

NHS England

High Intensity Use Service Evaluation

March 2019

Synthesis of findings from the High Intensity Use Service case studies

# Introduction

In February 2018 the NHS England Evaluation team commissioned Arden and Gem Commissioning Support Unit to conduct an evaluation of the High Intensity Use service implemented in Milton Keynes on behalf of the NHS England Implementation Team. There was recognition that the programme had been implemented in different ways in Local Health Economies and therefore a further three evaluations were commissioned to understand variation at a local level. It should be noted that the Milton Keynes evaluation was more ‘in-depth’ as more resource was available to conduct it. The other three evaluations followed the same key lines of enquiry but with fewer stakeholders and so are considered more ‘light-touch’ however, the same semi structured interview schedule was adopted.

This report synthesises the findings from all four sites, identifying common themes and highlighting potential learning for future implementation. These reports are to accompany the full evaluation reports which are available from the NHS England Evaluation Team on request, as well as a Summary Report produced for the Implementation Team in October 2018.

Key terms

*Each site used different terminology to describe their service and clients therefore for consistency in this report the key terms are:*

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| HIU  | High Intensity Use | Defined by NHS England national team as being in the top 50 list of A&E attendances |
| HIU service | High Intensity Use Service | Umbrella term for the programme |
| HIU Lead  | The professional delivering the HIU service | Can be e.g. a nurse, a caseworker for a social enterprise, a paramedic etc.  |
| Client  | A person who uses the service |  |

# The HIU service concept

1. The HIU service was first established in Blackpool in 2015 and is based on the principles of *‘demedicalise, decriminalise and humanise’* High Intensity Use of emergency services.
2. A HIU Lead based in the providing organisation works intensively with clients identified as high use to understand the root cause of the problem; referring to other services spanning across health, social care and beyond as appropriate.
3. Since the pilot the NHS England Implementation Team has engaged with and offered other Clinical Commissioning Groups (CCGs) a programme of support to implement the service in their health systems.
4. In guidance from NHS England[[1]](#footnote-1) it is recommended that CCGs identify their top 50 use from A&E data. It is not prescriptive about the type of client but recognises that this a good base and local judgement is required regarding who to include/exclude.

# HIU service delivery

1. All four sites shared the same goals of reducing reliance on acute services and making positive changes to HIU’s lives specifically:
* Reductions in emergency service use
* Reductions in incidences of self-harm
* Improved experience of care for HIUs
* Improved perception/reduced stigma of HIUs among the community and healthcare staff
1. There was variation in how the sites chose to deliver the service based upon local need and resource available.
2. Variation also occurs in how HIU services choose to identify their HIUs dependent on maturity of system integration and ability to successfully utilise and share data.
3. A description of the detail of how the services were delivered, timescales and the resulting reductions in activity can be found in the summary table in Appendix 1.
4. A logic model detailing how the inputs are intended to result in the outcomes is included as Appendix 2.

# The Evaluation

1. The aim of the evaluation was to provide an assessment of implementation in four case study sites as of April 2018.
2. The evaluation sought to understand (1) How was the HIU service implemented? (2) What impact has the service had? & (3) What were the enablers and barriers to achieving impact?
3. Learning from the evaluation can be used to inform the future spread of the service.
4. The evaluation used a case study approach due to differences in implementation and execution of the service at local level.
5. An initial in-depth case study was completed in Milton Keynes and the scope expanded to examine a further three sites albeit in a light touch way: Hardwick, Birmingham & Solihull (BSOL) and a Norfolk consortium.

1. We used a Purposive Sampling method. This is a non-probability type of sampling whereby subjects of the sample are not selected at random but chosen based on the researcher’s knowledge of what the sample should include.
2. Since the services had already begun the evaluation is a retrospective, observational study and therefore considered a low grade of evidence.

# Service impact

1. The services are highly valued, with stakeholders from all four sites perceiving the service as having a positive impact for clients.
2. For the duration of the service, there has been an observable reduction in UEC related activity for clients are supported by the HIU services, details of which can be found in Appendix 1.

