healthwatch Haringey

North Middlesex University Hospital

High Intensity Users Pilot Study

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delivered by Public Voice

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Project objectives

There have been a number of studies, most notably one in Blackpool, that have used a social prescribing intervention to work with individuals who are very frequent visitors to A&E departments to successfully modify their behaviour and reduce their attendance levels.

The CEO of North Middlesex University Hospital (NMUH) was keen to explore a similar approach, working with Healthwatch Haringey (which is delivered by Public Voice), to understand the reasons why a significant number of residents frequently attended the NMUH A&E department and, taking a holistic approach, work with them to address the issues that underpinned this habitual behaviour.

The rationale for the Pilot Study was that it could provide information that would potentially reduce the numbers attending A&E and phoning the ambulance service; frequent attenders make up a significant number of visits in any one month. This would free up the time of A&E medical staff and ambulance services and help the residents to address their underlying issues in a more constructive and effective way. If there was a business case established through the Pilot Study NMUH would consider commissioning the service on a longer-term basis.

Findings

1. The Study, which started in February 2020, was disrupted by the coronavirus pandemic and Lockdown in March, but our Social Prescriber Susan Morrison continued to make frequent and regular telephone contact with clients on the High Intensity User (HIU) list over a five-month period. These calls were very much welcomed by the clients whose anxieties and concerns were heightened by Covid-19 experiences.

2. Susan did meet one patient face to face in a café setting prior to the lockdown and, despite some early resistance, this intervention had a positive outcome resulting in compliments from the patient's family, see Case Study A.

3. It is clear from the Case Studies that the clients had a wide range of underlying problems that needed to be addressed which, if resolved, would almost certainly remove their desire to attend A&E.

4. There were some surprising explanations, e.g. some clients used A&E attendance as an excuse not to be sanctioned by DWP for failing to meet their job search related obligations.

5. Ironically, some of their problems, e.g. fear of debt collectors and being sanctioned by DWP were less of a concern during the lockdown which reduced their anxiety relating to these pressures.

6. Some of the frequent attenders were living in care homes and other supported living accommodation.

7. Most of the clients did not have a positive experience when they attended A&E which makes their frequent visits even more difficult to understand but highlights the complexity of the reasons for them doing so.

8. An intervention from an individual with appropriate training and experience of working with vulnerable adults can, in many cases, help them resolve underlying issues and help them move to more constructive and positive behaviours.

Methodology

Healthwatch Haringey appointed Susan Morrison to work with a number of those residents who were the most frequent attendees at NMUH A&E department. Susan was initially given 70 patient's details all the information of which was input into our CRM after going through the patient list and making first contact via telephone introducing herself and explaining the reasons for the Project.

Susan was cold calling the clients as they had no prior knowledge of the Project or their involvement in it. Giving some feedback on Susan's experience in her own words provides an insight into the process:

> *During this initial contact some of the patients where very mistrusting and thought that I had a cheek to tell them when they could or could not go the hospital.*
>
> *To help my gaining the trust of the patients I gave them the telephone number of Healthwatch Haringey to allow them to personally check my credentials - if they wished to allay any suspicions that they had, for reference to help them further I also gave them the number of my own mobile.*
>
> *My giving them the option of contacting Healthwatch Haringey to clarify why I had contacted them helped them confirm that I was genuine and helped me obtain as much information as I could without visiting, which I was sadly unable to do in the pandemic environment, as I have noted below.*
>
> *I managed to make my first personal visit appointments for the week beginning 17th February 2020 during which time I met with two different residents but sadly consequently all my other appointments had to be cancelled due to COVID-19.*
>
> *My approach pre-COVID-19 was to meet with all the patients personally to gain their trust and try to ascertain the reasons why the visits to the hospital were so vital to them, to give them alternatives to this, also to coordinate signposting them to other organisations who could help them, and to reduce the impact on the North Middlesex Hospital A&E.*
>
> *The options were to either meet with the patients within their home environment or at a safe place so that I could find out exactly what their issues where and whether I could provide support and guidance.*
>
> *Pre-COVID-19 the conversations were specifically about their own personal concerns and worries, a lot of problems were their having financial or housing difficulties and the lack of support from the Council, Social Services and DWP. These concerns caused anxiety and mental health problems.*

Due to COVID-19, the conversations and phone calls changed dramatically and information regarding personal issues and concerns was easier to obtain as people needed to talk and were scared of the unexpected. This and the effects of COVID-19 brought on anxiety, the fear of going to the hospital and of contracting the virus. Social isolation and depression were also particular concerns post-COVID-19.

