

What patterns can we observe in people's patient journeys?

How could people attending A&E frequently be supported better?

Figure 1: Research methodology

> **A literature review of over 50 associated papers**

> **Analysis of a novel 6-year longitudinal nationwide HIU dataset covering 367,000 people**

> **14 in-depth semi-structured interviews with people who frequently attend A&E**

> **17 expert interviews including HIU service leads*, GPs and A&E staff**

> **Analysis of A&E, diagnosis and admission data from 3 major acute trusts**

This report also draws on in-depth analysis of health data from North West London, undertaken in 2020 by Imperial College Health Partners on behalf of the British Red Cross.[1]

Data sources are referenced throughout the report. For full methodology see Appendix B.

*See Section 8.3 for more information about HIU services and the role of HIU service leads.

Research during lockdown Fieldwork took place between March and November 2020, at the height of the Covid-19 outbreak. As a result, all qualitative research was undertaken over the phone and on a 1:1 basis.

All user stories have been pseudonymised and names and images are illustrative only.

1.3 Terminology

In this report we use the term 'high intensity use of A&E' to refer to the challenge faced by individuals and by health systems, and the term 'people who frequently attend A&E' to refer to individuals whose lives are affected by this issue. We use the term 'HIU service' to refer to the services that support individuals who frequently attend A&E, and which are built on the model first launched in Blackpool (for more information see Section 8.3).

We do not use the term 'high intensity users' or 'HIUs' to refer to individuals as we consider this to be unhelpful to the work to humanise people who frequently attend A&E.

2.

Introduction

Summary of key findings:

- While only 0.67 per cent of the English population attend A&E frequently, as a group they are significantly over-represented in emergency care, accounting for 16 per cent of all A&E attendances, 29 per cent of all ambulance journeys and 26 per cent of all hospital admissions in England.

- Our research estimates the cost to the NHS of the high intensity use of A&E to be £2.5bn per year.

- The mortality rate among people aged between 30 and 49 who frequently attend A&E is 7.5 times higher than among this age group in the general population.

- People who frequently attend A&E often feel unheard, leading to dissatisfaction and disengagement with health services more generally.

- Supporting people who frequently attend A&E would have a wide range of benefits, including improving people's life expectancy, quality of life and experience of care as well as reducing pressures on the healthcare system.

- Mortality rates are higher among people who frequently attend A&E than among the overall population of A&E attenders.

- The risk of mortality is highest among the younger members of this group. Those attending very frequently and with especially high levels of self-harm and suicidality are also especially vulnerable.

What does high intensity use of A&E mean?

High intensity use of A&E refers to use of emergency services such as ambulance services and Accident and Emergency (A&E) departments at above-average levels. Most commonly, it is defined as the same individual attending A&E five times or more in one year; this is the definition used in this report and for all the data analysis conducted.

2.1 High intensity use of A&E in England

There is evidence that high intensity use of A&E is a major challenge in many healthcare systems across the world, including the USA, Canada, Sweden, the UK and Ireland. People who attend A&E frequently tend to have unmet needs: they repeatedly seek help without finding a resolution, in the worst cases feeling dismissed and not listened to. High intensity use of A&E has a detrimental impact on individual wellbeing and is also inked to lower life expectancy. Finding ways to better support people who frequently attend A&E will therefore have a real and lasting impact.

There is also a clear benefit for the healthcare system in reducing the high intensity use of A&E. According to our analysis of Hospital Episode Statistics data (HES, source: NHS Digital), a total of 367,000 people attended A&E frequently across England in 2015[ii], making 2.6 million visits between them in that year and accounting for 16 per cent of all A&E visits.

In 2015, individuals who attended A&E frequently made between five and 346 visits throughout the year. The average attendance rate was seven per person. Although this group of people represented just 0.67 per cent[iii] of the English population, data from recent years has shown they represent a much greater proportion of service use across the pathway:

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ii The Hospital Episode Statistics analysed throughout this report focus on 2015 data, to allow us to distinguish between those who frequently attended A&E in the longer-term (up to three years before and after 2015), and those who attended frequently during one year only.

iii Total number of individuals who attended A&E at least five times across the total estimated English population in 2015, according to the ONS.

Figure 2: How those frequently attending A&E use services across the pathway

People who frequently attend A&E account for...

29%
of all
**Ambulance
arrivals at A&E**

26%
of all
**Emergency
admissions**

16%
of all
**Visits to
A&E**

A&E

2%
of all
**Inpatient
bed days**

Now more than ever, and particularly in light of the Covid-19 pandemic and growing waiting times for elective hospital care treatment, our health and care systems are under considerable strain. Beyond the inherent value in ensuring all patients are properly heard and treated, and their needs met, a system that leaves persistent symptoms unresolved will bear the weight of additional demand and cost.

People who frequently attend are more likely to be admitted to hospital than people who attend less frequently: those in the datasets across the three trusts in our study were admitted between 60 per cent and 72 per cent of the time, compared to 16 per cent of the time among the general population.[iv]

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

2,500,000,000

2.2 The cost of high intensity use of A&E

To estimate the cost to the NHS of high intensity use of A&E, we conducted an analysis based on the average costs of providing health and care services to patients. Understanding the costs of high intensity use can help support the case for action, demonstrating the potential for savings if people can be supported to reduce their use of acute services.

Assessing the cost

We first benchmarked data on patterns of frequent attendance (using hospital episode statistics (HES)) against publicly available national data on A&E attendances and admissions. This allowed us to see what proportion of people were frequently attending A&E compared to the wider population – across all attendances, admissions, hospital bed days and ambulance visits. We then used NHS reference costs and London Ambulance Service costs to calculate the costs of these activities, excluding excess bed days (see Appendix B for more information on our methodology). This leads us to the estimated annual cost of £2.5 billion.

This estimate is based on average service costs. While it does not take into account the more nuanced patterns of need and treatment among the cohort of people who frequently attend, this figure provides a good indication of the overall cost incurred as a result of high intensity use of A&E.

For a more accurate cost analysis, detailed mapping of the duration and cost of each service accessed by people who frequently attend A&E would be needed, which was not possible within the confines of this research project. More work is needed to understand the journeys and associated cost of high intensity use of A&E, as well as the costs and benefits of people moving into alternative pathways of support.

[iv] NHS England. 2018-2019. Hospital Accident and Emergency Activity. This year was selected for national benchmarking as it matched the period submitted by the trusts.
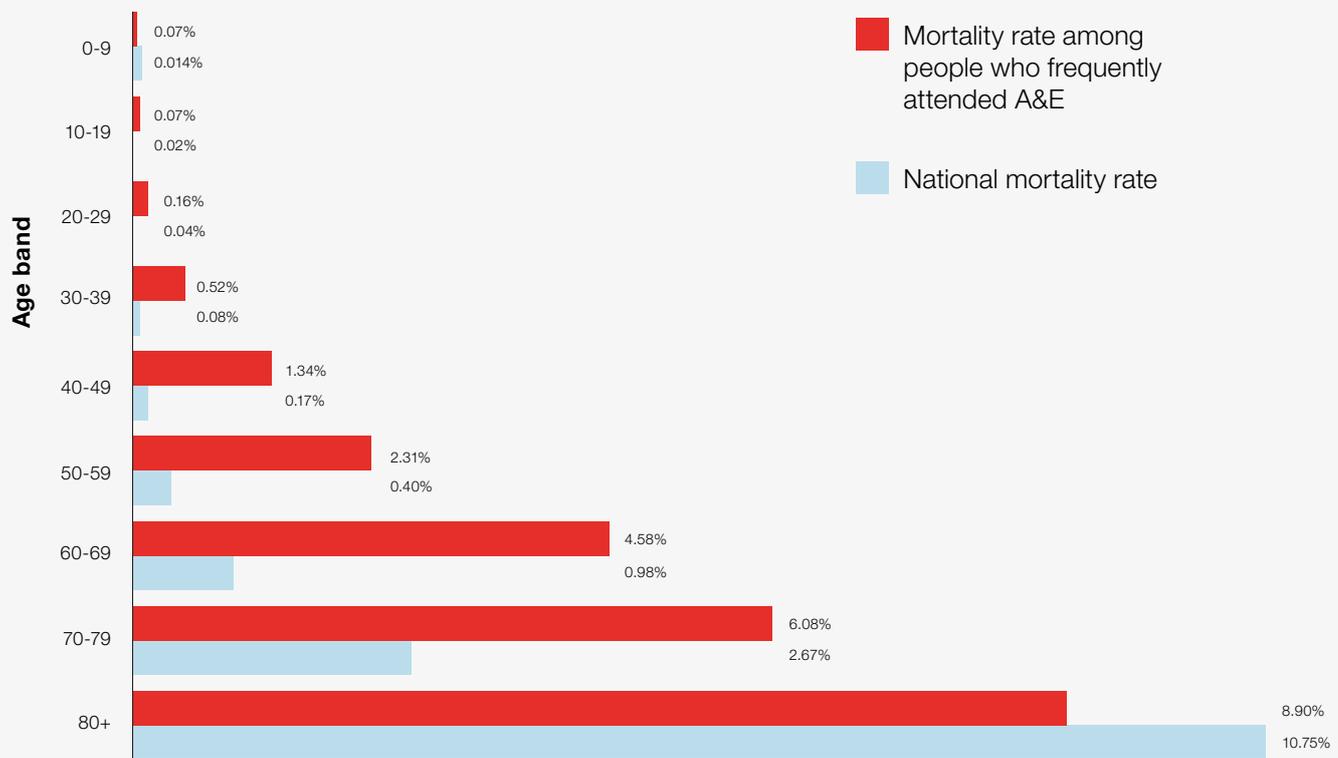
2.3 High intensity use of A&E and mortality

Our national-level analysis explores mortality across different age groups and levels of high intensity use of A&E (see Figure 3). Overall mortality rates among those who attend A&E frequently increase with age, mirroring the pattern in the wider population.[3] However, compared to the general population, middle-aged and younger people who regularly attend A&E are at the greatest risk, relative to their peers:

- The mortality rate in 2015 among people aged 30 to 49 who frequently attended A&E was higher than among this age group in the general population. This means people frequently attending A&E were 7.5 times more likely to die compared to the same age group in the general population.

- Those in the highest tier of high intensity use of A&E, visiting 16 or more times a year, had a mortality rate 1.5 to 1.9 times higher than those in the lowest tier, who visited between five and nine times a year, in each age band.

- In sharp contrast, people aged 80+ who frequently attended A&E that year had a lower mortality rate than the general population. Similarly, the mortality rate among those aged 60 and above who attended 16 or more times in 2015 was less than half that of those who attended between 5 and 9 times.

Figure 3: Mortality rates by age group (2015)

Legend:
- Mortality rate among people who frequently attended A&E
- National mortality rate

Age band	Mortality rate among people who frequently attended A&E	National mortality rate
0-9	0.07%	0.014%
10-19	0.07%	0.02%
20-29	0.16%	0.04%
30-39	0.52%	0.08%
40-49	1.34%	0.17%
50-59	2.31%	0.40%
60-69	4.58%	0.98%
70-79	6.08%	2.67%
80+	8.90%	10.75%

*Among those who frequently attend A&E, the mortality rate is calculated as the rate of deaths in each age group within a year of their visit to A&E. Among the general population, the mortality rate is calculated as the total rate of deaths per year in each age group.

As we go on to explore later in the report, high intensity use of A&E is closely associated with poor mental health (see Section 4), as well as deprivation and a range of other inequalities (see Section 3), all of which are linked to lower life expectancy. Our qualitative research suggests that increased mortality rates in the younger group could be a result of self-harm and suicide attempts. As the box below explores there are clear links between poor mental health and increased risk of mortality.

Poor mental health and mortality

Higher mortality rates among people who frequently attend A&E may be explained by the link between frequent attendance and poor mental health (explored in Section 3.4).

For more than 25 years studies have shown that people with mental ill health die younger than people without a mental health condition.[4] People with serious mental illness die on average 10 to 17 years earlier than the general population.[5]

The causes for this higher mortality are often linked to poor physical health. 46 per cent of people with a mental health condition are estimated to also have a long-term physical health condition.[6] People with mental ill health are known to have high rates of respiratory, circulatory and infectious disease. And they are more likely to die from these diseases. The death rate from respiratory disease and disease of the digestive system is four times higher for people with mental ill health compared to the general population, and from circulatory disease it is 2.5 times higher.[7]

Mental ill health does not occur in isolation. The following groups have been shown to have a higher risk of mental ill health[8]:

people from the most deprived areas	people from Black and minority ethnic groups	people living with physical disabilities	people living with learning disabilities
people with alcohol and/or drug dependence	prison population, offenders and victims of crime	lesbian, gay, bisexual and transgender (LGBT) people	carers	homeless people
refugees, people seeking asylum and stateless persons	children living in poverty	children with parents who have mental health or substance misuse problems	children in public care	adults with a history of violence or abuse

People who frequently attend A&E can have a multitude of the risk factors outlined above, which can compound their already complex mental and physical health issues.

Acknowledging physical health concerns alongside people's mental health and wider socio-economic issues is imperative if we want to address the inequality in mortality for people with mental ill health. A recent report by the Chief Medical Officer estimated that 60 per cent of these excess deaths can be prevented if the following risk factors can be addressed:

1. Poor lifestyle behaviours in people with mental ill health such as smoking, obesity, lack of physical activity, harmful alcohol and drug consumption and poor diet.

2. Poor access to physical healthcare services

3. Treatment of mental health conditions in isolation of other physical health concerns. heard in our interviews with professionals.[9]

3.

Who frequently attends A&E and what drives high intensity use?

While the range of drivers behind the high intensity use of A&E is very broad, there are certain demographic and socioeconomic characteristics that precipitate a specific pattern of A&E attendance. These include deprivation, age, health conditions and housing insecurity.

Summary of key findings:

- **Demography** The most common age groups to attend A&E frequently are those aged 20 to 29 and 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 close to hospitals, and in areas that are deprived and urban.

- **Housing insecurity** People who attend A&E frequently are estimated to move homes at least 25 per cent more often than the general population.

- **Criminality** Some studies and interviewees reported that 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. 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.

- **Poor physical and mental health** There is a strong relationship between poor physical and mental health and the high intensity use of A&E. Broadly, poor physical health more than doubles the likelihood of the high intensity use of A&E. Our analysis also shows that people with a pre-existing mental health diagnosis are likely to attend A&E services more frequently than people without. Individuals who attend A&E frequently are often dissatisfied with the treatment and diagnosis they receive, leading to further A&E visits.

- **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).

- **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.
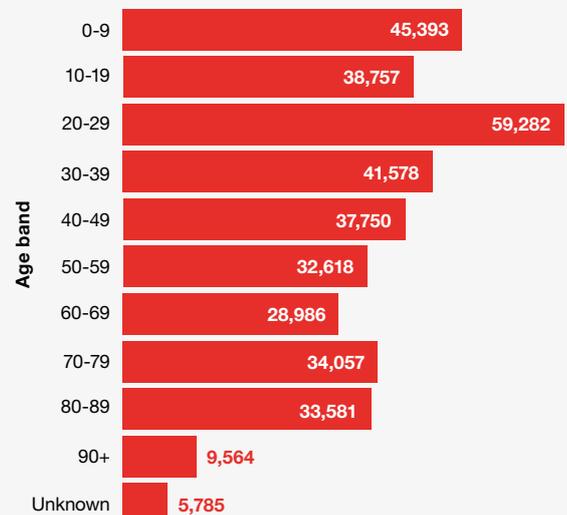
3.1 Demography

3.1.1. Age

People of all age groups attend A&E frequently (Figure 4). However, two age groups stand out in our analysis. A younger cohort, typically aged between 20 and 29, made up 16.1 per cent of those who had attended frequently in the national dataset for 2015. This is a large and important group, however this age group also makes up a similar proportion of the overall A&E-attending population. This is also in line with the general population in England.

The rate of frequent attendance at A&E tends to decline with increasing age, however this increases again among the age groups of 70 to 79 (9.3 per cent) and 80 to 89 (9.1 per cent). These older age groups are over-represented as compared to the proportion of the general population that they make up.[v] However, these proportions are in line with the wider A&E-attending population.[vi]

Figure 4: Number of people frequently attending A&E by age group (2015)
(n=367,351)

Age band	Number
0-9	45,393
10-19	38,757
20-29	59,282
30-39	41,578
40-49	37,750
50-59	32,618
60-69	28,986
70-79	34,057
80-89	33,581
90+	9,564
Unknown	5,785

[v] ONS. 2016. Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2015.

[vi] NHS England. 2016. Hospital Accident and Emergency Activity - 2015-16. (This year was selected for national benchmarking as it matched the period in the national HES data)

Experts on the high intensity use of A&E described differences between these two age subsets and the ways in which they present at A&E. For the older subset of our interviewees, the themes of social isolation and loneliness were prominent. On the other hand, the younger cohort was largely thought to be composed of individuals who commonly experience health anxieties with underlying mental health conditions such as depression and low self-esteem.

While these reports from experts are valuable, we should also be attuned to potential biases in perception around certain social groups (e.g. older people being more lonely than younger people).

3.1.2 Sex

The relationship between sex and the high intensity use of A&E varies heavily across different studies. While many studies in the UK have found a high proportion of people who frequently attend A&E are men, the national HES[vii] dataset tells a different story, with this sample showing an equal balance between women (51 per cent) and men (49 per cent), and no evidence that sex is a significant driver of high intensity use. The equal split of men and women in the cohort of people who frequently attend remains consistent, even where the number of attendances at A&E in a year is very high.

Some studies, including our analysis of North West London data, have shown that a sub-cohort of individuals attending A&E more than 16 times a year are more likely to be men. These differences may therefore be down to population differences, including regional variation. This area merits further exploration.

