**HIU Service Specifications**

*This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the NHS Standard Contract Technical Guidance.*

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| **Service Specification No.** | Draft\_V1 |
| **Service** | High Intensity Use Scheme |
| **Commissioner Lead** |  |
| **Provider Lead** | TBC |
| **Period** | TBC |
| **Date of Review** | TBC |

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| **1. Population Needs** |
| * 1. **National/local context and evidence base**   **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. This project aims to replicate the Blackpool model as published in the Commissioning for Value Casebook, February 2015(Ref 1\*).  **Overview of the Blackpool Model**  Using data from a local ambulance service, people who called 999 or attended A&E more than expected were identified through a range of data sources. From previous work undertaken in Blackpool, it was clear that some individuals had little clinical reason for doing so; others had genuine reason for calling or were 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. This had a significant impact on reducing unplanned service use across the system (Ref 1\*).  Prior to this work it was felt that the group being focused 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 clients, 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.  In (add area), we have a high number of High Intensity Use. Table one below present’s data from 2015, summarising the number of people attending A&E five times or more over the year. It can be seen that the top 33 alone account for 1,020 A&E attendances and 306 associated admissions indicating significant potential for reducing workload on unscheduled care services and the wider health economy.  **Table One:** High Impact Use Activity in 2015 at (add receiving hospital and own data )   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Clients with >20 A&E attendances** | **Minimum** | **Maximum** | **Average** | **Totals** | | **People** |  |  |  |  | | **Attendances** |  |  |  |  | | **Emergency admissions** |  |  |  |  | |  |  |  |  |  | | **Clients with 11-19 A&E attendances** | **Minimum** | **Maximum** | **Average** | **Totals** | | **People** |  |  |  |  | | **Attendances** |  |  |  |  | | **Emergency admissions** |  |  |  |  | |  |  |  |  |  | | **Clients with 5-10 A&E attendances** | **Minimum** | **Maximum** | **Average** | **Totals** | | **People** |  |  |  |  | | **Attendances** |  |  |  |  | | **Emergency admissions** |  |  |  |  |   We need to commission additional resource to work with people to understand the ‘real’ reason for calling 999 and to provide emotional / psychosocial support as opposed to the traditional medical model. Learning from Blackpool indicates that this role does not need to be delivered by a healthcare professional, qualities such as resilience, high emotional intelligence, good problem solving and interpersonal skills are key.  **Fit with Local & National Strategies**  The vision and care model for integration outlined within the (add CCG) Better Care Fund plan responds to the strategic commissioning framework established by (add CCG). This plan sets out a move from fragmented services and delivery for people with long term conditions and vulnerable older people, to a system of integrated ‘seamless’ care that can be tailored to the needs of clients, and which supports significant admission avoidance and a proactive focus on self-care.  The development of this integrated pathway meets the objectives of:   * The Better Care Fund * The Care Act * ? Health and Wellbeing Strategy * CCG Strategic Plan 2014 – 2019 * ? CCG Care Closer to Home Strategy * ? Older People’s Strategy * (CCG) Joint Strategic Needs Assessment * (CCG) Integrated Plan; * QIPP Plans; * Recommendations from the Right Care pack * Sustainable Transformation Plan (STP) – Vision for Urgent Care, & 7 day working indicators |
| **2. Outcomes** |
| Employment of an HIU lead in (CCG) aims to deliver the following outcomes:   * Effectively manage, coordinate and sign post High Intensity Use of the local A & E within the CCG footprint. * Reduce the activity High Intensity Use 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. * Safely manage and coordinate the chaotic and demanding nature of the client group through the use of multi-agency support and the volunteer sector. * Provide fertile commissioning intelligence across all providers and in doing so, lower the stigma associated with High Intensity Use. * Coordinate a replicable service which can be integrated and managed over the longer term across other providers.   **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | Preventing people from dying prematurely | √ | | **Domain 2** | Enhancing quality of life for people with long-term conditions | √ | | **Domain 3** | Helping people to recover from episodes of ill-health or following injury | √ | | **Domain 4** | Ensuring people have a positive experience of care | √ | | **Domain 5** | Treating and caring for people in safe environment and protecting them from avoidable harm | √ |   **2.2 Better care Fund (BCF) National Conditions**   |  |  | | --- | --- | | **BCF National Conditions** | **Condition met** (please indicate with a tick) | | Maintaining provision of social care services |  | | Supporting the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and facilitating transfer to alternative care settings when clinically appropriate | √ | | Better data sharing between health and social care, based on the NHS number | √ | | Ensuring a joint approach to assessments and care planning. Where funding is used for integrated packages of care, ensuring that there will be an accountable professional | √ | | Developing out-of-hospital services, which may include a wide range of services including social care | √ | | Reducing delayed transfers of care |  | | Reducing avoidable acute admissions to hospital | √ | | Proposal jointly developed with wider stakeholders | √ |   **2.3 Local defined outcomes**  The objectives of the scheme are to:-  **Measurable:**   * Identify those at