I had no way of finding out whether these patients were attending hospital or had made 999 calls. Naturally, this was a problem because I could not confirm whether the information given to me at the time was correct and not being able to meet the patients in person or to carry out home visits made the Study especially difficult.

Also due to COVID-19 lockdown there were no debt collector calls, giving patients breathing space to come to terms with the issues.

Some of the patients where based in Assisted Living Accommodation or Care Homes. Consequently, information was very difficult to obtain from where they lived due to not being able to make personal visits myself and the staff there not being able to share personal information due to Data Protection. Some of the patients that I did manage to speak to within these environments were very worried about the lack of visits from their family, friends and health professionals during COVID-19, and the first lockdown made it extremely difficult to obtain information as staff priorities were naturally to ensure patients safety.

The inability in the current circumstance to meet the patients in person made collating information very difficult, because gaining trust over the telephone was difficult. Not all the patients wanted to relay any information to me and said outright that I had no right telling them when they could or could not go to the hospital, others were concerned that I was intruding and being judgemental about the number of times they attended A&E. This did not apply to all of the patients as others wanted the support and gladly welcomed discussing their own issues. Another of the obstacles that the inability to meet in person caused was that some of the patients suffered from hearing impairments and could not be on the phone for long periods of time and, consequently, kept requesting me to call them back.

I ensured that I called patients at regular times, to retain consistency - at the same time each week for example - to save them from becoming confused, especially for the elderly clients. The information I received and recorded was from either the patient themselves, their family members or care givers.

Telephone calls increased considerably from the end of March through to May 2020 due to COVID-19. From the outbreak of the pandemic to lockdown being imposed, in 80% of my telephone calls the patients only concerns were relating to coronavirus. Consequently, it was an extremely difficult time during the Study.

I made contact with at five patients on each of the 2.5 days (contracted hours for the Study), however because of the anxiety/stress levels due to the virus, calls were sometimes required to be made daily. These calls could be from 10 minutes long to a two-hour conversation, especially during the months of March, April and May, i.e. during the first full Lockdown.

My conversations were mainly supportive, keeping the patients informed of services available to them. I used relevant agencies to signpost them to this support for example –

- *Engage Haringey*
- *Haringey Reach and Connect*
- *Social Services*
- *Haringey LAC*
- *gov.uk*
- *Tottenham Foodbank*
- *Mind in Haringey*
- *Social Care*
- *Women's Aid*
- *Bereavement Counselling*

Underlying Issues
The issues and characteristics were different depending on age, sex, ethnicity:

- Lack of Trust
- Mental issues – Including anxiety and depression
- Financial
- Health
- Housing
- Bereavement
- Stress
- Family
- Social isolation
- Menopause
- Midlife crisis
- Loneliness
- Anger
- Racism
- Cultural differences
- Immigration
- COVID-19

Pre COVID-19 issues
Losing their property due to loss of income following redundancy, having to live with relatives, health issues, poor diet, smoking, diabetes, depression and anxiety, housing, drug use, being sanctioned (and using A&E as a reason not to be sanctioned), not having money to go to interviews, and the anxiety of not receiving relevant Benefits. Mental health was a very prevalent issue.

Post COVID-19 and during first lockdown
Once coronavirus became the focus, the conversations changed dramatically as personal information (issues and concerns) was easier to obtain from some patients. However, the concerns caused by the coronavirus pandemic made the conversations more intense as patients were afraid of contracting the virus and were therefore keeping away from A&E.

The fact that they could not gain access to A&E, unless of course in an emergency, reduced their ability to visit as frequently as they once had, thereby curtailing access to a place that the HIU group of people relied on as a safe haven.

Profile of issue by age

Age Group	Depression	Isolation	Mental Heath	Financial Difficulty	Health Issues
50-70	50%	40%	60%	50%	70%
70+	40%	90%	30%	25%	97%

The information for the table above was gained from the clients themselves and/or from carers and family members. The profile of the issues for each age group is what one might expect and is not surprising, but the incidence is high and frequently patients experienced a number of these issues and were overwhelmed by them.

Case Studies

To comprehend the reasons for clients frequently attending A&E and identify potential interventions to support a change in behaviour, it is necessary to understand their story. Each patient has a different story which many are willing to share once a trusted relationship is established. Some of these stories are outlined below using Susan's own words to describe both the process of building trust and the substance of patient experience. The case studies illustrate that it is possible to provide interventions and support that will benefit the patient as well as reducing their dependence on A&E and the ambulance service.