# Key strengths contributing to the services meeting objectives

1. **Strong** **Leadership** was referred to by all sites. In Hardwick all evaluation participants commented on the key role of the CCG Lead who understood the value of the service and was the key driver for its establishment. A shared vision across all agencies involved was recognised as a key to the service working. Similarly, in Milton Keynes the CCG Transformation Manager played a pivotal role in motivating colleagues and partner agencies to become part of a new approach.
2. The **approach, culture and ethos of provider** chosen was cited as an enabler to achieving objectives. Milton Keynes benefitted from the experience of P3, a respected provider already working in the area. Hardwick benefitted from the experience of Derventio Housing who had experience of working in the area of hard-to-reach clients with the HIU Lead having the appropriate skillset for managing clients.
3. HIU Leads having the **right skillset** for supporting this type of client was emphasised by stakeholders and service leads. Norfolk specifically commented on the importance of recruiting the right people to the role being a determinant of the success of the service.
4. **Persistence in the face of scepticism** from clinicians emerged from the Norfolk evaluation. Initially A&E staff were sceptical of the value of non-clinicians working with people with complex needs in an unstructured way. A few months after the introduction of the service HIU Leads were welcomed and their views and opinions sought.
5. **Strong** **links with other services** for example in Norfolk clinical issues are taken to a lead nurse who will advise whether a client needs to be referred to a GP. It should also be recognised that it takes time to build links with services as network and trust develops. P3, the provider in Milton Keynes already worked in the area and so had already established good local networks of support services and had an ethos of routinely sharing information about new services or support groups.
6. **Multi-Disciplinary Team working** was a key to building and enabling strong links by all case study sites. Milton Keynes stated it was a key enabler, allowing different agencies to understand each other’s remits, boundaries and capacity. Birmingham & Solihull provide a service that is managed by a dedicated team of clinicians working collaboratively with a Multi-Disciplinary Team to take collective responsibility for managing this cohort of clients.

 “[The HIU service] is invaluable to the local system, the glue, the hub, that holds it all together. They [HIU nurses] are at the centre of all the work we do to support this cohort of vulnerable clients”.

ED Consultant, BSOL

1. **Direct work with clients;** a person-centred and solution focussed approach to working with clients was flagged by Hardwick as a key part of the programme’s success in getting HIU’s to engage with the programme. Norfolk cited thinking creatively about the sorts of solutions that would work for individuals concerned. A clear understanding of the role and the boundaries of the service is required – a balance between ‘doing’ things for clients referred and coordinating other organisations to provide support. The biggest difference for the HIU is the time given to them. GPs often don’t have the time and can only deal with the presenting problem whilst a HIP can unravel complex stories.
2. In Solihull, **addressing lifestyle needs** has had the knock-on effect of improving health outcomes. The HIU nurses take time to not only listen to the HIU but also their families.

“The service is one of the most positive things I’ve experienced in the NHS. HIPs offer low level practical support, empowerment, initial introduction (to other services) and confidence building. They have worked wonders and brought back a level of befriending and practical support that has been lost in the health service.” Senior Manager, Acute Trust Norfolk

# Key Challenges

1. **Stakeholder enthusiasm** for the service waned over time in some cases. Hardwick found complex geography a stumbling block and the police stopped engaging due to a feeling that the service was not adding value. There was interest from other CCGs in the Derbyshire area but a lack of funding meant they were not able to commission a HIU service.
2. **Information sharing** was revealed as a big issue across sites. Hardwick in particular found this to be a significant barrier and were unable to identify a list of top 50 HIUs. They overcame this by organising individual engagement activities and getting referrals from GP practices but this took time. Norfolk initially found it difficult to gain access to data from the acute trust but have since developed clear process maps describing how data will be anonymised and passed to the HIU provider. BSOL also now have data sharing agreements in place.
3. **Data collection and analysis** proved challenging, especially across different agencies. In Milton Keynes it took time to agree who would collect what and when. Norfolk know anecdotally that ambulance call outs and s135[[2]](#footnote-2) detentions have decreased but lack of information sharing agreements means this has not been collected to date. Solihull HIU Leads said they would like to see formal evidence of the impact beyond the health service.
4. **Adhering to the aims and objectives of the service** was cited as a key challenge in Norfolk. Strategic objectives are kept in mind, that only frequent attenders are managed to reduce attendances and admissions to A&E. However, HIU Leads are frequently asked to take on other equally complex and worthy cases and so must be clear about their boundaries. This can be challenging particularly in the context of wanting to build good relationships and develop credibility.
5. The **time to engage** clients was a challenge for example, BSOL gave an example of one client requiring seven months of engagement to stop frequently calling 999. In Milton Keynes HIU Leads described the importance of having manageable caseloads and adequate time and duration of engagement to really understand and respond to individual clients.
6. was viewed as a challenge by Norfolk, particularly given the personal nature of the relationship developed. They have tried to overcome this by establishing volunteers who can mentor those who no longer require the formal HIU service.

# Evaluation limitations

1. There are some key considerations when reading this report.
2. Given the range and complexity of services implemented across each of the four evaluation sites and the context within which each is working it is difficult to:
* make comparisons of outcomes between services; and
* assign attribution of outcomes and impacts; particularly the impact of changes observed in the wider system metrics.
1. The evaluation is based on when clients are receiving support from the HIU service only. It does not examine the sustainability of the service.
2. Though client stories are available in the individual reports, the evaluation did not examine the type of client this service impacts upon in depth.
3. Maturity of systems needs to be considered meaning services started from different bases i.e. some areas had already made progress in this area.
4. The four sites reported their data in different ways depending on local requirements and so it is not recommended that comparisons are made.
5. In most cases a three-month pre and post intervention methodology was adopted and so regression to the mean is possible.