3.1.3 Ethnicity

The literature is inconclusive on the relationship between ethnicity and the high intensity use of A&E, largely because of a lack of quality data. While ethnicity was included in the national data analysed, it is likely to have a high error rate as it is commonly recorded by staff rather than being specified by the individual attending A&E. Only 50 per cent of those in the national HES dataset who had frequently attended A&E were consistently recorded as being of the same ethnicity. This is most likely to be attributed to classification errors in hospital records, which have been found to occur frequently across NHS trusts for ethnic minorities.[10]

While the findings around ethnicity in this study are not conclusive, our analysis focusing on North West London found that Black or Black British people were 1.3 times more likely to visit A&E frequently, the highest rate of all ethnic groups. People from an Asian/Asian British background, on the other hand, were less likely to attend A&E frequently compared to those who were White.

Without better quality data and further analysis it is not yet possible to know whether these disparities are due to regional differences or data quality issues. It should be a priority for health bodies and HIU services to collect better data around ethnicity and the high intensity use of A&E.

3.2. Geography

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.
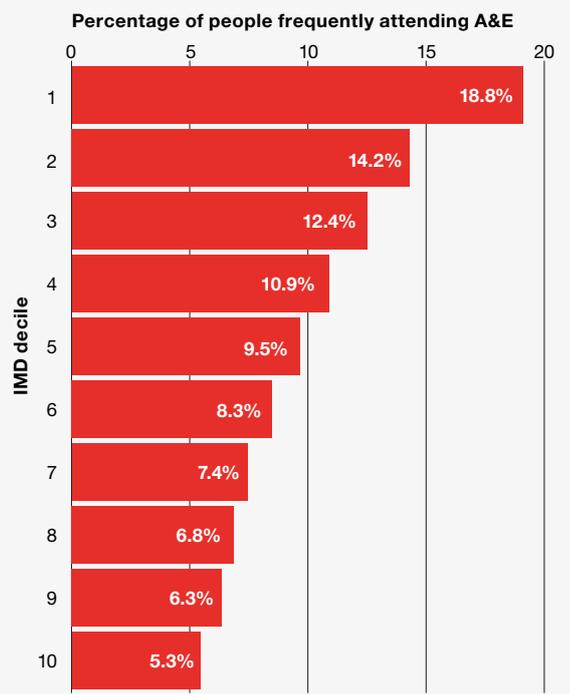
Information on where those frequently attending A&E live provides us with insight into the socioeconomic factors related to the high intensity use of A&E.

3.2.1. Geographical location

Our national HES dataset shows that people who frequently attend A&E are disproportionately likely to live in areas with higher levels of deprivation (based on the standardised measure of deprivation, the Index of Multiple Deprivation or IMD) with 20 per cent living in the most deprived areas (IMD band 1 of 10). Figure 5 shows the distribution of people visiting A&E frequently across each IMD decile.

The IMD decile is determined based on residency (at the lower super output area (LSOA) level). Individuals whose LSOA area changed during the period 2012–2019 have been omitted from the dataset so as not to double-count.
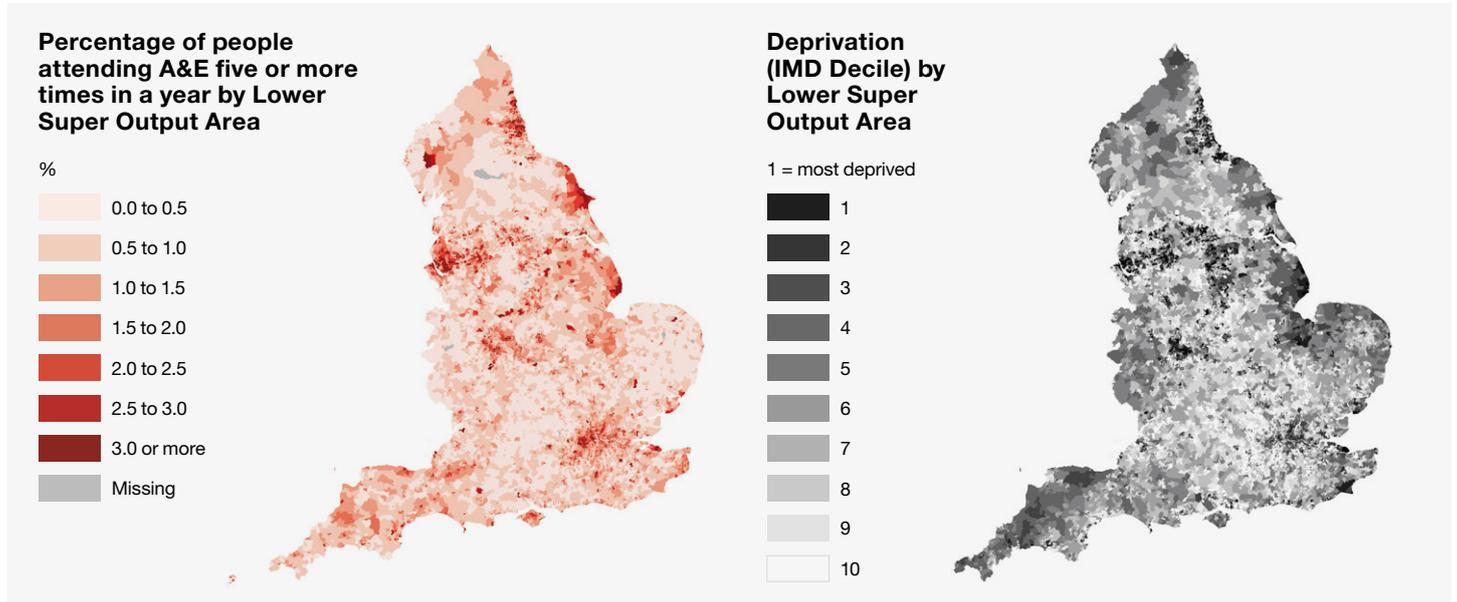
Figure 5: Percentage of frequently attending cohort in each IMD decile, where 1 is the most deprived decile (2012 - 2019 inclusive) (n=367,351)

Percentage of people frequently attending A&E

IMD decile	Percentage
1	18.8%
2	14.2%
3	12.4%
4	10.9%
5	9.5%
6	8.3%
7	7.4%
8	6.8%
9	6.3%
10	5.3%

[vii] Hospital Episode Statistics (HES) is a database containing details of all admissions, A&E attendances and outpatient appointments at NHS hospitals in England.

The maps below (Figure 6) also show a marked similarity between the poorest parts of the country and those with the highest concentrations of individuals attending A&E frequently.

Figure 6: Geographical distribution of the number of people attending A&E 5 times or more in a year, and deprivation by IMD decile (2015)
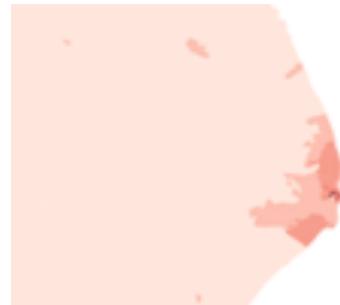

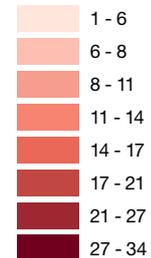Percentage of people attending A&E five or more times in a year by Lower Super Output Area

%
- 0.0 to 0.5
- 0.5 to 1.0
- 1.0 to 1.5
- 1.5 to 2.0
- 2.0 to 2.5
- 2.5 to 3.0
- 3.0 or more
- Missing

Deprivation (IMD Decile) by Lower Super Output Area

1 = most deprived
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

London   **Liverpool**   **Lincoln & Skegness**

Key: % of the population that attended A&E 5 or more times in a year
- 1 - 6
- 6 - 8
- 8 - 11
- 11 - 14
- 14 - 17
- 17 - 21
- 21 - 27
- 27 - 34

These findings are also seen in other studies using alternative indicators of deprivation, such as family income levels[11], value of personal resources[12], and reliance on state benefits and/ or pensions.[13] Overall, higher levels of deprivation are associated with greater levels of high intensity use of A&E in many healthcare systems around the world.[14]

An Irish study of 20 people that had attended A&E frequently found they were all unemployed.[15] In our qualitative sample of 14 people, 13 were unemployed or retired and several spoke about being in receipt of state benefits and/or having financial problems.

Another key factor is the rural and urban classification of areas. Our national HES data analysis revealed that 91 per cent of those making frequent visits to A&E lived in an urban area compared to 83 per cent of the general population.[viii] While this is significant, it may be driven by the fact that urban areas tend to be more socioeconomically deprived, rather than by the impact of a rural or urban setting alone.

That said, looking at wealth combined with rural versus urban living areas shows some interesting patterns. Levels of deprivation among the cohort of people who frequently attend A&E tend to differ between cities and rural areas.

For example, three quarters of those who live in urban areas (73 per cent) are in the most deprived half of the population (IMD deciles 1 to 5), while only two in five of those who live in rural areas (41 per cent) are in the most deprived half of the population. Those living in more rural areas are not only more well-off, but they are also likely to be older. This suggests that there is

viii DEFRA. 2015. Rural Population 2014-15. (Dataset selected as closest available to that analysed through the 2015 HES dataset)

one cohort of older and wealthier people living in the countryside, whose high intensity use of A&E is likely to be driven by different factors and who may face different challenges compared to the poorer and younger individuals living in cities. Anecdotally, there is a belief that the high frequency use of older, more well-off individuals, may be a result of a lack of local services, in contrast to the physical and psychological factors that are thought to drive A&E attendance among younger and less well-off individuals living in cities.

Proximity to A&E has been found to be another strong predictor of the high intensity use of A&E, with the addresses of those attending frequently tending to cluster near hospitals.[16][17] However, this pattern varies with age, with the average distance travelled to A&E being shorter for those aged 65 or above in comparison to younger people attending frequently.[18] Our analysis of patient data from one NHS trust also showed that two fifths of people visiting their A&E frequently (41 per cent) lived within 10km. While this figure is not available for the general English population, data published in 2018 by the Department for Transport suggested that only 30 per cent of the population live within a 15-minute drive of a hospital[ix], which would indicate that people attending A&E frequently do live closer than average. There is insufficient evidence to conclude why proximity is a driving factor of frequent usage, but it may be a question of familiarity or convenience.

The national data also revealed some hotspots for the high intensity use of A&E. There were 21 LSOAs where over 10 per cent of the population was recorded as having attended A&E more than five times in a year (see three examples above in Figure 6). 19 of these areas were in the lowest IMD band; all were urban; and all were in or adjacent to hospital-containing LSOAs. The area with the highest rate of high intensity use of A&E also had a prison located next to the hospital. These areas warrant further local investigation to understand what is driving such high rates of high intensity use of A&E, and whether they would benefit from having targeted or specialised HIU services in the future.

The wider determinants of health

The wider determinants of health (also known as social determinants) are a diverse range of social, economic, and environmental factors which influence people's health outcomes, these include[19]:

Family, friends, and communities (social connection)	Money and resources	Housing	Education and skills
Good work	Transport	Surroundings (built environment)	Food	Exposure to crime, violence, and social disorder (public safety)

A growing body of research, including the Marmot Review[20], has found that wider determinants can have a greater influence on health than health care, behaviours, and genetics. The World Health Organization reports that the social determinants of health account for between 30 and 55 per cent of health outcomes within the population.[21]

[ix] Department for Transport. 2018. Journey Time Statistics.

3.2.2. Frequency of moving home

We estimate that people attending A&E frequently move homes at least 25 per cent more often than the general population.[x] As the number of registered addresses a person has increases, so too does the intensity of their use of A&E. Those attending more than 16 times a year are significantly more likely to have changed address at least once in the previous five years (70 per cent), compared to those attending between 5 and 10 times in a year (48 per cent). Those with the highest number of address changes in a five-year period are over-represented among those in the highest tier of frequent usage, with a predictive value that was 16 times more powerful than the next most important socioeconomic variables, including age and urban/rural setting.

This again has links to deprivation, but frequent moving may also be connected to other factors that could drive the high intensity use of A&E. For example, the challenges of registering with a GP[22] in a new area or, as described by a number of our interviewees, the loss of close support networks. There are also related issues that can lead to housing insecurity in the first place, such as having to leave home at a young age, being a care leaver and living in temporary transitional accommodation, relationship breakdown, and problems with neighbours.

In addition, research has shown that individuals who frequently move home are more likely to report poorer mental health when compared to those who do not[23], with this being particularly prevalent among people who move home during childhood and adolescence. This is thought to be linked to weakened social ties, disturbance of social networks, household disruption and social isolation.[24] Moving to a new house is considered a highly stressful event, which involves navigating new networks and processes, including access to healthcare services, a lack of information about local services, and a lack of trust (as well as a feeling that one needs to re-share their story). For people who move especially frequently this stress, and the erosion of social support networks is likely to be heightened and may explain the high intensity use of A&E.

Figure 7 shows the extent to which the five strongest socioeconomic variables were predictive of the three key outcomes: frequency of attendance; recurrent periods of frequent A&E attendance; and high intensity use of A&E over the long term. The numbers and shading in the grid reflect the relative importance of each variable and capture the proportional difference in their predictive values. The figure also shows that some factors positively correlated with the high intensity use of A&E, as well as the recurrence and intensity of A&E attendance. This means for example that the more often a person changed addresses, the more likely they were to frequently attend A&E, and the more likely they were to do so over the longer term and at a higher frequency. However, there was a negative correlation between frequent attendance and the number of GP practices a person had been registered at, as well as the safety rating at their GP practice. This means that the fewer GPs a person has been registered with, and the lower their GP's public rating in terms of safety, the more likely they are to frequently attend A&E.

---

[x] See Appendix B for benchmarking methodology.

Figure 7: The association between socioeconomic variables and three key outcomes

	High intensity use of A&E	Recurrence of high intensity use	High intensity use over the long term
Number of registered addresses	50.6	21.8	67.1
Frequency of attendance in 2015			59.3
Number of ethnicities coded	3.1	2	3
Number of registered GP	-2.4		
Age band	0.6		
Urban / rural classification		0.1	0.1
GP practice rating for safety		-0.1	-0.2
Sex		0.1	
GP practice rating for effectiveness	-0.2		

= *Positive correlation*

= *Negative correlation*

Darker shading indicates a stronger association of factors. The closer the number is to 0, the weaker the relationship between the two variables The further the number is from 0, the stronger the relationship between the two variables.

Homelessness and rough sleeping

While only a small number of those we interviewed had experienced homelessness or slept rough, other studies have found that homelessness is associated with a significantly higher rate of emergency service use (for example, Ramasubbu et al., 2016).

People who experience homelessness in England are 60 times more likely to visit A&E in a year compared with the general population.[25] The reasons for this are complex and are underpinned by poor health outcomes and significant inequality for people experiencing homelessness. People living in dangerous conditions, such as squats or on the street are more likely to have lifestyles that can cause long-term health problems or exacerbate existing issues – 73 per cent of people experiencing homelessness suffer from a physical health problem and 80 per cent from a mental health problem.[26]

Pathway, a healthcare charity supporting people experiencing homelessness, reports that homeless people "attend A&E six times as often as housed people and are admitted to hospital four times as often and stay twice as long, largely because they are two to three times sicker when they arrive."[27] Homeless people often delay seeking medical help, going to A&E only once their health has deteriorated to the point of emergency and when they feel they have no other option.[28]

The experts we interviewed observed that the most common combination of characteristics that they see in individuals who attend A&E frequently is homelessness and drug use. Rough sleepers often lack a stable place to sleep and get food, especially during the winter season, which can also lead to A&E attendance. As well as homelessness impacting on health outcomes, the opposite is also true: unmet health needs can put a person at a higher risk of becoming homeless. Research from Groundswell shows that 54 per cent of people who are homeless feel that physical and mental health conditions and/or addiction contributed to them becoming homeless.[29]

Homeless people are also significantly more likely not to be registered with a GP compared to the general population. There are a range of possible reasons for this, including stigma and a misconception that you need a fixed address to register. For homeless people who are registered with a GP, frequent movement may also mean their surgery is no longer easy to access. This may mean that preventable healthcare needs are not treated in a timely fashion and can reach crisis point, again increasing the likelihood of A&E attendance.[30]

Many homeless people report experiencing discrimination from GPs and within GP practices[31], which may mean they feel less able to access primary care and are more likely to attend A&E. Research from the King's Fund[32] suggests that people may view A&E as a more neutral environment, when compared to other health settings; people can attend without an appointment, at any time of day and can feel more anonymous. A&E may also represent a safe and warm space, which provides a short-term escape from poor housing or rough sleeping. This may mean that for some people experiencing homelessness, A&E presents a more welcoming environment than other healthcare settings.[33]

Unfortunately, there is no consistent way of recording homelessness or rough sleeping within current standard NHS datasets[34], meaning the scale of this issue cannot be accurately predicted within the confines of this research.

3.3. Factors related to offending and time spent in prison

Several experts that we interviewed identified crime and time in prison as being linked to the high intensity use of A&E. A study in the US also found that recent parole, probation and arrest were all independent predictors of high emergency service use.[35] This may be driven by the fact that ex-prisoners often experience a significantly increased risk of medical issues upon re-entering communities.[36]

"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

Another driver of high intensity use is that one in seven people leaving prison are homeless upon their release[37] (see box above).

One of the HIU service leads to whom we spoke explained that the majority of their caseload had criminal records, and some had been in prison. This expert noted that such experiences were commonly combined with mental health or substance abuse issues. HIU service leads also told us that domestic violence was a significant factor for people they worked with, describing individuals they had worked with as both victims and perpetrators of domestic violence.