Patient A

"Patient A is a Female who is 60+ years old, she has really bad anxiety and after my initial call we arranged to meet at a local café. She is being sanctioned because she does not feel well enough to go for Universal Credit appointments because of her anxiety.
At this meeting she did not want to give me any information about her living conditions, this was because she was very worried and had convinced herself that I worked for the council, she did however inform me that she was moving home.
At the first meeting at the café, we met for 20 minutes, after which she agreed that I could call her the following day.
I called Patient A the following day and she was extremely anxious, I assured her that I was there to listen to her concerns and not to judge her, she was very worried that she would have to go to the hospital because she was feeling anxious.
She informed me that she started feeling this way since she was made redundant six years ago and as a consequence, she could not pay her mortgage, because of this she had lost her property and now lives with her son in the spare room, additionally she also suffers from COPD.
We talked for 110 mins about her old job and how she had lost all of her confidence, I listen to her intently.
A home meeting had been arranged for the following week, however, this had to be cancelled due to COVID-19 restrictions.
During another telephone call that I subsequently made, I discovered that for some reason she was still extremely worried about her information being shared with other agencies. I assured her that her information was private and that I was not there to report her to Social Services.
Since the initial meeting she is now feeling extremely isolated because of the virus and was scared of getting it. She does not seem to be worried about being sanctioned at this moment, her focus in the conversation was on COVID-19.

We discussed ways to calm down her anxiety, not watching the news constantly for example, and trying to watch funny movies instead. She will not go to the hospital because she is afraid of contracting COVID-19. I encouraged and advised her to contact Mind and passed on their contact details."

Below is a copy of an email sent in relation to Patient A from Susan to her family and their response to this Re: Heating vs Eating Voucher £50.00

On 31 Mar 2020, at 16:53

Hiya

Please see email below re-voucher as discussed.

We had a long conversation today and I hope all the information helped you and your mum.

Remember one step at a time, you're not in this alone, I will call mum next week.

Take care, all the best

Tue 31/03/2020 17:06

Hi Xxxxx

Thank you so much for the long talk with my mother, I really appreciate it.
I think it did her a world of good to hear some comforting words from you during this difficult time.

Also, thank you for the information, couldn't have come at a better time.

Wish you well

Kindest Regards

(Total number of visits to Hospital / A&E 61)

Patient B

"Patient B is a male who is 79 years old and lives in sheltered accommodation.
He smokes 40 cigarettes daily, his meals are provided, but unfortunately, he does not take part in any of the activities that are provided within the scheme as he does not like the other residents.
During my first initial telephone call he became terribly upset, to alleviate this I explained who I was in more detail.
Consequently, Patient B agreed to speak to me at another time that was convenient for him.
During this call he informed me that the NHS had no right to tell him when he can or cannot go to the hospital. I informed him that the NHS were not stopping him from going to the hospital if unwell. I told him that I was there to listen to the reasons that he believed that he should visit the hospital regularly. Patient B told me he gets lonely and feels sometimes you can find nice people in the hospital to talk to. I informed him that there were other ways to find people to talk to for example I suggested a Befriender, he refused this suggestion.
He informed me that he once had two cats that he had to put down and was distressed because the scheme would not allow him to get any pets at the moment.
Patient B was also worried about contracting Covid-19, because he lives in sheltered accommodation, which the media had highlighted as a hotspot.
Although he initially rejected my suggestion of a Befriender, he consequently said that he would like to have a Befriender to take him out when social distancing calms down."

(Total number of visits to Hospital / A&E 46)

PATIENT C

"Patient C is a male who is 89 years of age. He has breathing difficulties due to severe asthma, he also has diabetes and hearing impairments. He has carers and home help.
Patient C lives alone at a residential care home, and consequently he suffers from isolation and loneliness. He has no family.
He is very distrustful of carers and informed me that he had a black carer who stole something very important to him. I must point out that his language was racially challenging, he was however very apologetic afterwards, he was worried about upcoming hospital appointments, for example whether he would be allowed to go due to the circumstances of the pandemic.
I told him that if he had any appointments, the hospital would let him, or his care manager know.
Patient C said he does not like being on the phone and he would much rather have visits at home so that he can hear better, which due to social distancing restrictions I was sadly unable to do."

