# High Intensity User Project

# SPECIFICATION

| Version | Date of  Change | Issue Status | Changed by | Reason for Change |
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| Care Pathway/Service | **High Intensity User Project** |
| Commissioner Lead | **Commissioning Leads** |
| Provider Lead |  |
| Period |  |
| Applicability of Module E (*Acute Services Requirements*) |  |

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| **1. Purpose** | | | | |
| * 1. **Aims** * Effectively manage, coordinate and sign post High Intensity Users of the local ambulance service and A & E within the CCG footprint. * Reduce the activity High Intensity Users have on GP practices * Establish, utilise and coordinate multi-agency and existing professional services to negotiate an adequate reduction in 999 calls including connection with where necessary extensive care and neighbourhoods * Demonstrate a reduced workload on unscheduled care services and the wider health economy resulting from reduced 999 calls, which otherwise would have attended A&E, result in an admission. * To safely manage and coordinate the chaotic and demanding nature of the patient group through the use of multi-agency support and the volunteer sector. * To provide fertile commissioning intelligence across all providers and in doing so, lower the stigma associated with High Intensity Users. * Coordinate a replicable service which can be integrated and managed over the longer term across other providers.   1. **Evidence Base**   One of the areas of increasing activity and cost in relation to unscheduled care services is emergency ambulance call outs, with activity growing at approximately 6% per year. Using data from a local ambulance service, High Intensity Users of 999 and frequent attenders to A&E can be identified through a range of data sources. From previous work undertaken, it is clear that some individuals have little clinical reason for doing so; others have genuine reason for calling or may be highlighted as vulnerable. From August to 2013 to April 2015, the scheme managed the top 100 most frequent, chaotic and vulnerable callers of 999, reducing the number of calls by 88% and sustained over an 18 month period (figures based on if their pre intervention figures were to remain contact).  Prior to this work it was felt that the group being focussed on would be unresponsive to any intervention and that there would be poor compliance with any actions agreed. This perception was proved to be incorrect with people responding well to having someone to talk to about their wider social needs and helping them to address them.  Evidence from the pilot suggests that where it is implemented effectively, it has improved the quality of life for patients, families and serving healthcare professionals. It also supported better care outcomes, safely reduced the utilisation of ambulance resources, A&E attendances, police attendances and hospital admissions, enabling a more cost effective approach to unscheduled care activity.   * 1. **Objectives**   The objectives of the scheme are to:-   * Identify those at greatest risk of 999 calls, A&E attendance and non-elective admissions. * Proactively manage a rolling cohort of High Intensity Users using a truly personalised approach. * To coordinate, sign post and oversee other identified High Intensity Users * To provide training and support to other providers to ensure patients are empowered to take ownership of their health and well-being whilst decreasing their dependency upon unscheduled care services. * Forming robust network of community health, social care, mental health and police to manage patients, creating true integrated working. * Providing a service driven by quality with positive human outcomes observed. * Act as a conduit to negotiate and de-escalate issues before a crisis occurs; a situation which has historically led to a destabilisation of their condition and resulting in a 999 call. * Improving communication and partnership working between those involved in patient care 24/7. * Assist other providers to identify patterns and ‘causal factors’ which trigger relapse behaviours in former High Intensity Users in order to shape future commissioning of service and/or demand/capacity planning * Reducing 999 calls * Reducing A&E attendances and avoidable NEL admissions * Empower patients to self-manage.to enable discharge and to switch them from negative to positive contributors of society. * Drive equality and patient voice.   1. **Expected Outcomes**   The key outcomes that the proposed service will deliver are:   * Impact positively on reducing the amount of High Intensity Users emerging to replace those already managed * Support existing projects by coordinating and sign posting referrals and partnership working. * To support patients to flourish through sustaining job opportunities, reconnecting with families, improving quality of life etc. * A new culture of health coaching as a medium to deliver sustainable change. | | | | |
| **2. Scope** | | | | |
| **2.1 Service Description**  The focus of the work will include early intervention of homeless persons, self-harmers and medical / social presentations who are not accessing scheduled services and, therefore, rely heavily on unscheduled services for their health care.  Each potential High Intensity User patient will be contacted by phone and assessed using a personalised approach to uncover the ‘real’ reason for calling 999. This may reveal a range of complaints; social issues combined with alcohol dependency, mental health, criminal justice and potentially some extremely complex medical presentations.  The vast majority of interactions may involve addressing a combination of a range of factors in order to reach the desired end. This may require times of unsocial hours working (after 5pm, weekends and bank holidays) in order to be available by telephone to provide patients with a one-to-one, personalised approach of de-escalating issues before it results in a 999 call. The patient group may have issues around trust so prefer to work with a designated person to begin with before being referred to mainstream services. Even once referred, the lead may need to maintain connected with the patient to act as a central and familiar point of contact so to pull services in the same direction and increasing chances of sustainability. Each patient requires a bespoke exit strategy to reduce the dependency on the project lead in order to increase capacity to take on the next cohort of eligible patients and to promote independence and esteem.  