3.4 Mental and physical health conditions

Our research shows that high intensity use of A&E is closely associated with 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, across many studies. Generally, poor physical health more than doubles the likelihood of the high intensity use of A&E.[38] A mental health diagnosis also increases the likelihood of high intensity use[39], and our own analysis of data from North West London showed people who frequently attend A&E to be 11 times more likely to have a pre-existing mental health diagnosis; this increased to 26 times more likely among those who attend A&E 16 or more times in one year. Our analysis of national-level data also shows that people who attend A&E services for a longer period of time, and more frequently, are significantly more likely to receive a primary diagnosis relating to mental health.

3.4.1 Physical health

As seen in Section 2.1, people who frequently attend A&E are much more likely to be admitted than the general A&E attending population, and Section 4.2 identifies a range of primary diagnoses common among people whose use of A&E is high, such as gastro and respiratory issues, and cardiac and vascular conditions. According to analysis conducted with Imperial College Health Partners in North West London as part of this research, dementia, palliative care, heart failure, epilepsy, learning disability and osteoporosis are common features in the long-term care records of people who have attended A&E frequently. The research 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 (this is often referred to 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

This pattern was also reflected among several of our interviewees who had frequently attended A&E and often had multiple long-term physical health conditions. Several older interviewees reported diabetes and chronic pain, sometimes resulting from past operations.

Multiple long-term physical conditions and A&E attendance

Over half of all visits to A&E involve at least one long-term physical condition. These most commonly include[40]:

Arthritis	Back pain	Chronic obstructive pulmonary disease (COPD)	Diabetes	Angina

A House of Commons Health Committee report (2014) presents this figure as even higher, with 68 per cent of presentations at A&E linked to a long-term physical health condition and accounting for 77 per cent of inpatient hospital stays.[41]

Despite physical symptoms, participants in this research reported that acute services commonly struggle to identify and treat the underlying needs of patients who attend A&E regularly with persistent medically unexplainable pain (often termed 'functional' pain). These symptoms commonly include chest pain, back pain, headaches, gastro-intestinal complaints, and neurological symptoms.

Challenges in diagnosing the cause of these conditions is often compounded by psychological factors and while these physical symptoms are not 'harmful' to health in a clearly diagnosable sense they are disabling and distressing and can fuel ongoing cycles of emotional and physical symptoms.

3.4.2 Mental health

HIU service leads who build long-term relationships with people frequently attending A&E often see their issues in a different light from mainstream medical staff who tend to focus primarily on physical health. They describe a complex interaction between adversity, mental health and in some cases substance abuse issues, alongside physical health needs.

HIU service leads take a holistic view of the complex life journeys that underlie the high intensity use of A&E. Beyond a patient's physical health, these experts also observe common patterns around their clients' mental health and wellbeing, which sometimes manifest in diagnoses of personality disorders or substance abuse. These can often be linked back to adverse childhood experiences and a lack of fundamental support systems (although these experiences and their connections to an individual's high intensity use are rarely brought up by the service users themselves). All but two of the interviewees who had frequently attended A&E said they had mental health diagnoses, but none described these as the primary driver for their high intensity use.

Those attending A&E frequently often feel they have urgent physical conditions that need to be treated, as opposed to mental health needs. Some might benefit from support to understand the possible connections between their mental and physical health.

Links between physical & mental health

Research from the King's Fund highlights the complex relationship between physical and mental health conditions, estimating that 4.5 million people in England are affected by this type of multimorbidity.[42] The report demonstrates that this group experiences worse health outcomes as a result of their multimorbidity and that people with severe mental illness have far worse health outcomes because their physical health needs are often unaddressed.

Research from the Nuffield Trust supports these findings in its analysis of A&E attendance.[43] People with a mental health diagnosis attend A&E services more often than people without one, and most of these A&E attendances are related to their physical rather than mental health needs.

3.4.3 Adverse childhood experiences

Childhood adversity was a common theme in the interviews we conducted, though for similar reasons to those seen above, experts and people who frequently attend themselves viewed these experiences differently.

> **"I didn't have the best of starts. My mum had a drinking problem, and her partner was abusive, so I was on my own by the time I was 16. I wasn't very wise to the world at that age. Because of my childhood I have depression, suicidal thoughts, and can't deal with conflict."**
>
> **Alex, in his 20s**

> **"There was abuse when I was a child and all my problems stem from that."**
>
> **Vicky, in her 50s**

> **"I was very lonely as a child, bullied at school and at home."**
>
> **Bianca, in her 60s**

Experts viewed adverse childhood experiences as an underlying factor for a wide range of problems seen on the surface, such as substance-misuse issues and mental health conditions. HIU service leads in particular observed that the high intensity use of A&E is also linked to having spent time in care. According to some of the experts interviewed, younger people who have been involved with social services in the preceding decade are at a greater risk of attending A&E more frequently. A lack of social or family support can result in people turning to formal services, including A&E, as a way of eliciting care.

While the people we interviewed who had attended A&E frequently also often referenced adverse childhood experiences, they didn't see this as a direct cause of their later usage of health services.

3.4.4 Personality disorders

Diagnoses of personality disorders were common among many of those we interviewed with a history of high intensity use of A&E, as well as the cases we discussed with HIU service leads. Several specific diagnoses were referenced, including emotionally unstable personality disorder and borderline personality disorder. High intensity use of A&E may result from the strategies that people with personality disorders have for eliciting care or social interaction. For instance, it has been estimated that 65 to 80 per cent of people with borderline personality disorder also show signs of 'Non-Suicidal Self Injury'[44]: this can be used as a way of gaining a greater sense of control over their lives, as well as having a social function of obtaining care from a loved one or even a stranger.[45]

People with personality disorders tend to receive short bursts of treatment (e.g. Cognitive Behavioural Therapy), which are not as sustained or holistic as needed. This results in them turning to A&E for care – "the one place that can't say no", as one HIU service lead put it. HIU service leads said that those with personality disorders are sometimes seen by service providers as wanting to "seek attention" or "prove services wrong", which can fracture relationships and cause communication to break down. This makes it especially important for someone with a sympathetic ear to take the time to listen to and understand such patients coming into A&E.

People who frequently attend A&E services with a personality disorder diagnosis also often struggle with depression, anxiety and suicidality. As we will see in Section 3.5.2, high-risk individuals with severe mental health presentations often have several psychological diagnoses.

> **"Personality disorders come from childhood trauma and having to learn unhealthy strategies to get the care you need. You learn those behaviours for your whole childhood, so it takes just as long to un-learn those behaviours that don't help you in adult life."**
>
> **HIU service lead**

"I used to self-harm because I was taking so many medications."

Case study: Michaela, in her 20s

Michaela lives with her partner and pets. She has a limited social network, and spends most of her time at home. She interacts with her neighbours occasionally, but does not have close family as both of her parents passed away a few years ago.

She experiences a range of psychological difficulties, including severe and long episodes of depression and anxiety, which have previously led to suicide attempts. She also has a diagnosis of borderline personality disorder.

She struggles with unpredictable emotional ups and downs and finds it very difficult to understand what they are and how to express them to others, which has also prompted her to self-harm. She attributes these ups and downs and intense episodes to the heavy dose of psychiatric medication she has been prescribed.

Michaela started to attend A&E frequently to manage these episodes. However, she was flagged by services as a high-risk patient due to her self-harm and previous suicide attempts. This led to a few incidents where she had been taken to A&E unwillingly by the police or ambulance services for safeguarding reasons, and also sectioned under the Mental Health Act.

She has been seen by various mental health professionals and currently sees a Dialectical Behaviour Therapy (DBT) therapist. However, she does not feel well-understood or supported; her difficult experience of having been prescribed very high doses of medication in the past has made it more difficult to establish trusting relationships.

"I don't want to go waste my time as well as their time, because I know what they're going to say."

Michaela was able to regain a sense of control over her medication regime through a trusting relationship with her GP, which became a key aspect of her subsequent reduction in A&E visits. We explore more of Michaela's story in Section 8.3.

"All of a sudden, my emotions would change. My past experience would sometimes trigger it. I used to self-harm because I was taking so many medications."

"I felt like [the mental health worker] wasn't listening to me."

Michaela
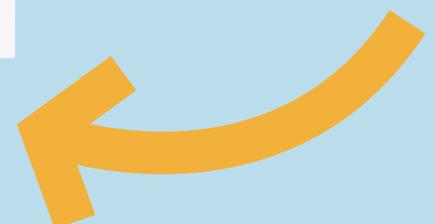
3.4.5 Substance abuse

"The driver to their drinking is something in the past, but never dealt with."

HIU service lead

Another factor frequently linked in our expert interviews to the high intensity use of A&E was substance abuse, including heavy drinking. In most cases, much like the high intensity use of A&E itself, this is linked to complex underlying issues and traumatic experiences from a person's past.

HIU service leads observed that mental health services often struggle to support people with substance abuse problems. One said that mental health services were often hesitant to take on these individuals, who were, in turn, often hesitant to engage with them. Besides any preconceptions practitioners may have around treating people who abuse substances, there are also practical challenges in treating this group, as it is very difficult to make an accurate medical assessment of a patient who is heavily intoxicated.

Another HIU service lead felt that traditional mental health services were limited in addressing some of these more entrenched difficulties and behaviours. She explained that she had moved from her previous role in a psychiatric service to her current role as an HIU service lead in order to "look at the person underneath". See Section 8.3 to read more on how HIU services support the whole person.

"A person is a person at the end of the day. The reasons people attend A&E are actually quite logical."

HIU service lead
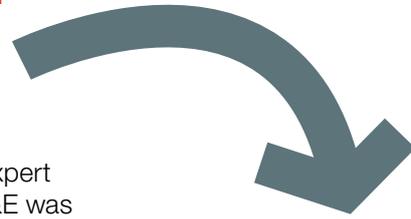
Substance abuse often occurs alongside other mental health conditions or diagnoses. People who have dual or multiple mental health diagnoses are known to be particularly vulnerable to poor health, poor self-care, increased suicide risk, aggression, incarceration, and poor medication compliance.[46]

However, as one HIU service lead cautioned, it is important not to reduce people who frequently attend A&E to their mental health diagnoses. Experts argued that successful support for people who frequently attend A&E necessitates treating them as complex, multifaceted human beings with a valuable perspective on their own experiences. People often seek support because they have complex needs that are not being met. We explore the experience and perspectives of people who frequently attend A&E in more detail in Section 4 and Section 6.

Our qualitative research suggests that people who attend A&E more frequently and who have underlying mental health, substance abuse or overdose issues may be perceived as having less of a medical need. As we explore in the next section, while this group is over-represented among people who frequently attend A&E, they are less likely to be admitted. When patients feel dissatisfied with these outcomes, it can exacerbate a negative feedback loop of service use, as illustrated in Figure 8 below.

Figure 8: The negative feedback loop. The cycle of negative experiences, concerns and belief systems that lead to high intensity use of A&E

"No one can help me"

Pessimistic beliefs are reinforced by mental health issues, low mood, or inability to cope

"I need to go back to A&E"

The dissatisfaction prompts them to make another visit to get a better explanation for their presentations

"They won't help me"

A&E

A person's belief system prompts them to develop negative expectations of their anticipated A&E encounters

"They didn't listen to me"

People feel dissatisfied by the service and outcome of their A&E visit

3.5 Incidence of poor mental health, substance abuse and overdose

3.5.1 Attending more frequently and for longer periods of time

Analysis of data from three hospital trusts showed that the likelihood of receiving a mental health, substance abuse or overdose-related diagnosis was higher among people attending A&E more frequently in a year and among those attending frequently over the longer term.

The incidence of mental health and substance abuse-related primary A&E diagnoses increases the more frequently people attend A&E departments. As shown in Figure 9 below, the likelihood of receiving these diagnoses was significantly higher for those in the highest tier of high intensity use of A&E, who attended 16 or more times in a year, compared to those in the lowest tier, who attended between 5 and 9 times a year. This is applicable to all age groups.

The likelihood of these diagnoses increases with the number of years for which someone's high intensity use of A&E continues. Those who continued to attend A&E frequently for more than a year were much more likely to receive a mental health, substance abuse or overdose-related diagnosis than those who attended frequently for only one year. Several of the people we interviewed with complex histories and multiple previous periods of intense usage fell into this category.

These findings are in line with findings from the Nuffield Trust which showed that people with mental ill health use emergency services more than people without a mental health condition.[47] This research also found that people with mental ill health accessed less planned patient care than people without.

3.5.2 Dual diagnosis

Our quantitative analysis also shows that people who have a primary diagnosis relating to mental health, overdose or substance abuse are significantly more likely to get a dual diagnosis with another such condition.

Although the majority of people who frequently attend A&E receive none of these diagnoses, those who do are very likely to also receive another one of these diagnoses compared to those who have none. For example, the incidence of a mental health diagnosis among those without a substance abuse-related diagnosis was 19 per cent, whereas for those with a substance abuse-related diagnosis it was 48.9 per cent (or 2.6 times higher). This indicates that people who attend A&E frequently, especially those who attend A&E most frequently, are likely to have multiple overlapping and complex medical drivers.

While a dual diagnosis of mental health and substance abuse issues was seen in 5.7 per cent of all those who frequently attend captured in this dataset, this figure is likely to be an underestimate of the true scale of this comorbidity, as it is based only on the primary diagnosis received in A&E settings and, as seen above, this may not always be complete.

3.5.3 Lower levels of hospital admission

As well as being likely to appear more regularly at A&E and over longer periods of time, those who have a primary diagnosis related to mental health, substance abuse or overdose are significantly less likely to be admitted than those who do not receive this diagnosis.

For example, admission rates for those with a mental health diagnosis was 45 per cent, compared to 62 per cent among those without a mental health diagnosis. Those in the highest tier of high intensity use of A&E are also around a third less likely (38 per cent) than those in the lowest tier (60 per cent) to be admitted.

These patterns of how admission decisions are made may reflect how medical providers assess patients' medical needs differently across subsets of people who attend A&E frequently. This area merits much further exploration, particularly in comparing these patterns against people who frequently attend A&E in other geographical locations across the UK, as well as the general population.

Figure 9: Likelihood of diagnoses across sub-cohorts of people frequently attending A&E

	Mental health diagnosis	Overdose diagnosis	Substance abuse diagnosis
Proportion of all people attending A&E 5+ times a year	**22%**	**15%**	**12%**
People visiting A&E 16+ times a year are...	**4.5 X** more likely	**4.7 X** more likely	**6.5 X** more likely

...to receive each diagnosis than someone attending A&E abetween 5 and 9 times a year

	Mental health diagnosis	Overdose diagnosis	Substance abuse diagnosis
People who frequently attend in the long term are...	**2.3 X** more likely	**2.9 X** more likely	**4.7 X** more likely

...to receive each diagnosis than someone attending for up to one year

"I was drinking so much that I couldn't remember, but I was doing silly things. It was a cry for help."

Case study: Zach, in his 30s

The distress Zach experienced when his son became seriously ill caused him to start attending A&E frequently. When the doctors said his son might not make it, Zach "hit rock bottom".

Zach had a challenging start in life and left home at 15, meaning he had to "grow up quickly". He attempted suicide when he was 18 and was diagnosed with depression. He's now been diagnosed with Emotionally Unstable Personality Disorder, which professionals have suggested could be due to childhood trauma. He developed a dependence on alcohol in early adulthood, but stopped drinking when his son was born.

However, when his son got ill, Zach started drinking heavily again and was blacking out.

During this period Zach was self-harming, which led to hospital visits. He was also involved in a dispute which led to him being incarcerated. His time in prison was particularly challenging as it took place during the Covid-19 pandemic, but he used the opportunity to establish an improved mental health regimen and reduce his alcohol intake.

On his release from prison Zach "didn't know what to do with himself", as the support for his mental health conditions and substance abuse fell away.

He started frequently attending A&E again. While he knew it wasn't necessarily the right place to get help, he didn't know where else to turn. That's when Zach was put in touch with a HIU service. His HIU service lead was someone he could talk to and who has helped him sort out his benefits and directed him to a local foodbank.

Looking back on his high intensity use of A&E, Zach says:

> "People in hospital did everything they could do; I was just all over the place and didn't know what to do with myself. My mental health wasn't in the best place.
>
> I saw these unwell people and I was sitting there feeling like I was in the wrong place. I should have said everything that was going on."

Zach is now in a better situation. He says he tries to keep himself busy and while he doesn't have a plan, he intends to **"make the best of what comes next"**.

"I was all over the place and didn't know what to do with myself."

Zach

"For other people in situations like mine, I want them to have someone to talk to."

3.6 Loneliness and social isolation

Loneliness was highlighted as a key driver in our interviews with experts and people who frequently attend A&E, as well as in the literature reviewed for this study. For example, lonely individuals aged over 65 make more visits to A&E compared to their non-lonely counterparts[48], and they are also 1.5 times more likely to become hospitalised upon attending A&E.[49]

While experts and previous studies tend to focus on the link between loneliness and the high intensity use of A&E among people aged over 65, this may be driven by stereotypes that associate loneliness with later life.

In fact, almost all interviewees – younger and older – mentioned relationship issues as a challenge in their lives. These included relationship breakdown, moving out of the family home at a young age, having difficult relationships with parents, and being separated from their own children. Romantic relationships were also important, with periods of feeling more satisfied with relationships associated with less regular A&E visits, and rough patches associated with phases of high-frequency attendance.

"My girlfriend was toxic and abusive, so we eventually broke up."

Alex, in his 20s

"My partner's never around to spend time with me."

Bianca, in her 60s

Psychiatric research has indicated that lonely people often share certain experiences: "Lonely people tend to have more of a history of loss, trauma, inadequate support systems and negative, critical and harsh parenting".[50] Across our interviews with people frequently attending A&E, family issues and tumultuous relationships were associated with loneliness and isolation.

"The A&E feels safe, because I don't have to sit on my own. Having people around me helps."