greatest risk of 999 calls, A&E attendance and non-elective admissions. * Proactively manage a rolling cohort of High Intensity Use using a truly personalised approach. * To coordinate, sign post and oversee other identified High Intensity Use * To provide training and support to other providers to ensure clients are empowered to take ownership of their health and well-being whilst decreasing their dependency upon unscheduled care services. * Reducing 999 calls * Reducing A&E attendances and avoidable NEL admissions   **More difficult to measure but essential:**   * Forming robust network of community health, social care, mental health and police to manage clients, 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 client care 24/7. * Assist other providers to identify patterns and ‘causal factors’ which trigger relapse behaviours in former High Intensity Use in order to shape future commissioning of service and/or demand/capacity planning * Empower clients to self-manage.to enable discharge and to switch them from negative to positive contributors of society. * Drive equality and client voice.   **Expected Outcomes**:  The key outcomes that the proposed service will deliver are:   * Impact positively on reducing the amount of High Intensity Use emerging to replace those already managed * To support clients to flourish through sustaining job opportunities, reconnecting with families, improving well-being etc. * A new culture of health coaching as a medium to deliver sustainable change.   It is recognised that the latter two points of expected outcomes are more difficult to measure but they are essential outcomes if a culture change is to occur to lower the stigma associated with this cohort. |
| **3. Scope** |
| **The service**  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 Use client 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 clients with a one-to-one, personalised approach of de-escalating issues before it results in a 999 call. The client 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 on to other providers, the lead may need to maintain connection with the client to act as a central and familiar point of contact so to pull services in the same direction and increasing chances of sustainability. Each client will require 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 clients and to promote independence and esteem.  Following the initial telephone consultation, a process of support will ensue with concordance underpinning changes in behaviour rather than compliance through fear of isolation from supportive services or fear of legal restrictions. The lead will act as an advocate for each client, 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 will identify and adapt the support to meet the need.  The service will be provided to any person who meets the eligibility criteria of having unscheduled care activity more than expected, experiencing crisis and chaotic lifestyles or at risk of becoming a High intensity Use on the emergency response system. The service will focus on and manage conditions such as;   * Addiction * Medically unexplained symptoms * Mental health * Medical complaints * Homelessness / housing issues / benefit complaints * Self-harm * Loneliness * Social issues * Vulnerable adults * Frequent fallers   **Accessibility/acceptability**  High Intensity Use will be primarily identified through data gathered from (local hospital) A&E. Adults who visit the department more than 5 times in a month will be identified and referred to the clinical lead to be managed.  **Whole System Relationships**  The project will interconnect Health and Social Care through establishing robust working relationships with:   * CCG * A&E * GP Practices and the wider primary care team * Mental Health Services * Drug and Alcohol Services * Local Police Force * Rapid Response / High Impact team & Community services * Social Services * Third sector – faith and voluntary * Ambulance service   The list is not exhaustive. The relevant service will be engaged dependent upon the needs of the client and then used to discharge the client from the clinical lead. The majority will require a combination of the above to align in order to sustain the positive behaviours demonstrated.  **Geographic coverage / boundaries**  People who live in the (CCG footprint) and are registered with a (CCG) General Practitioner  **Days / Hours of operation**  The service will be delivered 5 days per week within flexible hours to suit the needs of the clients 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 post holder will anticipate client need during the week for the weekend by identifying those in most need and will contact the client either out of hours or at the weekend if it is felt they require motivating through this period.  **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 * Aristotle ‘Bubble Report’   **Referral Route**  The Provider will accept referrals by e-mail, phone or face to face. A referral form will be completed by the Referrer and sent via secure e-mail to the service lead.  **Identifying the Cohort**  High Intensity Use are primarily identified through data gathered from the receiving hospitals A&E department.  A list of the top 50 adults aged 18 and over who visit the department the most in the previous 3-month period will be identified and referred to the clinical lead to identify, consent, connect and work with. If there is more than one receiving hospital in the CCG footprint then a list of top 50 individuals should be produced from each.  Each HIU Lead typically has a rolling caseload of 15-20 HIU clients, identifying and working with a ‘new’ cohort of 15 clients each quarter from the list of the top 50 from A&E. This is by far the most efficient and manageable method of supporting the most vulnerable people without burning out the HIU Lead.  Areas that rely on referral routes from other organisations and colleagues very often struggle with the ‘feast or famine’ situation of slow take up, inappropriate referrals coming through and the HIU Lead is not able to manage this in line with their annual leave or other commitments. Particularly if working alone.  