Following the initial telephone consultation, a process of support should ensue with concordance underpinning changes in behaviour rather than compliance through fear of isolation from supportive services or fear of legal restrictions. The lead should act as an advocate for each patient, guiding them through the complex journey and multifaceted approach which has resulted in appropriate use of unscheduled care. Whether the reason for calling is clinical, social, mental health, addiction, loneliness or a combination of any of these factors, the project lead should identify and adapt the support to meet the need.  **2.2 Accessibility/acceptability**  High Intensity Users will be primarily identified through data gathered from A&E. Those who visit the department more than 5 times in a month will be identified and patient data accessible to the clinical lead to be managed.  **2.3 Whole System Relationships**  **Key Stakeholders**  The project will interconnect Health and Social Care through establishing robust working relationships with:   * CCG * A&E * GP Practice and the wider primary care team * Mental Health Services * Drug and Alcohol Services * Police * Care and Repair * Social Services * Mental Health Helpline * Third sector – faith and voluntary * Community Services (community matrons, respiratory teams, falls teams etc.) * Ambulances service   The list is not exhaustive.  The relevant service will be engaged dependent upon the needs of the patient and then used to discharge the patient from the clinical lead. The majority have required a combination of the above to align in order to sustain the positive behaviours demonstrated. | | | | |
| **3. Service Delivery** | | | | |
| **3.1 Service model**  The service will be provided to any person within the area of the host Clinical Commissioning Group who fit the eligibility criteria of having unscheduled care activity more than expected, experiencing crisis and chaotic lifestyles or at risk of becoming a High intensity User on the emergency response system. The service will focus on and manage conditions such as;   * Addiction * Mental health * Medical complaints * Homelessness / housing issues / benefit complaints * Self-harm * Loneliness * Social issues * Vulnerable adults * Frequent fallers | | | | |
| **4. Referral, Access and Acceptance Criteria** | | | | |
| * 1. **Geographic coverage / boundaries**   Host CCG footprint   * 1. **Days / Hours of operation**   The service will be delivered 5 days per week within flexible hours to suit the needs of the patients with out-of-hours on-call telephone contact as required This requires some weekend on-call work as well as up to 9pm weekdays if required.  The lead anticipates patient need during the week for the weekend by identifying those in most need and will contacting the patient either out of hours or at the weekend if it felt they require motivating through this period.   * 1. **Referral criteria / sources**   **Referral Sources**  Referrals will be accepted from both primary and secondary care healthcare professionals including;   * Ambulance Clinicians / data feeds * Accident and Emergency department data * GP practices   **Referral Route**  The Provider will accept referrals by email, phone or face to face. A referral form will be completed by the Referrer and sent via secure email to the service lead.  **Eligibility Criteria**   * Aged 18 years and over * Registered with the host CCG   Patients with a history of violence with be managed via a discreet process which ensures the patient and service lead do not meet alone or without a chaperone. Any meetings will take place within the GP practice or public place.   * 1. **Location**   To be agreed, with flexible working hours including working from home.   * 1. **Exclusion criteria** * Individuals aged 17 and under * Patients in the Extensive Care service   1. **Response time & detail and prioritisation**   The service will respond to all referrals within 2 working days, upon receipt of a completed referral form.  The service will investigate the issues involved, collating background, contact the patient by telephone and manage accordingly. Individuals deemed vulnerable will take priority and be contacted within 24 hours of referral. | | | | |
| **5. Discharge Criteria and Planning** | | | | |
| Patients will be discharged from the service at a time when another service is accepting of the referral and can provide sustainable ways of moving the individual on (GP practice, volunteer sector, community services, mental health, peers groups etc).  Updates will be provided to primary care via the care plan or verbally as required.  All patients will be provided with the service lead contact number to re-contact should any re-lapse occur. On a case by case basis the lead will decide on the appropriate pathway of care (short term, or accept onto their case load). | | | | |
| **6. Prevention, Self-Care and Patient and Carer Information** | | | | |
| Each patient signs an individual data sharing agreement upon commencement of working together.  Patient Identifiable Information, along with progressive case notes, is only accessible to the clinical lead and is password protected. | | | | |
| **7. Activity and KPIs** | | | | |
| The Top 75 High Intensity Users of A&E will be identified and managed within 12 months before being discharged from the service into sustainable, robust, mainstream services.  Following this, a new cohort will be identified from A&E data and in partnership with GP practices and be managed on a rolling cohort.  **First year identifies a baseline for following year which may then focus KPIs on the following areas:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Performance Indicator | Evidence / Target | Timescale | Method of Measurement | Frequency of Monitoring | | Reduce avoidable 999 calls | 20% reduction on A&Es current position on this cohort | 3 monthly and year end | 3 month report and year end evaluation | 3 month report and year end evaluation | | Reduce avoidable A&E attendances | 20% reduction on A&Es current position on this cohort | 3 monthly and year end | 3 month report and year end evaluation | 3 month report and year end evaluation | | Reduce avoidable non-elective admissions | 20% reduction on A&Es current position on this cohort | 3 monthly and year end | 3 month report and year end evaluation | 3 month report and year end evaluation | | Measure potential reductions in self-harm attempts | 20% reduction on A&Es current position on this cohort | 3 monthly and year end | 3 month report and year end evaluation | 3 month report and year end evaluation | | | | | |
| **8. Price** | | | | |
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| Basis of Contract |  | Price | Thresholds | Expected Annual Contract Value |
|  | High Intensity Users scheme |  |  |  |
| **Total** |  | Cost of 1FTE |  |  |

**Invoicing Arrangements**

An annual invoice will be sent by the Provider, payment will be made in 1/12ths.