Bianca, in her 60s

Although it is closely linked to loneliness, social isolation is a distinct concept as it is objective, defined by the number of regular contacts one has with others.[51] We found that social isolation was also a key factor in high intensity use of A&E. At least 22 per cent of people who frequently attend A&E live alone, compared to 16 per cent of UK individuals.[52] Many of those we spoke with lived alone, and this had a significant impact on how they perceived their health conditions and went about seeking help.

For example, Bianca, a woman in her 60s who frequently visits A&E after episodes of heavy drinking, told us that living alone makes her feel unsafe, especially as her alcoholism exacerbates her underlying mental health conditions of anxiety and suicidality. See Section 8.3 for more on Bianca's story.

"I get depressed, I've got no friends. I've been treated horribly, so I sometimes feel low. No one comes to hospital to see me."

Amanda, in her 50s

3.7 Sudden crises or life changes

People often live for years with many of the challenges described in this section before they start attending A&E frequently. However, when one of these factors is exacerbated, it can tip an individual into crisis.

3.7.1 Relationship breakdown and loss

Relationship breakdown and conflict was a key issue for some individuals. A divorce, breakup or argument with family members sometimes caused an individual with other pre-existing conditions to enter a 'difficult patch'. One HIU service lead said that his client would have periods of stability when she could manage her alcohol consumption but would enter phases of high intensity use of A&E when she broke up with partners. In this and similar cases, relationship problems could lead to self-harm, which then led to an increase in A&E attendance.

"My drinking was normal until I was 48, then after my divorce it got really bad."

Bianca, in her 60s

In other cases, relationship problems have a practical knock-on effect on living conditions. Two people we interviewed said that conflict with neighbours had led them to periods of rough sleeping, and their high intensity use of A&E was partly in response to the dangers and strains of sleeping rough.

"I was having conflict with my neighbours. They threatened to kill me, so I was out on the streets."

Alex, in his 20s

Some HIU service leads also described the psychological or circumstantial impact bereavement can have on individuals, which then leads to a period of high intensity use of A&E. For example, one HIU service lead believes a miscarriage triggered a physical health condition in one service user, which led to her high intensity use of A&E.

3.7.2 A sudden change in physical health

As is seen throughout this report, the delineation between mental and physical health is rarely clear. That said, several of the individuals interviewed said that in spite of pre-existing mental health conditions, familial problems and past trauma, it was a change in physical health that led to their high intensity use of A&E. Chest pains were one of the most common ailments to occur suddenly, as well as seizures.

4.

Diagnoses of people who frequently attend A&E

Summary of key findings:

- There are clear patterns in the primary diagnosis received by people who frequently attend A&E, particularly when broken down by age. People who frequently attend A&E who are aged between 20 and 49 are more likely to receive a primary diagnosis of deliberate self-harm overdose on prescription drugs, while those aged 50+ are more likely to be diagnosed with cardiac and vascular or respiratory issues.

- People who frequently attend A&E are slightly more likely to receive no diagnosis (17.3 per cent) compared to the general hospital-attending population (14 per cent). The majority (around three quarters) have experienced at least one instance of having no primary diagnosis at A&E over a five-year period.

- People can become frustrated when they receive no diagnosis at A&E and can feel that their underlying issues are not being addressed. Given that many do have underlying physical and mental health conditions, this can lead to heightened anxiety about their conditions, which in turn can increase their visits to A&E as they try to get to the bottom of the problem.

4.1. Prevalence of 'No primary diagnosis'

Analysis of data from three hospital trusts conducted as part of this research identified that while 'no diagnosis' is the most common diagnosis type, it is only slightly more common among people who frequently attend than the general population (17.3 per cent vs. 14 per cent).

The vast majority of people who frequently attend A&E do receive a diagnosis (82.7 per cent), contrary to the persistent myth that people who frequently attend A&E are not in legitimate need of medical care.

At the same time, three quarters (73 per cent) of those who frequently attended A&E experienced at least one visit that resulted in a 'no diagnosis' outcome during a five-year period. We know from our interviews that this is a particular source of frustration for people who frequently attend A&E. Many have recently experienced serious medical episodes that did lead to hospital admission, even where no diagnosis is made, and they feel that their trip to A&E is justified.

Particularly for those who have a mental health condition, there is likely to be heightened anxiety around the seriousness of their need, making it more difficult to hear that there is no diagnosable condition despite them experiencing physical symptoms. Research from the King's Fund identifies the issue of 'medically unexplained symptoms' as particularly prevalent among people with mental ill health. The organisation estimates that the NHS spends at least £3 billion each year attempting to diagnose and treat medically unexplained symptoms.[53]

4.2 Variation in primary diagnosis by age

Our analysis also found that, where a diagnosis is made, the pattern of diagnoses, including both physical and mental health conditions, differs across age cohorts.

Certain conditions, such as those related to gastrointestinal problems, are highly common across all age groups. However, many conditions are more common among certain age groups; for example, deliberate self-harm (DSH) overdoses on prescription drugs are most common among younger adults and middle-aged people aged between the ages of 20 and 49, whereas respiratory issues and cardiac and vascular conditions become more common with increasing age, particularly for those aged 50 and above. See Figure 10 below for more details.

Figure 10: Most common diagnoses by age group among people frequently attending A&E services

Rank	20-29	30-49	50-69	70+
1	No diagnosis made	No diagnosis made	No diagnosis made	Cardiac and vascular
	14.2%	14.9%	13.3%	16.2%
2	Gastro	Gastro	Cardiac and vascular	Respiratory
	10.7%	11.7%	13.2%	13.6%
3	Soft tissue injury	Alcohol abuse / dependency	Respiratory	No diagnosis made
	6.5%	6.3%	12.2%	12.5%
4	Respiratory	DSH overdose prescription drugs	Gastro	Gastro
	4.8%	5.7%	10.6%	9.1%
5	DSH overdose prescription drugs	Cardiac and vascular	Diagnosis not classifiable	Alcohol abuse / dependency
	4.0%	4.8%	5.0%	4.7%

4.3 Feeling dismissed: how people who frequently attend A&E see their service usage

Being turned away from A&E without knowing what caused their symptoms can cause people who attend frequently to feel dissatisfied with health services.

There is ongoing debate and mixed evidence in the literature reviewed for this study on how people's needs are perceived and assessed during their frequent A&E visits.

A number of studies have examined how medical providers assess patient need among those who attend A&E frequently, and found that negative experiences of assessment, such as feeling dismissed or improperly informed about conditions or care plans[54], can sometimes exacerbate an individual's mental ill health and in turn affect their expectations of what A&E departments can do to address their physical distress. This creates a negative psychological feedback loop whereby the person's anticipation of an unsatisfactory experience whenever they visit A&E prevents them from having a satisfactory experience, prompting them to visit repeatedly until their needs are met[55][56] (see Figure 8).

Several interviewees in our research made a connection between the lack of a formal diagnosis of their condition and their high attendance at A&E (see, for example, Victoria's story in Section 4 and Alex's in Section 7.) Linking what we know about attendance and diagnosis patterns with the complex personal stories of our interviewees, we can begin to see the negative and counterproductive effects of dismissing these individuals or referring to them as 'frequent flyers' – a label that is sometimes used in healthcare settings.

While people who frequently attend A&E tend to experience a complex mixture of detrimental socioeconomic factors along with mental and physical health conditions, it is often a physical symptom that leads them to call upon emergency services.

"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."
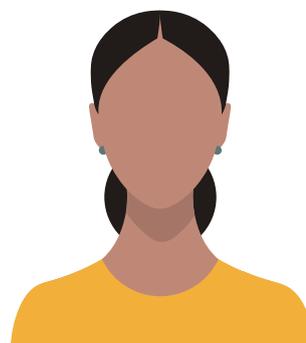
"I was getting put into a box."

Victoria
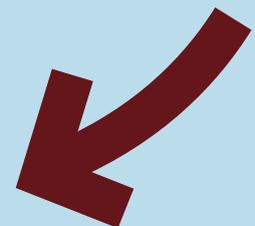
5.

Patterns in people's health and care service use

Analysis of the 2015 national dataset[xi] offers a view of the frequency of A&E attendance, and the length of time for which high intensity use of A&E persists.

Summary of key findings:

- Most people who frequently attend are in the lowest tier of high intensity use of A&E (attending five to nine times per year). Although the rate of high intensity use of A&E in a year varies widely, approximately three quarters of people attending A&E visit between five and nine times a year, 14 per cent attend between 10 and 15 times, and eight per cent attend 16 times or more.

- Those who visit eight or more times in one year become more likely than not to attend in the longer term. Attendance rate and length of high intensity use of A&E increase hand in hand. By their eighth visit to A&E in one year, a person frequently attending A&E has a 56 per cent chance of sustaining their high intensity use of A&E for two years or longer.

- Erratic changes in patterns of attendance can be an indicator of longer term high intensity use of A&E. Those who attend A&E frequently over the long term are more likely to experience a sudden and drastic rise or drop in their attendance rates.

- Observable patterns in high intensity use of A&E should be used to drive interventions. The patterns of high intensity use of A&E seen above are useful indicators for where interventions could focus their efforts. Sub-groups of individuals who experience these sudden changes or sustain high intensity use of A&E in the long term are likely to be more vulnerable and may particularly benefit from targeted support.

- Individuals who attend A&E frequently are more likely to attend at night than the general population, but showed no bias for any particular days of the week.

- Individuals who frequently attend A&E are significantly more likely to arrive by ambulance than the general population.

Figure 11: Highest number of attendances in one year*, short vs. long term attendance
(n=367,351)

Legend:
- People attending frequently long term (2012-2019)
- People attending frequently short term (2015 only)

People attending A&E eight times a year or more are likely to attend frequently long term

Y-axis: Number of people frequently attending A&E
X-axis: Highest number of attendances per year
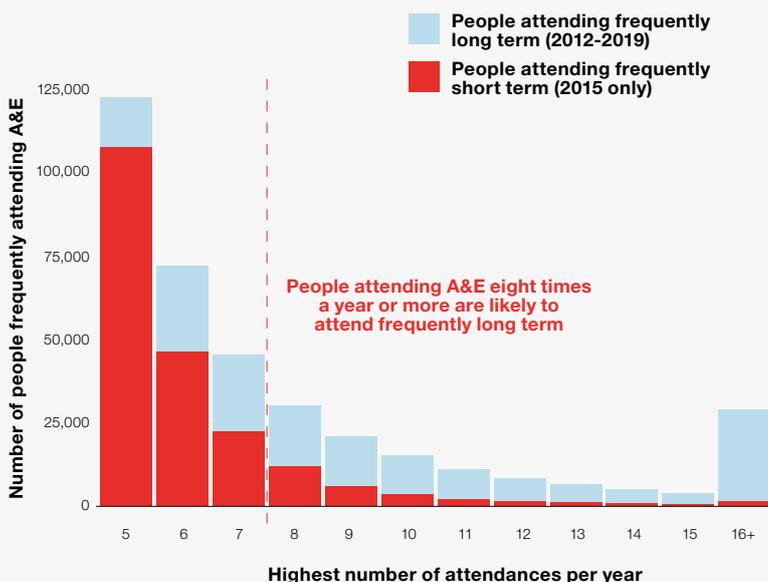
*For people attending frequently in the long term, this figure shows the highest yearly attendance for that individual during the period 2012–2019.

In the analysis below we look to identify differences between those identified as frequently attending in the **short term** (five or more times in one year only) vs the **long term** (at least five times in two or more consecutive years). We also identify **recurrent** high intensity use, where someone attended frequently in multiple but non-consecutive years.

We also look at three tiers of frequent A&E attendance: low (between five and nine), medium (between 10 and 15) and high (16+) annual visits.

Identifying patterns within these groups could help in developing more targeted interventions in future.

5.1 Range and tiers of high intensity use of A&E

The maximum number of A&E attendances in a one-year period ranged extremely widely, with individuals attending between five and 346 times annually. Looking at the cohort of people who frequently attended in 2015 and their attendance patterns over a seven-year period, the majority – 64.6 per cent across the country – never attended more than five or six times in a given year (Figure 11). Those attending more than 100 times accounted for a marginal proportion of only 0.1 per cent of all who attended frequently in 2015.

xi The data was requested in early 2020, with the most recent data available at the time being for 2019. As we wanted to understand the patterns of attendance over time, we selected the year 2015 so that we could trace the attendance patterns of those same individuals over the four years that followed.

In a wide range of studies, people frequently attending A&E are classified into categories defined by the number of attendances in a year, including five to nine times; 10 to 15 times; more than 16 times (though these are not standardised and can vary). In the national HES dataset, 78.8 per cent of these people attended between five and nine times a year, 13.5 per cent attended between 10 and 15 times a year, and just a small minority of 7.8 per cent attended more than 16 times a year.

Those attending 16 or more times each year account for 12.9 per cent of all visits to A&E made by people who frequently attend. This represents more than 3.5 times the proportion of the frequently-attending population they make up.

5.2 Length of time for which frequent A&E attendance persisted

Many people's high intensity use of A&E will last for one year and then return to normal levels (55.9 per cent of people in the national dataset fell into this category). However, a large proportion (44.1 per cent) continued to attend frequently for two or more years.

Figure 12: Distribution of low/middle/high tiers of people frequently attending A&E x length of frequent attendance (n=367,351)

Figure 13: Probability of those frequently attending A&E going on to attend frequently over the long term (n=367,351)

In our analysis, those attending frequently for two or more years continued this pattern for an average of 3.1 years. However, had this dataset captured data for a longer period beyond the 2012 to 2019 range, a slightly higher average number of years would be expected. Within this cohort of people who frequently attended over the long term, approximately half resumed their patterns of high intensity use of A&E despite having a significant interim period of reduced attendances that lasted at least one year. This group covered 20 per cent of the wider sample in our dataset.

These statistics indicate that just over half of all people who frequently attend A&E are likely to experience a reduction in attendances after one year. While the data doesn't allow us to break down the reasons for reductions in high intensity use of A&E, our qualitative evidence suggests this may, in some cases, be a result of disillusionment or choosing to seek help elsewhere. In other cases, it may be the result of problems being solved after a period of struggle – for example, seeing an improvement in a symptom or being referred to a suitable pathway.

Our analysis finds that the **frequency** of A&E attendance and the **length of time** for which high intensity use of A&E persists increase hand in hand: those with moderate and high rates of A&E attendance were also more likely to continue this pattern over several years, compared to those with relatively low rates of attendance (see Figure 12 below). This also shows that the vast majority of those attending frequently over the long term attended more than 16 times in one year (27,167 out of 28,749 people who attended frequently in the long term, or 94.5 per cent of this cohort).

This signifies that the people frequently attending A&E with the most at-risk and complex characteristics tend to attend at a very high rate over a long period of time, and this group should be a priority for targeting HIU services.
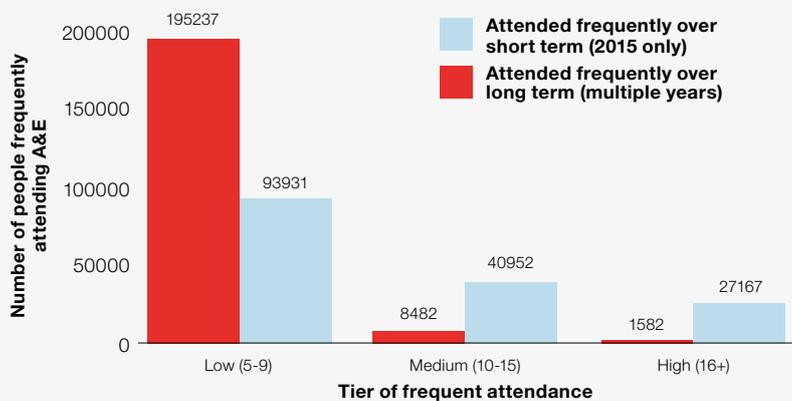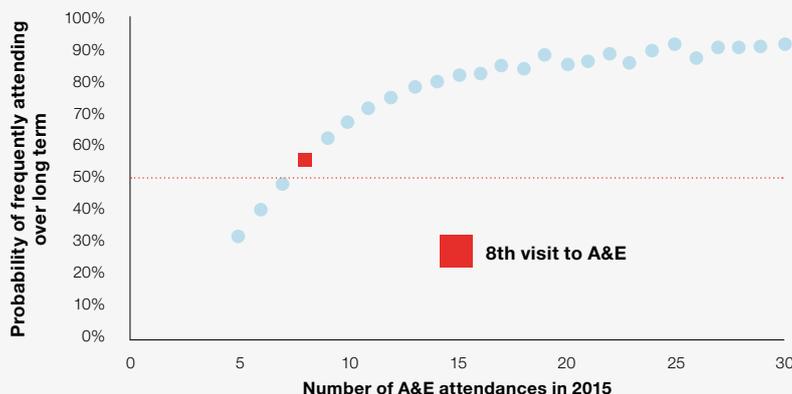
5.3 The journey through long-term high intensity use of A&E

People who attend A&E most frequently are more likely to attend over a longer period of time. For example, Figure 13 shows that, by their eighth visit in a year, a person frequently attending A&E has a 56 per cent chance of continuing their high intensity use of A&E for two years or longer. This probability reaches more than 80 per cent by the 15th attendance.

Understanding these patterns can indicate potential intervention points – for example around the seventh or eighth visit – that might help to prevent a person going on to attend frequently over the long term.

5.4 Attendance patterns across key groupings

Based on the exploration of a range of demographic, socioeconomic and medical factors, three key groupings of people frequently attending A&E emerged. They can be grouped primarily by age, and have distinct patterns of high intensity use of A&E:

Figure 14: 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

5.5 Nature of A&E visits

The visits of those who attend A&E frequently differ in nature from those of the general population. Our analysis of NHS trust datasets across three regions[xii] provides an insight into these differences.