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| Appendix 1: Summary of Evaluation Sites |
|  | Milton Keynes | Solihull (pilot, next phase covers merged Birmingham & Solihull) | Norfolk Consortium (North Norfolk, South Norfolk, Norwich) | Hardwick |
| **Programme dates** | Feb-Sept 2017 (pilot)Dec 2017 – present (next phase)  | Oct 15-Oct 16 (pilot)Apr 17-Mar 19 (next phase) | Oct 17-Oct 18 (pilot phase)Extended for another year to Oct 19 | Apr 17-Dec 19 (NB paused July 18 due to changes at Provider) |
| **Dates reported data from** | Oct 17-Feb 18 (five months) | Oct 15-Oct 16 (one year) | Nov 17-Mar 18 (5 months) | Apr 17-Mar 18 (11 months) |
| **Client cohort for dates data reported on** | 13 (only clients receiving a min. of 3 months service included)  | 17 clients pilot (only clients on the programme for 12 months included) | 79 (across the 3 localities) | 24  |
| **Reductions reported by CCGs** | A&E attendances – 37%A&E Admissions- 24%999 calls – 38% | A&E attendances-38%A&E Admissions – 51%999 calls – 15% | A&E attendances - 50%A&E admissions – 49%  | A&E attendances – 84%NEL admissions – 84%999 calls – 78% |
| **Approach to identifying cohort** | Referrals | Case finding  | Case finding  | Referrals |
| **Chosen delivery method** | 1 x P3 link worker who uses an MDT approach meeting regularly with multiple agencies.  | Pilot phase: 1 x Paramedic Next phase: Staff seconded from Birmingham community health care NHS trust 2x band 7 nurses | 3 x Health Improvement Practitioners (non-clinical role) to cover the three areas  | 1 x FTE worker from Derventio Housing Trust who is deployed where needed across Hardwick CCG. Clients are referred to this service from e.g. Police, Hospital, GP  |
| **Key lead for delivery**  | National charity P3, who had provided link worker support to adults with complex and multiple needs in Milton Keynes since 2007. A P3 Link Worker was identified to be the key lead.  | For the pilot West Midlands Ambulance ServicePhase 2 the comm healthcare trust | Norfolk Community Health and Care based in City Reach  | Derventio Housing Trust  |
| **Reported challenges** | Stakeholder engagement Information sharingData collection and analysis  | Data sharing – time to set up approach Administrative resource required to maximise the effective use of the clinician | Resistance from other agenciesInformation sharingManaging demand effectivelyTime to build service profile  | Stakeholder workingInformation sharingData collection and analysis Service use challenges |
| **Enablers of benefits** | Leadership of the Transformation ManagerExperience of P3Person-centred and solution focussed approach to working with clients | LeadershipConsistency of modelSystem-wide approach Targeted access to and use of services which are already commissioned and in place | Skills of HIU LeadsPositioning of HIU provider in systemGood clinical and operational management supportClear understanding of role and boundaries | Leadership and project development Approach, culture and ethos of providerPerson centred approach to working with clients |

Appendix 2: HIU Service logic model

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| **Inputs** | **Activities** | **Outputs** | **Outcomes** |
| HIU Lead: at least one FTE resource (Band 5,6,7 or equiv)Training of HIU Lead Top 50 High Intensity Use identified (rolling cohort as each 50 are managed) Criteria for identification: High A&E use or, presented less but had high risk of episodes of self-harm or homelessness | Establish, utilise and coordinate connections with multi-agency and existing professional services, particularly community services and the voluntary sector HIU Lead provides a ‘1:1 personalised coaching service’ Telephone contact is made with HIU to identify underlying reasons for frequent calling  | HIU connected with appropriate services HIU is heard HIU can continue to contact HIU Lead in times of crisis to prevent relapseUnderstanding is gained about the real reasons HIUs are high service use Fertile commissioning intelligence across all providers is developed | A replicable service is created which can be integrated and managed over the longer term Stigma associated with HIUs is improved among the community and healthcare staffImproved experience of healthcare for the HIU Reduction in incidences of self-harmEconomic benefits from reductions in:* 999 calls
* A&E attendances
* Non-elective admissions
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1. High Intensity Use Resource Pack:<https://www.england.nhs.uk/wp-content/uploads/2019/07/setting-up-a-high-intensity-user-service-march-2021.pdf>. [↑](#footnote-ref-1)
2. Section 135 (1) of the Mental Health Act is the power to remove a person from a dwelling if it is considered they have a mental disorder and that they may be in need of care and attention for this. With the agreement of the person they can be assessed at the dwelling or removed to the place of safety for the assessment to take place there. [↑](#footnote-ref-2)