(Total number of visits to Hospital / A&E 54)

Patient M

"Patient M is male and is widowed, his wife died seven years ago.
He used to be an accountant, however since losing his wife he was been diagnosed with depression.
I've called this patient several times and we had four calls before he would open up and talk, he simply misses his wife and refuses to get over her.
He used to travel with his wife, they have no children.
Unfortunately, because of his state of mind the RSPCA people took his wife's pet away, which resulted in the pet dying.
He said that for years since losing his wife he did not want to do anything.
I asked him why he had not asked the doctors for help, advice, support and bereavement counselling. He said he would rather not and preferred to dilute any pain with alcohol, we have spoken four more times since.
He tried to seek help a few years ago for his alcohol problems, this was at an alcohol abuse project that was within his local area. However, he felt that the staff were too intrusive because they would call him weekly, which he especially did not like and, as a consequence, he left the scheme and tried to cope on his own.
Since then, he started doing manual work outside with an old friend, but this only lasted for a few days.
Whilst he does not drink anymore, he has health problems caused by the drinking.
He would not tell me what his actual health problems were but feels bad about all the bad things he used to do whilst drinking and gets flashbacks. Consequently, he runs to the hospital because he believes that he his dying. I informed the him that he really needs someone professional to support him and to help him with his anxiety as this would help him to concentrate on living again. He said he would look into this.
His Anxiety levels are heightened because of the virus, and during our subsequent calls the conversation tends to lead to the pandemic and the fact that he is scared to go to the hospital.
On each call he asked if support could be arranged via Bereavement Services, *I said yes and have offered to help arrange this service for him.*
I asked him if he would let me refer his information on to Bereavement Services to facilitate this, but he continuously refuses. He is very articulate and is great to talk to, however, he is also very private and ashamed of his past and consequently he will not share that information with me."

*(***Total number of visits to Hospital / A&E 78)**

Patient N

"Patient N is female and lives in Sheltered Accommodation.
In the initial contact in February 2020, she said that she was very isolated, however, she talks extremely fast so is quite hard to understand. She loves talking but to my perception she sounds very confused at times.
From what I could ascertain she would love to have a befriender and someone to visit her.
I could not ascertain the reason why she goes to the hospital.
I've made contact three times and she sounds confused each time and says that she does not remember speaking to me.
I've tried to contact the Scheme Warden to find out a bit of information about the patient. Making sure of sticking within the boundaries that they must adhere to the Warden informed me that the family are looking to move the patient into a are home because her care needs have increased. She has been diagnosed with Alzheimer's, but until the care home move takes place they wondered if I or someone could visit as a befriender.
Due to the virus this is not possible, as all tenants are to stay within their flat and only socially distance carers are allowed to visit."

(Total number of visits to Hospital / A&E 71)

Patient O

"Patient O is female and lives with her oldest son. She suffers with breathing difficulties and because of this she would go to the hospital every time she felt pains in her chest.
She informed me that since the coronavirus outbreak this has been different because she gets worried as people of colour, like herself, are more likely to catch the virus. She does not want her son to go out, so she receives a food parcel every week, which she really appreciates.
I have made various calls to this particular patient during which she said that she is willing to have a befriender. I said that this was really good as it would help with her anxiety. To further aid relieving this, I advised that she should not watch the news every day because the stories are pretty much all focussed on COVID-19 and, therefore, maks her more anxious."

(Total number of visits to Hospital / A&E 68)

Patient P

"Patient P lives with his brother. From our telephone conversation it seems that both the brothers are of similar age and it transpired that they both look after each other.
The Patient was very talkative at first. Calls since then are less tolerable as he sounds very angered that the hospital shared information about his attendance at A&E.
I explained to him the reason was because of the sheer number of his visits to A&E, which he denied, informing me that "they were lying".
I just listen and allow him talk, it seems from our conversations that he mainly cares for his brother, he buys food from Lidl and also goes to Iceland.
He said he needed help with his benefits. I asked him what help he particularly needed? He told me that he could not remember and that he would have to ask his brother, asking if I could call back the following day. I tried calling him back as agreed, the phone was ringing but I did not get a reply. I called three more times."

(Total number of visits to Hospital / A&E 101)

Patient Q

"Patient Q is female, she suffers from COPD and lives alone. She has carers helping with home help.
She feels that she can do the clearing up herself but is not confident that she can stand for long periods of times because of her breathing difficulties.
I asked her the reason why she goes regularly to the A&E. She said sometimes she goes because she feels unwell and believes that the staff at the hospital can help her with her breathing.
I asked her if she had breathing medication at home. She said that does, but she needed to be sure that she could get help faster because at the GPs it takes too long to get an appointment. She said the GP usually takes three weeks and she said she could die if she waited for an appointment.
I asked her if she had explained this to her doctor, she said yes and that the doctor said that her health is fair and that she is fine. However, she does not believe him, as she believes that he just wants to fob her off. This is why she goes to the hospital.
I explained that by doing this she is taking up a lot of time from someone else who may have a serious emergency. She said that she had never thought of that.
I have called the patient since and these calls have been mainly focussed on COVID-19, where she said that she does not want to go to the hospital because the nurses are already working too hard. This patient would benefit from a befriender."