5.5.1 Attendance hours

In one NHS trust dataset we found that people who attend frequently are more likely to visit A&E during night-time hours, with 39 per cent of visits between 8pm and 8am, compared to the general population whose night-time attendances account for only 25 per cent of total attendances (see Figure 15). This is in line with the findings of other studies[57], but the root cause of this pattern has not yet been uncovered.

Moreover, while A&E attendances among the general population are significantly higher on Mondays than on other days of the week, the visits of those who attend frequently are more evenly spread throughout the week. This might indicate that people who frequently attend A&E have become disillusioned with other services and established a habit of going directly to A&E, which means their behaviour is less shaped by the opening hours of other services.

5.5.2 A&E arrival mode

A significantly higher proportion of people who frequently attend A&E arrive by ambulance, compared to the general population of people who attend A&E. Ambulance journeys account for between 39 per cent and 61 per cent of their arrivals, depending on the region[xiii], compared to 22 per cent among the general population.[xiv] It is not possible to say from the available data in what proportion of these cases the ambulance trip was essential, though the fact that many have previously had inpatient stays suggests the proportion may be higher than among the general population. Whether essential or not, the difference reflects the commonly reported feeling among people who frequently attend that when they are going into hospital, they have an urgent need for care.

People who frequently attend A&E often speak extremely highly of ambulance paramedic staff, however this may be because they help to meet a broader need for emotional support and reassurance among people who frequently attend.

Figure 15: Comparison between attendance hours among people who attend frequently and national average across all A&E attendances in 2017

(n=5,962)
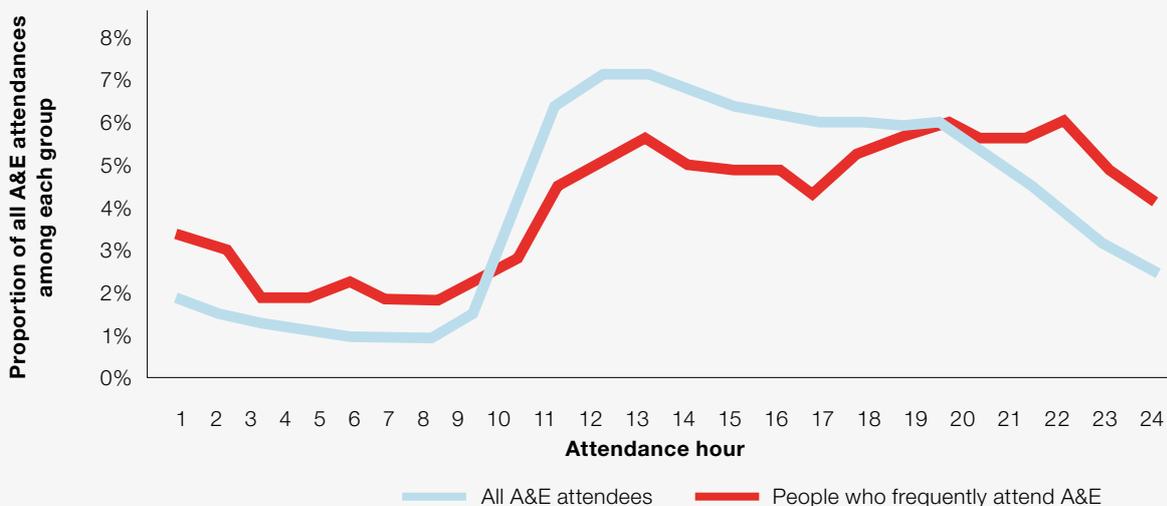
[xii] The availability of variables explored in this report varied significantly across the three NHS trust datasets that were analysed. Datasets were combined and analysed where data was consistently available; where it was limited, single analysis was conducted on a single dataset. NHS trusts have been anonymised.

[xiii] Finding based on analysis combining trusts A, B and C.

[xiv] These figures come from trust data analyses, but local demography and conditions (e.g. transport) mean these figures vary nationally.

6.

How people who frequently attend perceive A&E services

Summary of key findings:

- Half of the interviewees who frequently attend A&E had positive accounts of feeling supported by staff in A&E while the others had more negative feedback, commenting that they felt dismissed or not listened to.

Around half of the 14 people we interviewed about their high intensity use of A&E had only positive things to say about their experiences in the emergency room. They expressed gratitude towards A&E staff (and also the paramedics who brought them in) for being attentive, caring, and "doing all they could". They often expressed feelings of guilt or embarrassment about adding to the workload of hardworking staff.

"They didn't treat me as just a drunk."

Case study: Bianca's positive experiences of A&E

Bianca, a woman in her 60s who lives alone, recalls how she visited A&E to feel safer than she would at home, especially after episodes of unintended heavy drinking:

"The A&E feels safe, because I don't have to sit on my own. Having people around me helps."

She believes that if she wasn't being given medication to deal with her withdrawal symptoms, she would find herself in a shop getting more alcohol for herself which would be extremely dangerous.

Bianca found that A&E staff had a non-judgmental stance towards her no matter how often she visited. Her positive view of the services remained even after her high intensity use of A&E had declined for a while.

See Section 8.3 for more of Bianca's story.
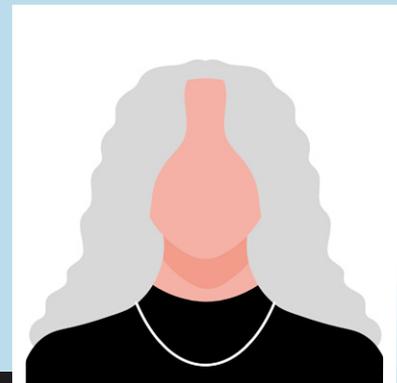
Bianca

"They saw my alcoholism as an illness and didn't treat me as just a drunk."

By contrast, the other half of the people we spoke to who frequently attended A&E were less satisfied with their visits, and this had a strong negative impact on them. They felt they weren't well listened to or understood, and that they might be judged for attending. As these people still felt they had an urgent need for physical care in those moments, they didn't stop going to A&E as a result of their dissatisfaction.

Rather, they just had increasingly negative experiences.

HIU service leads said that they had also encountered clients who had "given up completely" on receiving appropriate care, and so they had started to attend A&E less frequently and continued to "suffer in silence".

"I was being ignored. I never got what I needed there."

Case study: Kirsty's negative view of A&E

Kirsty, a woman in her 60s, felt that the A&E staff were dismissive of her diabetes and other complaints she was presenting with and that in the end she didn't get what she needed from them. She wasn't sure if this was just because the staff were "[run] off their feet".

Her A&E attendance has decreased recently because she's afraid of being dismissed or ignored, not because her condition has improved.

The perceived lack of care and empathy made the trips to A&E feel disheartening, and if a person willing to listen to Kirsty's concerns hadn't become available, Kirsty would have ceased to seek help at all.

In Kirsty's case, she has found a lot of support from her GP and is able to use this to moderate her attendance at A&E.

"[My GP] is brilliant. If she thinks I should go down to A&E, she'll make me."
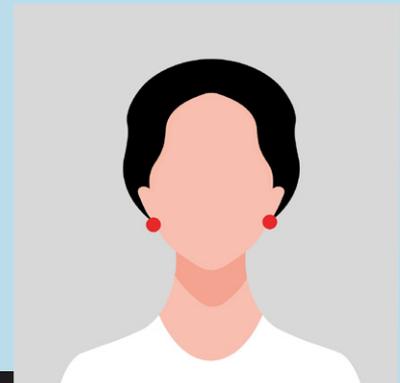
Kirsty

"They brush you aside when they know you have diabetes, and when I tell them I have chest pain they don't offer me pain relief."

"There's no point in going there."

Case study: Cathy's negative view of A&E

Cathy is in her 70s and spends most of her time alone at home. She started to experience pain all over her body including her chest, back and breasts five years ago following an operation, which has not improved since. Cathy used to be good with her hands and worked a lot on her garden, but she no longer feels able to because of her pain.

Cathy feels that her pain presentations have never been taken seriously by A&E doctors.

"They are very ignorant and very abrupt; I don't like that."

On one occasion, although she proposed that her back pain may be a type of hernia, the doctor quickly dismissed her claims and insisted that it was associated with surgical injections she received a long time ago.

Following multiple experiences where she felt she wasn't taken seriously, Cathy started to hesitate about attending A&E and claims that she now "just copes with it without talking to anybody". The only time she recently attended was when a friend was so concerned about her symptoms, he thought he had no choice but to call the ambulance.

"I wouldn't choose to go back to the A&E because there's no point."

She seemed to feel let down, without options to get help or feel better. Despite a decrease in A&E attendance, the problem that drove to Cathy's high intensity use has not been addressed.

"I live alone and spend most of my time by myself during the day."

"I only go to the A&E because it's difficult to get a slot with the GP to deal with my chest, back and breast pain. The doctors there are so abrupt, and I don't like it."

Cathy
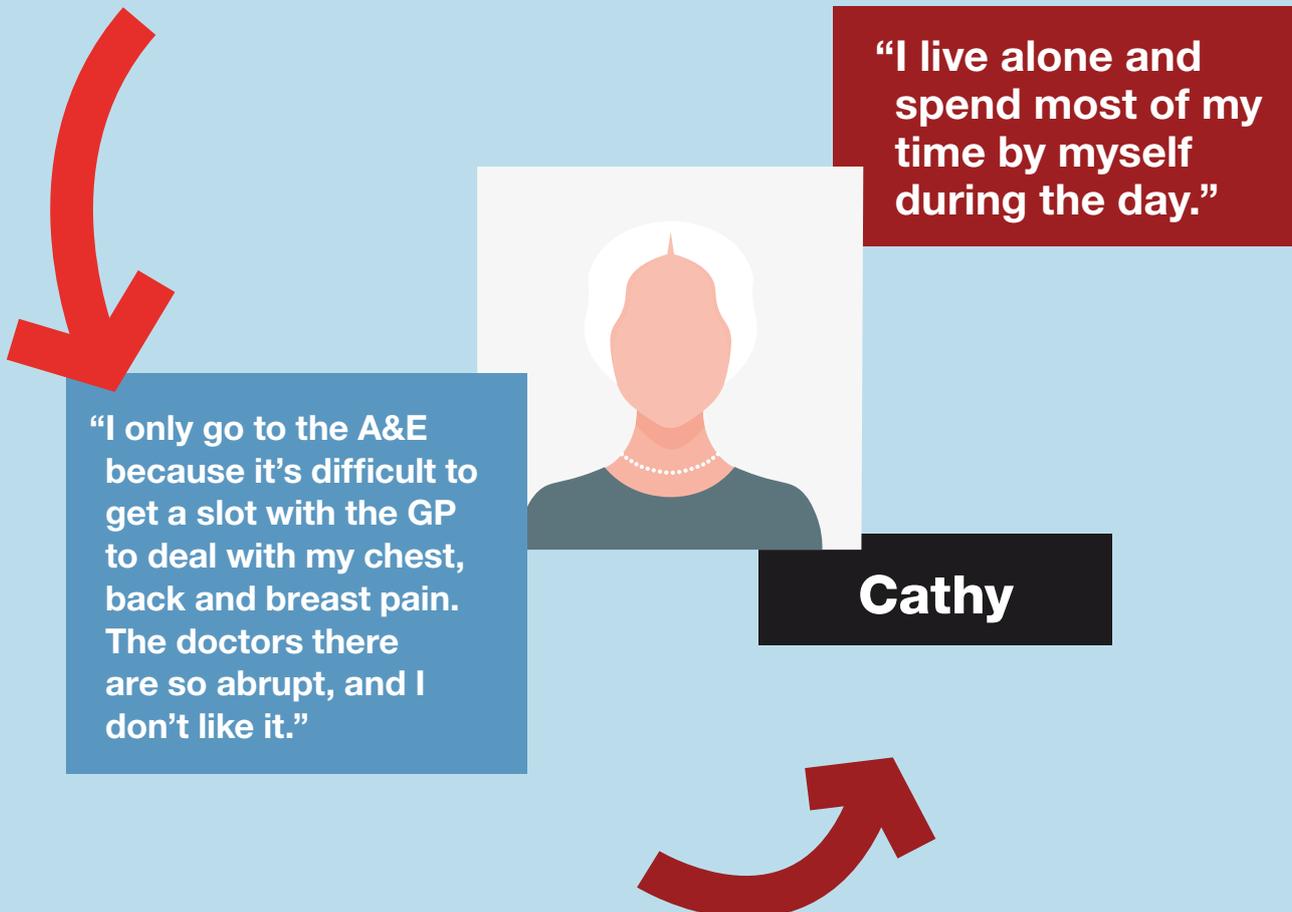
7.

How people's experiences with other parts of the health and care system lead to high intensity use of A&E

Summary of key findings:

- Many people who frequently attend A&E have atypical attendance patterns with GP and community services, which can emerge before their high intensity use of A&E.

- The majority of individuals who frequently attend A&E have engaged with other healthcare services first and are registered with a GP. Some individuals will seek help from emergency services when they are dissatisfied with the previous care they have received.

- Due to the limited and stretched capacity of GPs and mental health services, patients often do not receive the care they need at their first point of contact, and this results in frequent attendances at A&E.

People who frequently attend A&E have often engaged with other healthcare services first. They are highly likely to engage with other parts of the system, such as social care and mental health services as a first point of contact.[58][59] According analysis conducted as part of this study, 99 per cent of people attending A&E in North West London more than five times a year had engaged with other health services during their first year of crisis attendance. The most common engagement in their first year of high intensity use of A&E was an inpatient stay, followed by engagement with mental health or social care services. This suggests recent medical traumas might be contributing to the ongoing physical symptoms people who frequently attend are concerned about. It may also explain higher levels of anxiety among this group, driven by a genuine risk that they could become seriously ill again.

The service that is most commonly studied alongside A&E is primary care. More than 90 per cent of people who frequently attend A&E are registered with a GP[xv][69] and the British Red Cross and Imperial College Health Partners found that this group in North West London is three times more likely than their general local population to have had a GP appointment in the last year. At the same time, information on GP registration can be misleading: while people may be registered, they may no longer live in the area or may not have provided up-to-date contact details.

Everyone we interviewed said they had been to a GP about their health problems in the past, before beginning to use emergency services. In some instances, the transition from seeking help at the GP to seeking help at A&E happened rapidly after a period of being disappointed with their GP's response. In other scenarios, it happened over a longer period, where past experiences with a GP or healthcare services meant that GPs were no longer the first port of call for new issues.

Some people we interviewed said they'd gone to A&E on occasions where they couldn't get a GP appointment. Healthwatch England report that since the outbreak of Covid-19 75 per cent of people (from a sample of near 200,000) said they had faced challenges with GP access, leaving them feeling negative about their ability to access primary health care. It is also reported that, due to a public perception that GP practices were not open during the pandemic, many went to A&E because they felt they could not or should not call their GP.[61]

Attendance at A&E can sometimes be a result of limited or untimely access to GP services, in instances where individuals feel they need support sooner rather than later.

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

Several interviewees who frequently attended A&E identified a link between their dissatisfaction with their GP and their need to go to A&E in order to get a second opinion or reassurance about their health. These interviewees felt their GP wasn't listening to, acknowledging or fully understanding their issues. After a series of unsatisfactory encounters, they started to bypass their GP[xvi] and go straight to emergency services instead.

[xv] The only data available is whether individuals are registered with a GP: this does not account for the fact that someone may be registered with an out-of-date GP (i.e. one associated with an old address).

[xvi] Analysis of overall GP satisfaction scores nationally vs. for the GPs with greater numbers of people who frequently attended A&E showed no significant relationship.

"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."

Despite these negative reports, some interviewees who frequently attended A&E had developed positive relationships with GPs as an alternative source of care after their A&E attendances declined. Interviewees told us that these positive relationships were characterised by their GP being patient and willing to listen to concerns, as well as offering reliable and timely access to appointments.

"My GP is fantastic, she's basically my counsellor and I can get an appointment with her whenever I need one."

Kirsty, in her 60s

7.1 Primary care and people who frequently attend A&E: the GP perspective

GPs are often the gatekeepers to other health services, including specialists and mental health services. However, we heard that there are a range of issues that can lead to an impasse, in which an individual feels they need specialist care or further investigations, but the GP is not able to offer this.

GPs told us that their ability to make referrals can often be limited by restrictive eligibility criteria, gaps in local provision and overstretched community services.

They also struggle because sometimes it is difficult to identify a clearly diagnosable condition in order to make referrals. GPs also have to balance the need to support patients and to provide effective triage and decision-making, while not becoming a proxy emotional support.

The GPs we interviewed told us that they also lacked options on what to do next if the service they had already referred on to was not addressing the root cause of their patient's problems.

There can be particular issues in relation to mental health services as only half of mental health services accept self-referrals[62], meaning that if a GP is unwilling or unable to put a patient in touch with a mental health service, many won't be able to access support.

"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

"You get those patients where you're not sure [whether] to refer them onwards or not. In your heart of hearts, you know there's no physical problem."

GP

Evidence shows us that high intensity use of GP services and A&E are linked, and this demonstrates the importance of ensuring GPs are fully informed about the availability of other community services in their area, including social prescribing and HIU services, that can provide more person-centred, holistic support for people who are presenting with non-physical symptoms that cannot be addressed within short appointment times.

GPs should also be trained to look out for emerging patterns of high intensity use and be informed of the best pathways to support patients who may already be, or may be at risk of becoming, people who frequently attend A&E.

The GPs we interviewed broadly agreed that services targeted towards people who frequently attend A&E would be more suitable than primary care for understanding and supporting the social and holistic needs of these patients, and thus welcomed HIU services.

7.2 Other community-based services

In line with the feedback from GPs our qualitative interviews demonstrated that gaps in other community services could leave people with nowhere to turn but A&E.

A couple of the interviewees who frequently attended A&E had already been referred to other services (for example, they had a visiting mental health nurse), which still hadn't met their underlying needs.

"I do have a mental health coordinator but that's quite a slow service."