By having a relatively fixed cohort for each quarter provides stability to all and ensures a steady, predicable, controlled outcome and expectation from the outset.  **Eligibility Criteria**   * Aged 18 years and over * People who live in the (CCG footprint or are registered with a (CCG) General Practitioner   Clients with a history of violence will be managed via a discreet process which ensures the client and service lead do not meet alone or without a chaperone. Any meetings will take place within the GP practice or public place.  **Location**  To be agreed, with flexible working hours including working from home.  **Exclusion criteria**   * Individuals aged 17 and under   **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 client by telephone and manage accordingly. Individuals deemed vulnerable will take priority and be contacted within 24 hours of referral.  Clients 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 clients 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).  Each client signs an individual data sharing agreement upon commencement of working together and the Information Sharing Policy & Privacy Statement approved for the pilot will be adhered to.  The Top 50 High Intensity Use 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.  **Support with Rapid Implementation: The Frequent Use Programme**  It is proposed that the pilot is initially supported by the original project lead from Blackpool to ensure we replicate an effective model locally. The programme of support is outlined below.  **The Frequent Use Programme Includes:**   * Interviewing and appointing the right person(s) for the role * Classroom training - learning the techniques used to change the behaviours and attitudes of complex clients * 1:1 staff telephone mentoring * Staff resilience training to prevent burnout * Maximising the use of data sharing agreements * The organisation can identify *their* frequent use and shadow the consultant on a home visit to see the techniques and practices used in real time * Case reviews on complex clients * Identify and connect with services required to ensure project success * Aftercare coaching for four months to maximise project outcomes |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (eg NICE)**  To apply national best practice standards, (e.g. NICE guidance) to all interventions undertaken.  **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**  Competent bodies include CQC; Professional bodies e.g. GMC, NMC; Public Health; NHS England, Royal Colleges etc.  **4.3 Applicable local standards**  Safeguarding  The Provider shall adhere to the (CCG) Safeguarding Children and the Safeguarding Adults Board. Inter-Agency Policy and Procedures to Safeguard and Promote the Welfare of Children and Adults and the NHS (CCG) Safeguarding Children/Adult Policies. These policies and procedures shall be available to all staff and the Provider is required to give assurance to the commissioners on compliance with their safeguarding requirements and any jointly agreed local policies.  Information Sharing  Information sharing is key to delivering integrated services that are coordinated round the individual and their carers. It is essential to enable effective early intervention. Information sharing: guidance for practitioners and managers (HM Government 2008) sets out content that is common to everyone and some that is relevant when working with specific groups. The aim is to support good practice in information sharing by offering clarity on when and how information can be shared legally and professionally in order to achieve improved outcomes. This guidance shall be used by the Provider and disseminated to all staff as the basis for information sharing with regard to the service.  Clinical Governance  Responsibility for clinical governance is held by the Provider who shall work within a clinical governance framework for the services delivered which is in line with those adopted elsewhere in the NHS. The Provider shall produce an annual clinical governance report to (CCG). The clinical governance framework shall include:  · Clear and documented lines of responsibility and accountability for quality of care  · Specific programmes of quality improvement  · Clear policies for managing risks  · A system for reporting, monitoring and taking action on significant events  · A programme of clinical audit  · A process for dealing effectively with complaints  · Research and development processes in place  · Evidence based guidelines on clinical procedures  · Standards are in place for record keeping, data protection and confidentiality  The Provider shall also ensure that the following standards and best practice guidance are met:  · The Provider shall ensure that each professional within the service shall be registered with the appropriate professional body, shall meet required professional standards and shall work in accordance with the standards set down by the relevant professional associations and Royal Colleges.  · Each professional shall have a satisfactory Disclosure and Barring Service check, updated yearly.  · Practice shall be evidence based in so far as there is a sufficient body of evidence available and relevant to the presenting problems, and shall take account of guidance on best practice where this is available and authoritative, as for example NICE.  · The Provider shall make suitable arrangements for the appropriate and confidential maintenance of staff records in accordance with relevant policies and procedures.  · The Provider shall maintain a record of any reported serious untoward incident, complaints and compliments received.  The Provider shall make suitable arrangements for the appropriate and confidential maintenance of client records in accordance with relevant policies and procedures. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-C)**   2. **Applicable CQUIN goals (See Schedule 4D)** |
| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:** TBC |
| **7. Individual Service Use Placement** |
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