(Total number of visits to Hospital / A&E 62)

Patient R

"Patient R is male and is distressed because his dog died two years ago, and he cannot recover from her death. He has the dog's ashes at the flat and every time he feels sad because she is no longer there. He believes that he needs to go to the hospital, to check to see if he himself is ok.
I asked if he had seen his GP. He told me he did not want to because the doctor had simply told him to get over it.
He informed me that the GP was Asian and did not understand why he could not recover from the loss of a dog. I just listened and let him explain.
I told him that they were some charities who would help him with pet bereavement.
He told me that he would like to speak to someone, but he also enjoyed speaking to me because I had pets so could empathise with him.
He said he was too old to get another pet I told him he was not too old.
However, when I said this he said that he may not live too long, and he didn't want to take on another pet.
I asked him if I could refer him to a befriender, he said "only if they know about pets, if not forget it".
Since the Coronavirus all our subsequent calls are solely about this issue."

(Total number of visits to Hospital / A&E 78)

Patient S

"Patient S is female, she cares for her husband who suffers from vascular dementia.
He screams every time a carer tries to help him with his personal care, constantly refusing carer support and only wants his wife to do all the work herself.
She cannot manage this and needs help; this is difficult because he screams and shouts at everyone else who visits the home.
He went to a centre two times each week but caused so much trouble that he wasn't allowed to go again.
Patient S does not sleep because her husband always walks around the house at night screaming and waking the neighbours. Patient S feels embarrassed.

She has three grown up children, two that live abroad and one that lives in Surrey and she doesn't like to bother them as they have they own families. Due to her circumstances with her husband she is extremely exhausted and needs support.
I asked her the reasons why she visited A&E and she informed me that she was stressed and always had pains in her chest.
I asked her if she had informed her GP. She did not say but said that the hospital had not wanted to listen to her because they don't like her accent. It became apparent during our conversation that my taking time to listen to her explain her situation had helped her.
She also has heightened blood pressure and gets this checked weekly. She said that the GP had wanted to put her on depression tablets, but she had refused.
My initial call was to offer help with respite support for her husband.
The call after was made to support her, but her husband sadly died a few weeks before with COVID-19. Since the Lockdown and the death of her husband she is now staying with her daughter in Surrey."

(Total number of visits to Hospital / A&E 81)

Patient T

"Patient T is female and lives alone since her husband died two years ago from heart attack. She is a retired teacher and her daughter lives near her and visits her weekly.
She told me that her daughter feels responsible for her since her husband died but the patient does not want to pressurise her daughter because she has her own family.
She prefers to do her own thing and not to bother anyone.
I offered to meet with the patient before the COVID-19, however, she turned this down. At this point I realised that she did not want me to visit her in her home, as she informed me that she was a very private person. We agreed to meet but had to cancel because of COVID-19.
I called the patient and tried to make her feel at ease because of the failed meeting.
At this point the patient connected me to her daughter who is very supportive of her but told me that her mother is very stubborn and refuses any form of help. Even though her daughter knows that she can do things for herself, and is very capable, she believes that her Mum needs some form of counselling or even a befriender who can speak to her every couple of days.
Daughter said that mother finds it hard to communicate with her because she does not want to be a burden to her.

The patient is very private and believes that information should be kept to one's self rather than talking about it.
I informed the daughter that you could not change a person, you could only suggest but not force a subject matter on to them.
She agreed, especially when someone has depression or had a bereavement, the person needs to be coaxed rather than forced.
The daughter informed me that she had taken her mother to the GP, but the doctor had "spoken down" to the mother apparently, and because of this the mother goes to A&E instead of the GP.
She also said that the GP practice appointments are very few a far between. I explained to the daughter that A&E is not for general appointments but for people with emergencies. The daughter agreed totally and explained that her mother was very stubborn.
I asked the daughter about her mum's health issues. She said that her mum is depressed and that the GP had told her to get in contact with MIND, but her mum refused. Since the loss of her father her mother had become a sort of recluse - she did not want visits from friends or family and just wanted to be left alone.
I have spoken to the patient five more times since the coronavirus outbreak and the she seems to really enjoy our conversations. She talks about her husband with so much joy. I told her that I could arrange bereavement counselling for her or a befriender. She refused both.
Since the coronavirus pandemic, all conversations have been mainly about that subject and that she cannot attend A&E like she used to. As a result of this her anxiety has heighten. Her daughter visits every day and checks on her mum. In our last conversation the patient finally agreed to a befriender."

(Total number of visits to Hospital / A&E 46)

END