Michaela, in her 20s

The All-Party Parliamentary Group (APPG) on Mental Health notes that people with serious mental health conditions struggle to access support closer to home before reaching crisis point.[63] The report also highlights the high eligibility thresholds which prevent people from accessing support in the community.

7.3 Treating the whole person

Experts in the high intensity use of A&E feel that the majority of health services are unable to see an individual as a "whole person" with a complex interplay of needs.

Many of the experts we spoke to felt that most health services were not able to meet the complex needs of people who frequently attend A&E, because health services are usually focussed on individual clinical problems, rather than seeing and treating people holistically, meeting their non-clinical needs as well as their clinical needs. Equally, mental health problems are often treated in isolation from physical health concerns.[64]

"Boundaries are usually set up so you can't be yourself and support people on a human level. These are people who have been dehumanised a lot."

HIU service lead

Some of the experts we interviewed told us that services are often not set up to allow health professionals to engage with people on a personal, humanised level because of the rigidity of the professional boundaries that are drawn. This is a particular challenge because it is often what those who frequently attend A&E most need.

The HIU service leads we spoke to had found that people who had gone through these difficulties in the past had often brought negative views and beliefs with them when they started receiving support from HIU services, which initially created additional barriers to support.

One expert told us that budget cuts over the last 10 years across health and social care had made it even more difficult for services to deliver holistic support. She described community mental health teams as "stretched to their limit" in terms of budget and resource, with inevitable impacts on the quality of care for service users with complex needs.

Covid-19 and high intensity use of A&E

Conducting this research during the Covid-19 pandemic, we saw the negative effects of the outbreak magnified within the experiences of people who frequently attend A&E.

One interviewee was incarcerated during the pandemic, and the build-up of social isolation during this time contributed to a period of mental breakdown and high intensity use of A&E upon his release:

"I couldn't see people because of the virus. I was locked up all day apart from 20 minutes for a shower."

Zach, in his 30s
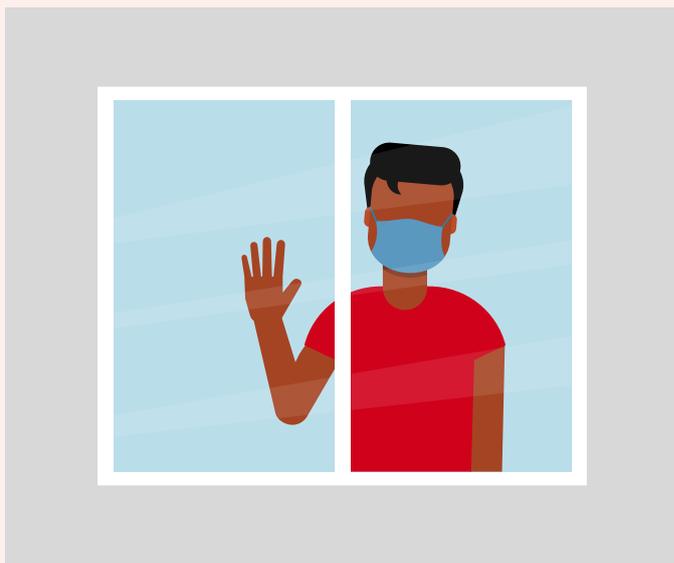
Interviewees who regularly visited A&E commonly spoke of lockdown limiting social contact with loved ones. Those without custody of their children particularly struggled with being unable to make their usual visits:

"What set me off is that I couldn't see my kids because of the virus."

Michaela, in her 20s

People were also cut off from some of their usual coping strategies, such as going to a day centre or receiving an in-person visit from a mental health nurse. Sometimes interviewees appeared to feel abandoned by the services they had previously relied on. Two said they hadn't heard from their key worker or mental health nurse for several weeks, without explanation.

The majority of people we interviewed didn't report attending A&E less frequently as a result of the virus, despite expressing stronger feelings of guilt about attending under-pressure A&Es when "the staff are already run off their feet". Further supporting the hypothesis that people tend to visit A&E frequently due to a genuine perceived need for medical assistance, several told us:

"If I need to go, I'll go."

Kirsty, in her 60s

Only one interviewee said that she was too scared to attend A&E, although this was due to the virus in combination with several other negative experiences she had had there in the past, related to feeling ignored and dismissed.

Our analysis of North West London data concluded that A&E attendance dropped significantly during the first lockdown (March to May 2020) for both the general population and people who attend A&E frequently. However, attendance rates among individuals who attend A&E frequently recovered much faster after lockdown than among the general population. This has indicated that the Covid-19 pandemic has not impacted A&E attendance rates for individuals who attend A&E frequently. In fact, some anecdotal reports have suggested that over the long term, the pandemic may lead to an increase in the number of people who attend A&E frequently, perhaps unsurprisingly when you consider the emotional and mental health impacts of isolation and lockdowns.

8.

Moving away from high intensity use of A&E

A wide range of interventions aimed at supporting individuals who frequently attend A&E to reduce their visits have been implemented and studied across the world. Interventions that take a holistic approach to people's health and wellbeing tend to be more successful.

In this section we explore what has helped people who have experience of frequently attending A&E services to reduce their use while maintaining and managing their health and wellbeing.

We also consider what changes can be made to address the factors that underlie high intensity use of A&E.

Summary of key findings:

- A&E attendance naturally declines after one year for most people who frequently attend. However, one in five people who attended frequently in 2015 (21.4 per cent) had a prolonged period of high intensity use of A&E in the years between then and now.

- HIU services are unique and effective in reducing frequent attendance at A&E because they are holistic, proactive, and are not time limited. People who frequently attend A&E benefit from a range of social, emotional, and practical support alongside support in accessing health and care services. Addressing the wider challenges people face day-to-day alongside their health conditions is critical.

- More can be done in the community to support people who frequently attend A&E. This group highlights communication challenges with health and care professionals and strict accessibility criteria to mental health and social care services as barriers to maintaining their health. ICSs can do more to improve access to community-based support in line with the NHS Long Term Plan.

- It is imperative to act on the wider determinants of health to reduce the high intensity use of A&E services. Frequent attendance at A&E is closely linked with deprivation and other social determinants of health. These social determinants of health need to be addressed in order to improve people's health in the most deprived areas.

8.1 Key factors in moving away from frequently attending A&E

National HES data shows a 'natural' decline in high intensity use after one year for the majority of people who have frequently attended A&E. However, the problem persists for a significant minority, with one in five people who attended frequently in 2015 (21.4 per cent) having a prolonged period of high intensity use of A&E in the years between then and now.

Our interviews with people with experience of frequently attending A&E and with HIU service leads demonstrated that a range of factors were critical in enabling people to move away from high intensity use of A&E.

Some people successfully move away from high intensity use of A&E by improving their understanding of and confidence in navigating the system, allowing them to engage well with other services that meet their needs elsewhere.

Safe and stable relationships with one or more service providers outside of A&E had helped some interviewees to move away from high intensity use of A&E. Michaela, for example,

developed a sense of empowerment and ownership through more positive relationships with her HIU service lead and GP.

Experts believe that the key to preventing people from returning to former patterns of regular A&E attendance is to ensure that they find a purpose in their lives. This could be achieved in various ways, for example, through community groups or volunteering.

Transitions away from high intensity use of A&E can be circuitous and involve 'trial and error', featuring new strategies and sources of help as well as finding ways to navigate and work better with support and services already in place. While some people who use HIU services are supported to 'step down' to other services, including social prescribing services and other community-based support, HIU service leads told us that for some service users there are no suitable alternatives to the support they offer: in these cases, HIU services act as a safety net for individuals, offering an easy-to-access place where people can feel listened to and looked after when they are in need.

While some may move on from periods of high intensity use of A&E for positive reasons, we know that others do so because they feel dismissed or misunderstood by A&E staff and believe their needs will never be met. Such individuals are likely to continue suffering with the same problems without support, with a continued detrimental impact on their physical and mental health. Extending HIU service support to a wider range of people would be one way of ensuring that people like this do not fall through the gaps.

"My attendance has reduced a lot because I'm scared to go... scared of being ignored."

Kirsty, in her 60s

8.3 High Intensity Use (HIU) services

HIU services in England follow a core model set out in guidance issued by NHS Right Care, but are adapted to local needs. The first HIU service was launched in Blackpool in 2015 and services now run in over 100 of England's Clinical Commissioning Groups (CCGs).[65] CCGs often commission VCSE organisations to deliver these services, but alternative clinically-led models are delivered by NHS trusts and Primary Care providers. HIU services have a successful track record of impact, with a range of between 38 and 84 per cent reductions in A&E attendances and between 24 and 84 per cent reductions in emergency admissions across all services evaluated.[66]
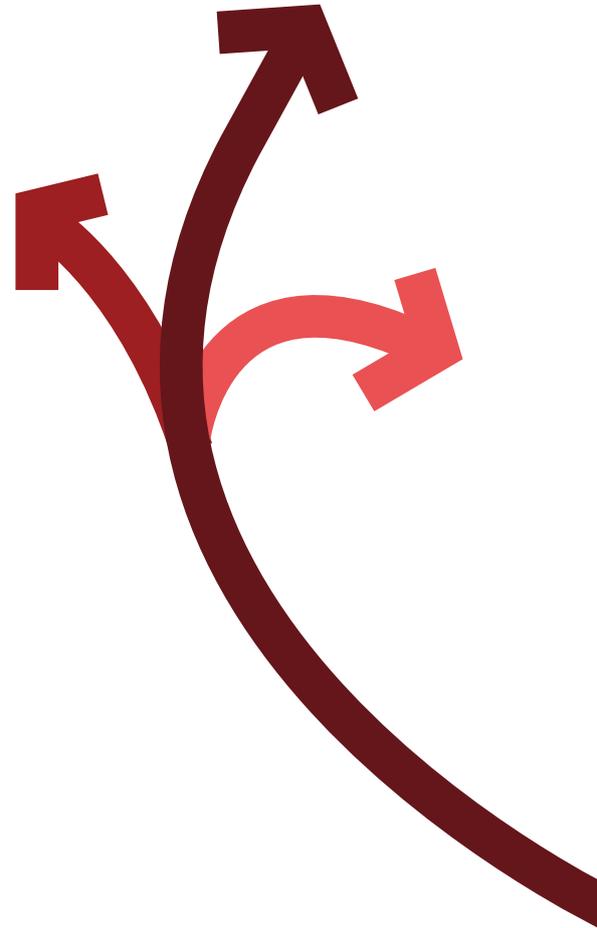
British Red Cross HIU services

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.

Our approach is based on the NHS Right Care model, in which an agreed number of people who frequently attend A&E are identified by our practitioners for support, and asked if they would like to try something different.

Once accepted on to the programme, we take a person-centred and strengths-based approach to identify unmet social needs that may be exacerbating physical or mental health conditions and leading the person to attend A&E. Our approach is de-medicalised and decriminalised. Everyone who is supported by HIU services starts from a 'clean sheet', so that from the moment they accept support they can 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 support the individual to access 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 either 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 to bring down the barriers so that they can be heard, and can take control of their own wellbeing.

Because our services are part of the wider British Red Cross independent living offer, we are able to 'bolt on' additional support to the Right Care model, offering step-down support for people who are ready to move on from our HIU services. We offer support to engage in community activities either through peer-led or social prescribing support. These services can also be deployed preventatively with people who have escalating use of A&E.

Our HIU model is now being deployed in a range of settings including:

- **Mental health services** With Liaison Psychiatry Services, Community Mental Health Teams (CMHT) and with people detained under the Mental Health Act

- **Primary Care** Primary Care Networks are using the HIU model for people who need more intensive support than can be offered in social prescribing services. This includes people with enduring mental health conditions, multiple long-term conditions and unmet social needs.

The British Red Cross invests in bespoke service infrastructure to ensure that staff are trained, developed and supervised appropriately to stay safe and well and enable them to maintain high levels of intervention. Staff receive bespoke, ongoing training to maintain fidelity to the Right Care model, and to the core principles of the programme. HIU service leads have high levels of emotional intelligence and bring skills from their previous practice. Their training includes reflective practice in action and learning across subjects including trauma-informed care, CALMER (an approach developed by the British Red Cross psychosocial and mental health support team), and motivational interviewing as well as professional boundaries, safeguarding and information governance.

We carefully track the impact of our services, accessing data from health partners and undertaking regular evaluation of the outcomes and goals achieved by individuals as well as reductions in service use. Analysis of demographics, activation levels, satisfaction and information around the wider determinants of health is captured to inform future commissioning and service development.

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

8.3.1 How HIU services differ from mainstream care

In our research, HIU service leads and experts emphasised three key features of HIU services that make them different from mainstream health and social care services, and which allow them to make a difference to people who frequently attend A&E:

Figure 16: How are HIU services different?

Proactive	Holistic	Long-term
Most healthcare services are reactive and responsive. As a service user, you need to find your way to them, meaning that you need to be aware that the service exists, and be convinced that it might help you. HIU services identify people who need support and then make repeated attempts to first gain contact, and subsequently to build trust.	Most healthcare services treat people based on a specific diagnosis or referral, be that a broken bone or depression. HIU services don't operate with this perspective, but rather assume that any combination of social, physical, or psychological factors could be the root cause of frequent A&E attendance. This creates more opportunities to help individuals whose conditions don't fit into a single, easy-to-diagnose category.	Most healthcare services have an end-goal of discharging a patient, which assumes that there is a single issue which can be 'cured'. HIU services understand that the complex circumstances of people who frequently attend are unlikely to have a quick fix, and that their clients have ups and downs over time. For this reason, there's never an 'end date'. Service users can get back in touch whenever they need to.
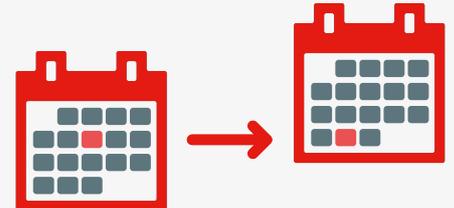
Service leads believe that HIU services offer individuals a rare opportunity to develop a one-to-one relationship with a service. One service lead said, "The key thing is to get trust and engagement at the beginning". One way services do this is by offering space for clients to share their stories without the pressure of time-limited appointments.

HIU service leads observed that, to build trust, each client must be seen and treated as an individual who has a unique background and set of needs, and that means taking the time to find out what matters most to them. This is seen as a crucial step to building an effective relationship, but is often missing in people's interactions with other parts of the health and care system.

HIU service leads view establishing relationships with their clients as a key part of their role. One said that she focused on finding "something to connect the two of us", and that the experience of being treated with respect built up her clients' confidence and improved their optimism around going on to find other support mechanisms. She said a client had told her: "You've restored my faith in humanity".

> **"We're just allowed to be normal people and interact with people in a human-to-human way. This doesn't happen very often."**
>
> **HIU service lead**

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

"I know that she won't judge me for my past."

Case study: Michaela's story – continued

Michaela fears that her case files in the healthcare system portray her in a specific light, highlighting the petty crimes she committed in the past.

"They read the files and judge me for mistakes I've made when I was much younger".

She feels distressed when she is allocated a new social worker or mental health worker, as she has had negative experiences of being patronised.

She reflects that her experience with her HIU service lead has been different.

Michaela never felt judged by her and felt that she instead brought a much more positive attitude into her interactions.

"The way she speaks and how she presents herself is helpful."

The HIU service lead approached building the relationship as more of a 'friend', being open to chat about anything and to talk and have meetings on terms that Michaela felt more comfortable with. This made a big change from the more formal nature of typical health and social care services.

> ## "I know that she won't judge me for my past. It's her attitude and the way she speaks."

Michaela

High Intensity Use services and Covid-19

During lockdown, HIU services were unable to provide face-to-face appointments or home visits to engage with or check on clients. Instead, they often relied on phone calls, supplementing these with creative approaches such as sending activity packs through the post.

While clients missed face-to-face contact, they valued phone check-ins from their HIU service leads, as they represented a refreshing break from the boredom, isolation and loneliness of lockdown.

8.3.2 How HIU services help

Through our interviews with HIU service leads and people who were frequently attending A&E, the following elements were highlighted as important features of the support offered.

Support at the right time

As experts we interviewed highlighted, the wide range of triggers and the complexity of experiences associated with frequent attendance at A&E make targeted early interventions more challenging to achieve. It can take time for people who are already frequently attending A&E to feel ready to receive alternative support.

In our interviews with people who frequently attend A&E, it was notable that none were able to suggest things that might have prevented their period of high intensity use of A&E, besides more responsive care from other health services such as their GP.

Proactive outreach to individuals is important. Many of the HIU service leads we interviewed had identified and approached individuals to offer support, while people who frequently attended themselves rarely identified that they needed this type of support on their own.

Many HIU service providers say that timing is key to a successful intervention. The individual must be prepared to engage with the HIU service so that a trusting foundational relationship can be built. Experts were hesitant to recommend a 'one size fits all' method to enable early intervention, as the right time and approach varies by person.

"I don't know if I would've been ready if the help came earlier."

Case study: Bianca's story – continued

Bianca has started accessing a multitude of services to manage her problems with drinking in the last few years.

She says that she only came to realise her need for help when she reached a breaking point:

"I was getting injured from drinking too much, breaking my fingers and such, and it was becoming really dangerous."

She believes that if the support had come at an earlier point, she may not have been ready to acknowledge that she needed it. She sometimes struggles to engage with the drugs and alcohol service, but finds the HIU service useful as it's easier to reach out to them freely and talk about a wider range of issues.

Bianca has successfully maintained a period of sobriety for 18 months, which has ultimately reduced her frequent visits to A&E.

"I have carers that help me at home and a weekly Zoom with an alcohol and drugs service."
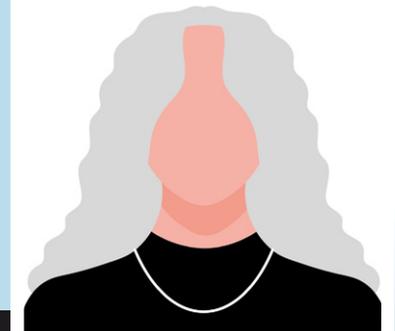
Bianca

"I've been working with a HIU service lead for 16 months. He knows when I'm in a bad patch and rings me every day."

The people interviewed all struggled to put their finger on exactly what enabled them to take up the offer of help from HIU services, but they tended to approach the relationship with frustrations about their current services alongside a hope that this one might be better. The nature of the HIU service approach was crucial in making this happen. HIU services reach out with a clear intention to talk about the individual's needs on the individual's terms: this is a compelling offer when people feel they haven't been heard elsewhere.

One limitation of this study is that we were not able to speak to people that had declined HIU services and therefore haven't been able to understand what the common barriers are to taking up the offer. HIU service leads told us that people in phases of heavy substance abuse and who are homeless were less likely to engage with their support, due to challenges in getting hold of these individuals and in meeting regularly enough to build a trusting relationship. There was no easy answer for helping people in these circumstances.

Support with practical needs

People who use HIU services receive a range of social, emotional, and practical support. Across the board, the people we spoke to were positive about receiving help with solving practical problems in their living circumstances. Help navigating the benefits and social housing systems; accessing new services, from support groups to food banks; and making adjustments or improving their facilities at home were all referred to as helpful interventions.

One person interviewed said that due to his mental health condition, he was only receiving part of his weekly pension payments, which weren't enough for his basic needs. He described how the housing provider, his keyworker, and the local authority had made decisions "above his head" and he had no idea how to navigate the multiple systems in order to receive the money he needed.

The complexity of the various systems with which people need to engage means that relatively simple fixes (e.g. getting the money for a new kettle) can be very difficult for a vulnerable person to achieve on their own.

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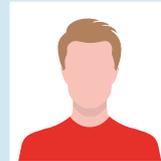
"I would never have known what was wrong if I hadn't been helped to find someone that listens."

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.

Some people benefit from simple signposting to more appropriate services; one HIU service lead told us, "The ones that are easier to help have fixable physical issues and just don't know about relevant services." However, most people have complex needs and require a supportive broker to help them identify and build confidence in services and support in the community.

HIU service lead training and qualifications

The HIU model is de-medicalised, so HIU service leads do not require either a clinical background or formal qualifications. Instead, HIU programmes tend to focus on recruiting people who have high levels of emotional intelligence; are inquisitive and confident; have strong negotiation and problem-solving skills; understand the health and social care system and have an ability to connect easily with people.

HIU service leads come from a range of backgrounds. These are sometimes clinical but also commonly include working in the VCSE sector, advocacy services, counselling, community engagement, or specialist mental health or addiction support services. HIU service lead job descriptions often emphasise the importance of being willing to provide support in a non-uniform way, to enable a more holistic, approachable and less clinically-orientated relationship with people who frequently attend A&E. The British Red Cross talk about their staff 'thinking outside the box'.

Because HIU service leads tend to have a range of backgrounds, and because the HIU model differs from more traditional health and care services, many programmes have a strong focus on providing on-the-job training, coaching and mentoring, to ensure the principles of the model outlined above are embedded in practice.

While the principles guiding HIU services are largely similar, they are commissioned on a CCG-by-CCG basis, and approaches are driven by local systems and patterns of frequent attendance. Different organisations therefore run their services in different ways, meaning there is variation in the support provided to people who frequently attend, and the training and operating model guiding those who support this group throughout the country. You can read more about the British Red Cross model in the box on page 46.

Support in developing better coping mechanisms

HIU service leads stress that effective support relies on them not becoming a permanent bridge between the individual and other services, but on supporting clients to build their confidence and understanding of the system, so that eventually they can navigate it independently. "You have to empower the client to make informed decisions", said one expert in frequent A&E attendance.

Experts also stated that the majority of people who frequently attend A&E, especially those who are younger, lack coping strategies to manage challenging situations. As many people who frequently attend A&E experience mental health difficulties, it is crucial to help them learn how to regulate their emotions, as well as build up their confidence and self-esteem. This allows them to respond to such situations either independently, or through the use of more appropriate services.

Some service providers use specific techniques like motivational interviewing, which aims to evoke the client's intrinsic motivations for change and encourage them to make decisions autonomously.[67]

One HIU service lead described a frequent pattern he observed in his clients: he said that someone with anxiety might experience chest pain, and that their anxiety would lead to extreme panic about the physical symptom; this in turn would exacerbate the chest pain, creating an escalation of panic and pain which would lead an individual to call an ambulance. He coached his clients to have more awareness of this pattern so that they could find ways of calming down earlier on in the process.

Several of the people that have used HIU services talk about having learnt coping mechanisms for stress and anxiety. One said that she would try to write down her feelings, and another said he would now call a friend or his HIU service lead rather than calling for an ambulance straight away.

People who have used HIU services also say it's important to feel listened to, and to have someone to talk to – not just about their condition but about the wider challenges they face. This was one of the key characteristics that service users said made HIU services stand out.

"I write in a book or have a conversation to get my feelings out."

Michaela, in her 20s

"It felt really good when she phoned me. It's just nice to have chats and I could have a laugh."

Bianca, in her 60s

The importance of talking

Cathy, in her 70s

Cathy recalls her time with the HIU service warmly. She appreciated how frequently her HIU service lead called her, over the course of a few months. The casual conversations that came out of it lifted her spirits and allowed her to feel cared for.

Although she is sad about getting fewer calls now, she understands that the HIU service lead has other service users to attend to.

Bianca, in her 60s

"We'd talk about anything, not necessarily about a specific issue that I have. And this definitely helps a lot."

Bianca appreciated that her HIU service doesn't focus on her struggles with specific issues in her life but offers a way to casually communicate and connect with someone regularly through a pleasant conversation about their day.

8.4 Improving access to support in the community

While improving access to High Intensity Use services will be critical to bringing down the numbers of people who frequently attend A&E and in reducing the burden placed on health systems by high intensity use, if we want to see real change, we also need to address the gaps and failings in other services that lead people to feel they have nowhere to turn but A&E.

As outlined above, people who frequently attend A&E have often engaged with other health services first, including GPs, mental health and social care services. Resourcing of health and care services, including the workforce, in the most deprived areas has been continuously highlighted as a challenge.

The NHS Long Term Plan set out a clear vision for shifting support for health away from acute settings and into the community and to moving away from treating people as a collection of diagnoses towards person-centred support. However, there is still much to be done to realise this vision.

The creation of Integrated Care Systems (ICSs) has brought together partners across the health system to work collaboratively with others - including local authorities and the VCSE sector - to improve health across communities. This creates a fresh opportunity to address some of the gaps in support that can lead people to start to attend A&E frequently. By encouraging more collaborative, cross-sector working, and channelling resources towards preventative approaches, as well as supporting more coordinated work across acute settings, ICSs can play a key role in ensuring that people at risk of frequently attending A&E have access to the support they need.

Drawing on the lessons from our research, priorities should include improving the capacity of GPs and other health professionals to identify and support people at risk of frequently attending A&E, including by making referrals to less intensive holistic support services such as social prescribing. Also important will be addressing gaps in mental health support, and social care services, and increasing the capacity of the VCSE sector in communities to offer people opportunities to engage in activities that give them a sense of meaning and purpose and help to maintain their wellbeing.

8.4.1 Improving support in primary care

Our research demonstrates that high intensity use at A&E is linked with frequent attendance at GP services both during the year of crisis and before. We believe that there are several opportunities to improve people's interactions with their GPs and to address their holistic needs.

- **Training** Equip GPs and other health professionals in the community with the skills and tools to identify those at risk of high intensity use of A&E, recognising common behaviours, such as high primary care attendance, as well as key triggers, such as significant life transitions.

- **Investment** Increase investment in primary care services in line with population need and deprivation levels.

- **Holistic care** Continue to roll out personalised care so that more health and care professionals are equipped to treat the 'whole person' and focus on 'what matters to them'.

- **Support services** Continue to roll out social prescribing link workers across primary care, particularly in the most deprived communities; invest in VCSE sector capacity to meet needs for practical and emotional support in the community, which can prevent issues from escalating; and develop more intensive support models for those with complex needs.

- **Multi-agency teams** 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.

Enabling more GPs and other health professionals to identify and support people with complex needs could potentially play a role in preventing people from reaching the point at which they feel they have nowhere else to turn but A&E.

There are plenty of examples of where GP practices are already working hand-in-hand with VCSE organisations, other community-based services and social prescribing link workers, and as part of multi-disciplinary teams to better support people at risk of frequently attending A&E. However, these models are few and far between and need to be rolled out more widely, especially in more deprived areas.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)

The City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)[68] helps manage the complex needs of people who often fall between gaps in mental health provision.

PCPCS is an innovative outreach service provided by the Tavistock and Portman NHS Foundation Trust that started in 2009. It supports GPs to manage patients with complex mental health and other needs that result in frequent health service use.

The services are offered from a GP surgery and typically can include an assessment, extended consultation, brief psychological treatment, group psychological treatment, case management and family therapy and couple therapy.

The model was independently evaluated[69] and found that:

- 75 per cent of all patients show improvements in their mental health, wellbeing and functioning as a result of treatment.

- 55 per cent are shown as having 'recovered', meaning an improvement in mental health, which moves a patient to below the threshold after treatment.

- The resulting financial savings were equivalent to about a third of PCPCS treatment costs.

- The service achieved very high satisfaction ratings among local GPs, pointing to increased capacity thanks to this service.

8.4.2 Improving support around hospital discharge

Another key opportunity to provide earlier support to people who may be at risk of frequently attending A&E comes at the point of discharge, from hospital. In line with the latest hospital discharge guidance[70], staff need to ensure that people's holistic needs are assessed and addressed adequately at the point of discharge, by checking their practical, social, psychological, physical and financial needs, either prior to leaving hospital or within 72 hours of going home. Following this assessment people should be referred or signposted to the appropriate support in the community.

These holistic welfare checks can help to break the cycle of repeated A&E attendance and admission and enable people to manage their holistic needs in their homes, but there is still work to do to ensure they are consistently available.

8.4.3 Improving access to mental health support

We know that mental health support in the community can make a real difference, but at the moment there are significant gaps in provision.

The Five-part Independence Checklist

The British Red Cross has long been calling for the introduction of a five-part independence checklist[71] as part of the hospital discharge process. We welcome the introduction of holistic welfare checks in the latest hospital discharge policy. These checks facilitate a conversation between health and care professionals, patients and their families and carers about their physical, practical, social, psychological and financial needs. It is vital now that implementation of the policy is monitored and that data is shared to support the evaluation of the impact of such checks.

Practical independence: Can they manage at home? Are there any unmanageable physical obstacles?

Social independence: Are they at risk of loneliness? Do they have good social connections and support?

Psychological independence: How do they feel about returning home? Are they stressed about living/coping with their illness or injury?

Physical independence: Can they look after themselves, their home and potential dependable persons?

Financial independence: Do they have any financial issues as a result of their injury or illness?

The Lambeth Living Well Hub

The Lambeth Living Well Hub[72] is a single point of access to mental health services. The Hub provides integrated support that bridges the gap between primary and secondary care and works preventatively to reduce pressure on secondary care. The Living Well Hub was comprised of the following services:

- Lambeth Council (social care staff)

- South London and Maudsley Foundation NHS Trust (psychiatry, clinical nurse specialists, occupational therapy)

- Thames Reach, Certitude, Look Ahead, (voluntary sector organisations, support workers and those with expertise in housing, benefits and engagement)

- Clapham GP Practice (administration, management and nursing/occupational therapy staff)

Anyone can introduce a person needing support, including the person themselves. There are no referrals or 'handoffs' between organisations. Pathways between primary and secondary care are clear and people can easily move between these services.

An independent evaluation of the Living Well Hub found[73]:

- Reduced waiting times for accessing mental health support – from within one month to within one week.

- A reduction in referrals to secondary care teams by 25 per cent since the launch of the Hub.

- A reduced average cost of support of £138 per person. The national Reference cost is estimated at £258 per person.[74]

- An increase of 21 per cent in the number of people accessing mental health support.

The NHS Long Term Plan for mental health sets out a framework for improving access to mental health support and ring-fenced investment is promised.

However, the experts to whom we spoke for this research described gaps in community mental health services, with one expert describing teams as "stretched to their limit". These gaps have real implications for the quality of care delivered to service users with complex needs. Furthermore, the Covid-19 pandemic has seen an increase in need for mental health support, particularly among women, younger people and people who live in the most deprived areas.[75]

Ensuring timely access to mental health support, including community-based crisis support, will therefore be a priority.

8.4.4 Addressing other gaps in community-based support

As our research has demonstrated, people who frequently attend A&E often have a complex mix of practical, social and emotional needs as well as mental and physical health conditions. Many require support from a range of services, but do not meet eligibility criteria set by individual services, or find that services are not accessible at the times they are needed.

There are gaps in community-based support for health conditions. Our findings around the range of conditions with which people who frequently attend A&E are diagnosed (See Section 4) suggest there may be particular gaps in support available to people at the end of life, people who have dementia and people with learning disabilities.

ICSs could play a critical role in assessing data around A&E attendance and emergency admissions to identify and address gaps in support in their communities, drawing together funding across sectors.

However it is clear that in some areas chronic underfunding at a national level is a major driver of problems in access to services, leading to costly admissions down the line. The Government's recent announcements around the future funding of social care[75] hold out hope of increased funding for social care services in the longer term, but there are clear and immediate gaps in provision which require investment right now.

Alongside this there is a need for investment in wider community-based support, including in the activities and services through which people are able to make connections and find meaning and purpose. This includes specialist services for people experiencing homelessness and substance abuse issues, and support for people with particular conditions, as well as broader community capacity.

NHS England's investment in social prescribing link workers is welcome, but in many communities, there remain significant gaps in the capacity of community-based organisations to meet the needs that link workers identify. Ongoing investment in the VCSE sector will be critical. In the most deprived communities, the need for investment is greatest and investing in community infrastructure and community development to build capacity will be critical.[77] Recent guidance from NHS England recognises the critical role of ICSs in developing strategic approaches to building community capacity[78], working alongside partners from across sectors and building new approaches to commissioning and funding this work. It will be vital that ICSs draw on data from across the community, including around high intensity use of A&E, to help them understand where there is a need for investment.

8.5 Addressing the wider determinants of health

This research demonstrates that high intensity use of A&E is closely linked with deprivation and to a range of other key factors that sit outside the remit of the health and care system.

Action on these wider determinants of health will be vital if we are to address the issue of high intensity use in the longer term. However currently the indicators are going in the wrong direction. Covid-19 has exacerbated inequalities, with people in the most deprived areas twice as likely to die compared to people in the least deprived areas, and the wider impacts of the pandemic felt unevenly across communities.[79]

The long-term underfunding of public health is a significant barrier to more proactive approaches to promote health across communities. However there is also a need for action across a wider agenda including, for example, housing, work and the criminal justice system.

Addressing the complex issues which underlie health inequalities requires action across all areas of public policy and across all sectors.

The Government's levelling-up agenda presents an opportunity for action across Government to ensure that people across all areas regardless of their background can realise their potential and live in good health. However, tackling deep-seated inequalities will require deliberate action and investment.

That is why the British Red Cross has joined hundreds of other organisations in calling for a national cross-government strategy to reduce health inequalities, which recognises the need for action across departments to address the wider determinants of health.[xvii]

[xvii] The British Red Cross is part of the Inequalities Health Alliance.
See: https://www.rcplondon.ac.uk/members-inequalities-health-alliance.

9.

Conclusions and recommendations

9.1 Conclusions

This research has explored people's journeys towards the high intensity use of A&E – their behaviours, needs, experiences and health outcomes. It paints a complex picture of intersecting physical and mental health needs, social and economic difficulties, and often negative experiences of care elsewhere. But it also identifies a series of missed opportunities across the health and care system to identify and support these people earlier on – from misconceptions among healthcare professionals, to a lack of joined up care and integration, to an ever-shifting, but still widespread, disregard for the importance of addressing people's wider social determinants of health through de-medicalised care and support.

We have found that the high intensity use of A&E currently costs the NHS £2.5bn per year. The case for change to shift investment from emergency care to community and primary care is clear, when looking at the economic and health impact that some best practice examples, including HIU services, have for people frequently attending A&E. These services have successfully reduced emergency attendance and admissions and improved people's health and wellbeing by increasing capacity and navigation in primary and community care.

With the development of Integrated Care Systems creating a fresh impetus for collaboration across health and care system partners and with communities to make the best use of resources, we have an opportunity to refocus and redouble efforts to address the issue of high intensity use of A&E. This will require action in three key areas:

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

9.2 Recommendations

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 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 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 high 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 reduce inequalities 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.

10.

Appendix A: Patterns of high intensity use of A&E

To capture how attendances typically rise, sustain and decline, trajectories of high intensity use of A&E over the long term were analysed. Patterns were determined by the combination of high intensity use of A&E tiers (no high intensity use of A&E, low, medium, high) throughout the seven-year period (2012 to 2019) captured in this dataset. These attendance patterns were found to be widely varied among our sample of 367,351 individuals, with over 7,000 different combinations.

These patterns were categorised into the following trends:

Figure 17: Trends in high intensity use of A&E

Trend type	Description
Flat or gradual 	- High intensity use of A&E begins and ends gradually. Attendances increase or reduce by no more than five additional or reduced attendances in one year compared to the previous year. - **The shorter the length of time for which frequent A&E attendance persisted, the more likely it was for the trajectory to be flat or gradual.** 80 per cent of those frequently attending for two years experienced this trend vs. 34 per cent of those frequently attending for six years.
Sudden rise or drop 	- A sudden rise in the high intensity use of A&E occurred when individuals jumped from no high intensity use of A&E to more than 10 attendances in the subsequent year. This pattern was also seen for those who temporarily stopped their behaviour of high intensity use of A&E and later resumed. - A sudden drop occurred when individuals attended less than five times or no times after a period of high intensity use of A&E of more than 10 times in a previous year. - **The likelihood of both trends increased for those frequently attending for a longer period.** While only 14 per cent of those frequently attending for two years experienced either of these two patterns, the likelihood of both increased significantly among those who frequently attended for six years or more in total (where the chance of a sudden rise increased by up to 48 per cent, and the chance of a sudden drop increased by up to 40 per cent).
Both rise and drop 	- A third of those experiencing a sudden change in their high intensity use of A&E patterns had both a sudden rise and drop in their journeys. Again, **the likelihood of this pattern was significantly higher for those frequently attending A&E** over the longer-term (22 per cent for a six-year period) than over the shorter-term (9 per cent for a two-year period).
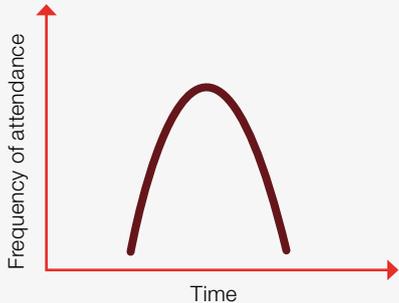
The flat or gradual trajectory is most likely to be reflective of a natural decline in high intensity use of A&E, with the individual's medical issues either passing or being sufficiently addressed. On the other hand, sudden changes in patterns of high intensity use of A&E could be attributed to a number of possible causes. Some that were highlighted in our qualitative research include:

- A triggering life crisis that has led to a sudden increase in the frequency of attendance (e.g. recent traumatic incidents within the family).

- A new health condition has emerged which cannot be, or is not, managed independently by the individual and requires frequent support.

- The individual disengages from A&E and withdraws by choice or due to a change in their circumstances, despite the medical need continuing.

- The individual passes away after a period of high-tier high intensity use of A&E.

In any of these cases, it is likely that those who experience these sudden shifts are particularly vulnerable individuals. Examining an individual's trajectory of A&E attendances is therefore another way of identifying priority individuals for intervention, and of identifying those who are more likely to sustain a high level of high intensity use of A&E over multiple years. Specifically, a drastic increase in A&E attendance from fewer than five to more than 10 times in the subsequent year could be used as a measure to flag those at a higher risk of high intensity use of A&E in the long term.

Although timing is important, our analysis finds that certain characteristics may be useful for identifying and intervening where people are at risk of becoming complex, long-term frequent users of emergency services.

As previously discussed, high intensity use of A&E often declines naturally within a year, while a smaller but significant subset (44.1 per cent) of people continue their high intensity use of A&E over multiple years. Our analysis of the national Hospital Episode Statistics dataset shows that by the eighth visit in one year, a person attending A&E is more likely to visit frequently over the long term. Attending eight times within a year also increases the likelihood of the user resuming their high intensity use of A&E, even if the pattern naturally ceases for a temporary period.

Analytical approach

The above patterns were found by conducting a logistic regression analysis on the national dataset of people who frequently attend A&E (n=367,351) to compare the extent to which various socioeconomic variables can predict those who are more likely to attend frequently at a high tier and in the longer term. The key output of these tests was 'importance values', as represented in the shading of the boxes in Figure 7. These values were artificially created for the purpose of comparing the predictive values between variables, meaning they have been created to allow the reader to easily understand which variables have the strongest predictive value. The values also allow direct comparisons between variables, meaning that variable A with a value of 67.1 is 22 times stronger than variable B with a value of 3.1.

Each regression model was built on part of the sample population and tested on the remaining sample to assess the accuracy of its predictions. All outputs reported here have an accuracy of 69 per cent or above, which is considered high for this type of analysis.
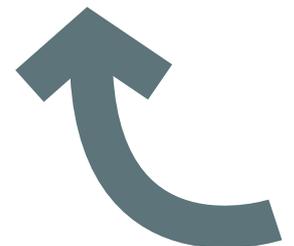
Appendix B: Methodology

This research aimed to explore comprehensively the high intensity use at A&E in England. It aimed to answer the following questions, including:

- What are the demographic characteristics of people attending A&E regularly?

- What triggers high intensity use of A&E services?

- What patterns can we observe in people's patient journeys?

- How could people attending A&E regularly be supported better?

In order to answer these questions we used a mixed-method approach including

- a literature review

- a quantitative analysis of a novel 6-year longitudinal nationwide dataset covering 367,000 people frequently attending A&E

- a quantitative analysis of emergency department diagnosis data from 3 major acute trusts

- 14 semi-structured interviews with people who were frequently attending A&E

- 17 expert interviews with health and care professionals supporting people who were frequently attending A&E services

- Imperial College Health Partners Research in North-West London analysed frequent attendance among a cohort of 2.2 million patients

Further detail about each method can be found below.

Research during lockdown: Fieldwork took place between March and November 2020, at the height of the Covid-19 outbreak. As a result, all qualitative research was undertaken over the phone and on a 1:1 basis. Our fieldwork ambitions were also limited as a result of the pandemic, making planned in-person workshops impossible and hampering our ability to recruit interviewees, as a result of social distancing and lockdown measures that were still in place in services across the country.

Definition of High Intensity Use of A&E

People who frequently attend A&E are individuals who use emergency services such as ambulance services and A&E or emergency departments (ED) at above-average levels.

Some studies and institutions categorise frequent A&E attendance using an absolute number: most commonly in the UK, five or more attendances per year is considered to be frequent. However, the minimum threshold varied throughout the literature analysed for this report, ranging from four to 10 attendances per year.

Moreover, some studies have extracted a specified number of service users with the most high intensity use of A&E in a given sample. For example, one study focused on 20 users with the highest attendance rates within a specific emergency service.[80]

Some HIU services focus on the 'top 50' users of emergency services at any one time. This is measured by number of attendances over a selected period.

In our report, the definition of high intensity use of A&E was specified to five or more attendances in a year. In some cases these visits can, however, total up to 300 or more in one year. Our intention was to develop recommendations that span across this wide range of presentations with a focus on those who are likely to attend A&E frequently over a longer period of time.

Literature review

Objectives and research questions

The key research questions were as follows:

1. What are the key triggers, drivers and circumstances that lead people to frequently attend A&E services?

2. How can reliance on A&E for people who frequently attend be prevented, and what are the most effective interventions to support this group?

3. What pathways do people who formerly attended A&E frequently take after they move on from the HIU services, and where do they access alternative support?

The literature review aimed to assess the extent to which the key research questions are addressed in existing literature, and to set this research in context.

This review was conducted in January 2020.

Approach to literature review

Our literature review covered academic papers from across seven international health systems, written over the past 35 years. The literature search was based on a list of key words and search terms covering a broad spectrum of factors associated with frequent A&E attendance, which was collaboratively produced by The PSC and British Red Cross.

The following keywords and their synonyms were used in the process of searching literature:

- A&E / urgent care / emergency department (ED)

- People who frequently attend / frequent flyers / high frequency / high intensity / repeat visits / super-utilisers / high volume / High Intensity Users

- Loneliness / social isolation

- Chronic illness

- Mental health / mental illness

- Homeless

- Ex-prison

Various combinations were attempted in order to expand the search while filtering relevant material (e.g. "emergency department people who frequently attend").

As the review proceeded, additional themes of interest were identified, and the associated literature was incorporated on a case-by-case basis. For instance, we looked at the extent to which individuals feel 'believed' in healthcare settings and the utilisation of primary care as these became relevant to our findings.

As well as academic journals, literature sources included news articles and policy papers.

Expert and user interviews

Design

Expert and HIU service user interviews were conducted to capture the perspectives and lived experiences of the people classified as frequently attending A&E, and those who provide support and services to them. Interviews were semi-structured, following an interview guide that was designed using insights from the literature review. Ethical protocols were followed to ensure the safety of participants; see 'Ethics and safeguarding' for more details.

Participants

Researchers contacted HIU service leads (those who provide support to people who frequently attend A&E) across all of England requesting contact details for any service users that: (a) had been attending their HIU service or attended in the past, and (b) were willing to be interviewed. A very wide range of service leads were contacted over a five-to-six-month period, but due to Covid-19 restrictions the recruitment became limited. This resulted in a high proportion of HIU service leads being linked to the British Red Cross.

The following table captures the characteristics of the sample for expert and service user interviews:

Figure 18: Table of research locations

Interview type	Criteria	Sample size	Geographical areas covered
HIU service users	Individuals who have a history of high intensity use of A&E, who have formerly accessed or are currently accessing an HIU service.	**14 people, covering:** **Ages 22 to 72** **5 men and 9 women**	- Lewisham - Norwich - South East London - South East Kent - Walsall
Experts in frequent A&E attendance	Professionals in roles where they provide frontline support to people frequently attending A&E.	**17, including:** **2 GPs** **2 A&E Consultants** **13 HIU service leads, including the founder of HIU services**	- Bristol - Bromley - Lewisham - North Durham - Norwich - Salford - Sandwell and West Birmingham - South East Kent - Shropshire - Walsall - Warrington

Approach to interviews & analysis

Interviews were conducted via phone calls with a semi-structured approach. Interview guides were created and used to cover a comprehensive set of questions. Interviews with people who frequently attend were conducted privately between the researcher and interviewee, and HIU service leads were not present.

The analysis followed a deductive approach whereby content was extracted from interviews and applied to thematic categories that were created based on findings and hypotheses from the literature review. Hypotheses were then iteratively developed throughout the research process as additional insights were gathered continuously with every additional interview.

A key priority for this research was to bring in the voices and narratives of people who have frequently attended A&E, we have extracted quotes from interview notes to illustrate their responses in their own words.

Ethics and safeguarding

Participants gave their informed consent to take part in the research. A safeguarding policy was in place to ensure appropriate aftercare could be sought if required.

Trust data analysis

Design

Datasets consisting of information about people who attended A&E frequently in 2017 were provided by three large secondary care trusts located in various areas around the UK, covering a total catchment population of 2.8m. Demographic and attendance characteristics were analysed for each trust.

The analysis incorporated data from all three trusts wherever possible. Reliable data on primary diagnosis was provided only by one of these trusts covering a catchment population of approximately 820,000. It contained patient demographic and A&E attendance data from 2015 to 2019 for all who attended A&E five or more times during 2017. The focus on high intensity use of A&E in 2015 allowed the research to capture a recent snapshot as well as a longitudinal view with at least three years leading up to and following the specified year.

None of the datasets used contained any patient identifiable information. Patients were allocated pseudonymised IDs. The analysis followed data handling protocols and regulations set out by the data provider.

Analysis

Analysis was conducted and outputs were created using Microsoft Excel. Some additional statistical tests were also conducted using Statistical Package for Social Sciences (SPSS) software.

Attendance data was analysed by patient or by visit. The following variables in the raw dataset were processed and analysed:

Figure 19: Table of variables analysed using SPSS

Raw data variable	Processed variable	Analysis
Pseudonymised patient number	- Frequency of attendance per patient in each year from 2015 to 2019	- Categorisation of each patient into subsets based on frequency of attendance and length of high intensity use of A&E
Patient age band	- Patient age group	- Age distribution of people who frequently attended A&E
GP practice code	- Used as a proxy for patient area of residence - Linked to deprivation metrics / urban-rural classifications / distance to A&E	- Distribution of people who frequently attended A&E across deprivation deciles - Distribution of people who frequently attended A&E across urban/rural categorisations
Attendance date and time	- Patient attendance days / hours	- Comparison of attendance dates and times among people who frequently attended A&E vs. broader A&E attendee population

Figure 19: Table of variables analysed using SPSS – continued

Raw data variable	Processed variable	Analysis
A&E arrival mode	- Proportion of arrival by ambulance	- Comparison of ambulance arrivals among people who frequently attended A&E vs. broader A&E attendee population - Ambulance arrivals across attendance frequency tiers
Method of discharge from A&E	- Proportion of discharges - Proportion of admissions	- Comparison of admission rates among people who frequently attended A&E vs. broader A&E attendee population - Admission rates across attendance frequency tiers
ICD-10 primary diagnosis	- Incidence of mental health diagnosis - Incidence of overdose diagnosis - Incidence of no diagnosis - Incidence of substance-abuse diagnosis	- Incidence across attendance frequency tiers - Rates of comorbid diagnoses

National data analysis

Design

A dataset extracted from the Hospital Episode Statistics (HES) database was used to capture a nationwide picture of people who frequently attended A&E. The database contained data items relating to A&E care delivered by NHS hospitals in England and a range of patient information. The dataset used in our analysis was specific to patients who attended A&E five or more times in 2015.

The dataset did not contain any patient identifiable information and patients were allocated pseudonymised IDs. The analysis followed data handling protocols and regulations set out by the data provider, which specified where and how the data could be stored, extracted and analysed.

Analysis

The dataset contained a large quantity of duplicates which were eliminated in the data handling process. Analyses were conducted using Python.

Figure 20: Table of Python analyses

Raw data variable	Processed variable	Analysis
LSOA code	- Linked to deprivation metrics / urban-rural classifications	- Distribution of people who frequently attended A&E across deprivation deciles - Distribution of people who frequently attended A&E across urban-rural classifications - Count of registered addresses - Comparison against national average
GP practice code	- Linked to GP practice rating	- Distribution of people who frequently attended A&E across GP ratings - Count of GP practices registered
Age band	- Patient age group	- Distribution of people who frequently attended A&E across age bands - Comparison against national average
Sex	- Patient sex	- Distribution of people who frequently attended A&E across sex
A&E attendances per year between 2012 and 2019	- Frequent A&E attendance identified as 5+ attendances per year	- Range of attendances per year among people who frequently attended A&E - Number of years frequently attended A&E - Categorisation of each patient into subsets based on frequency of A&E attendance and length of high intensity use of A&E
Year died	- Mortality rate	- Mortality rates across age bands / tiers of high intensity use of A&E / length of high intensity use of A&E - Comparison against national average

Figure 21: Regression analyses variables

A regression analysis was conducted to test the power of a range of socioeconomic variables in predicting certain outcomes related to frequent A&E attendance as follows:

Socioeconomic variables explored	Outcomes tested
Sex **Age band** **Number of ethnicities coded per individual** **Deprivation level (IMD decile)** **Urban / rural area of residency** **Number of registered addresses** **Number of GP changes** **GP rating components**	**10+ A&E attendances in a year** **Attendance rates in 2015/16** **Tier of frequent A&E attendance (low/middle/high)** **Total number of years of frequent A&E attendance** **A&E attendances between 2016 and 2019** **Frequent A&E attendance over the long term (more than 1 consecutive year)** **Recurrence of frequent A&E attendance**

The test accuracy varied between 14 and 84 per cent. In this report we only displayed the results of tests that had an accuracy of 65 per cent or above.

Benchmarking Approach

A&E attendances and admissions

To explain the relative size of populations of people who frequently attended A&E and their characteristics relevant to the general population, we benchmarked the bespoke HES data against publicly available national data on A&E attendances and admissions:

- Percentage of all attendances: calculated using requested National HES dataset and 2015 publicly available HES data on unplanned attendances in A&E in 2015.

- Percentage of all admissions: calculated using requested trust datasets from 2018 and publicly available HES data on admissions from A&E in 2018. The admission rates for the trusts were adjusted in line with the difference between the general admission rate of these specific trusts against the national average.

- Percentage of all bed days calculated using Average Length of Stay from 2018 trust dataset, adjusted using Model Hospital data on median length of stay, and 2018 publicly available data on total inpatient beds and occupancy. The Length of Stays for the trusts were adjusted in line with the difference between the Average Length of Stays of these specific trusts and the national average.

- Percentage of all ambulance visits: calculated using ambulance arrival rates from 2018 trust dataset, adjusted using national 2018 data on ambulance arrival rates. The trust ambulance arrival rates were adjusted in line with the difference between the ambulance arrival rates of these specific trusts and the national average for Type 1 providers.

Source: NHS England, A&E Attendances and Emergency Admissions 2017-18

Mortality

Mortality rates were compared against the England and Wales population-wide mortality rates in the same year (2015).

Source: Death rate by age group in England and Wales

Cost of attendance

These figures were subsequently used to model the cost impact of people frequently attending A&E. This was done using national NHS reference costs and London Ambulance Service costs.

Source: Department of Health, Reference Costs 2015-16; London Ambulance Service: Annual Report and Accounts 2018.

Changes of address

Changes of address among people who frequently attended A&E were benchmarked against an estimated national average. The average was estimated using modelling of data retained from sources below.

Source: Office for National Statistics[81], Zoopla and Simply Business.

Primary Diagnosis data

Characteristics of frequent A&E attendance were captured via quantitative analyses on datasets from three large secondary care trusts located in various areas around the UK, covering a total catchment population of 2.8m. Demographic and attendance characteristics were analysed for each trust. By zooming into one of these datasets containing diagnosis data in 2017, we explored the ways in which people who frequently attended A&E were perceived and assessed by staff there, by analysing their primary diagnoses.

It is worth highlighting that the primary diagnosis is a limited tool that only provides us with part of the picture. This is partly because diagnoses are recorded within a busy A&E department in haste, and in conjunction with a verbal staff handover which usually provides more information and detail for the purposes of treatment. Indeed, doubts have been cast on the overall quality and accuracy of A&E primary diagnosis data.[82] Finally, diagnosis codes are unlikely to reflect a person's full medical history and pre-existing conditions.

Despite these restrictions, primary diagnoses in the acute setting are a valuable tool in understanding frequent A&E attendance because they give us information about how a patient was understood within the A&E setting, and an indication of how they were treated.

Acknowledgements

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