**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 Service |
| **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 NHSE model as published [here.](https://www.england.nhs.uk/high-intensity-use-programme/)  **Overview of the NHSE Model**  Core principles of the NHSE HIU Model are that a service does not punish people for being it crisis, it provides a de-medicalised view of support and it’s very human in nature.  The HIU Service offers a robust way of supporting people who make high intensity use of health services, in particular A&E, non-elective admissions, primary care and mental health services. This [resource pack](https://www.england.nhs.uk/publication/high-intensity-user-service-resource-pack-supporting-documents/) provides support for systems on setting up a HIU service.  In 2019/20, NHS operational planning and contracting guidance set out that all health systems in England must implement a high intensity use service.  The HIU programme has received the following awards:   * 2019 Healthcare Transformation Award for ‘Innovation in Reducing Variation and Improving Outcomes’ * 2018 Kate Granger Compassionate Care Organisation Award   Evidence from NHSE programmes across England suggests that where it is implemented effectively, it has improved the quality of life for clients, families and serving healthcare professionals. It also supports better care outcomes, safely reduced the utilisation of ambulance resources, A&E attendances, hospital admissions and 999 calls, 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 XX alone account for XX A&E attendances and XXX associated admissions indicating significant potential for reducing workload on unscheduled care services and the wider health economy.  **Table One:** High Impact Use Activity in 2022 at (add receiving hospital and own data)   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Clients with >20 A&E attendances** | **Minimum** | **Maximum** | **Average** | **Totals** | | **People** |  |  |  |  | | **Attendances** |  |  |  |  | | **Emergency admissions** |  |  |  |  | | **Bed Days** |  |  |  |  | |  |  |  |  |  | | **Clients with 11-19 A&E attendances** | **Minimum** | **Maximum** | **Average** | **Totals** | | **People** |  |  |  |  | | **Attendances** |  |  |  |  | | **Emergency admissions** |  |  |  |  | | **Bed Days** |  |  |  |  | |  |  |  |  |  | | **Clients with 5-10 A&E attendances** | **Minimum** | **Maximum** | **Average** | **Totals** | | **People** |  |  |  |  | | **Attendances** |  |  |  |  | | **Emergency admissions** |  |  |  |  | | **Bed Days** |  |  |  |  |   We need to commission additional resource to work with people to understand any underlying social or emotional reasons for increased health care contacts and to provide emotional / psychosocial support as opposed to a clinical or medical model. Learning from the NHSE model, it 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**  HIU services should be aligned to the NHS England HIU model (non-clinical, non-punitive, improvement-oriented approach) for maximum impact. This model works on an outreach basis from A&E data lists and is provided in the community, often by commissioned organisations including third sector providers.  ICS/ICB have been asked to ensure that every Acute Hospital has a dedicated High Intensity Use Programme (aligned to NHSE approach). Each service should include community based HIU leads (these are not virtual ward or home-based care intervention). HIU Leads should have caseloads of no more than 50 individuals (per HIU lead) to support demand management in urgent and emergency care, with particular focus on reducing Health Inequalities by targeting Priority Wards.  **Inequalities:**  A British Red Cross paper on HIU[[1]](#footnote-1) found a clear link between high intensity use of A&E and wider health inequalities with HIU concentrated in the most deprived parts of the country. Those who frequently attend A&E are more likely to be experiencing a range of other disadvantages. Through understanding the unmet needs of those with HIU, the system could address any gaps in services and pathways.  NHSE ask for all A&E departments to have access to an HIU service that meets the NHSE service specification. Focus is on building capability and resilience amongst non-clinical workforce by embedding HIU workers to carry out challenging HIU roles to ensure maximised effectiveness in working with clients.  Supporting documents: [NHS England » High Intensity Use (HIU) service resource pack: supporting documents](https://www.england.nhs.uk/publication/high-intensity-user-service-resource-pack-supporting-documents/)  [NHS England » Next steps for urgent and emergency care letter and framework](https://www.england.nhs.uk/publication/next-steps-for-urgent-and-emergency-care/) |
| **2. Outcomes** |
| * Identify those at greatest risk of A&E attendance and non-elective admissions. * Proactively work with a rolling cohort of HIU clients, really understanding what they need. * To coordinate wellbeing and connect with other services, enrolling them to help to get to the desired end. * Reducing 999 calls as a natural by-product (possibly ambulance and police). * Reducing A&E attendances and avoidable non-elective admissions   **More difficult to measure but essential:**   * Drive equality and client voice. * 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 A&E attendance / 999 call. * Improving communication and partnership working between those involved in client care 24/7. * Identify patterns and ‘causal factors’ which trigger relapse behaviours in order to shape future commissioning of service and/or demand/capacity planning. * Empower clients to self-manage to enable sustainable discharge.   **Expected Outcomes**:  The key outcomes that the proposed service will deliver are:   * Impact positively on reducing the high intensity use of healthcare. * To support clients to flourish through sustaining job opportunities, reconnecting with families, improving well-being etc. * A new culture of 1:1 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 vast majority of interactions may involve addressing a combination of a range of factors in order to reach the desired end.  Following the initial telephone conversation, 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 HIU 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   **Accessibility/acceptability**  High Intensity Use will be primarily identified through data gathered from (local hospital) A&E. Individuals who visit the department more than 3 times in a month will be identified and referred to the HIU lead to be contacted and offered support. The threshold of attendance can be locally determined.  **Whole System Relationships**  The project will interconnect Health and Social Care through establishing robust working relationships with:   * ICB * A&E * GP Practices and the wider primary care team * Mental Health Services * Drug and Alcohol Services * Anticipatory Care Teams * 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.  **Geographic coverage / boundaries**  People who live in the (ICB footprint) and are registered with a (ICB) General Practitioner  **Days / Hours of operation**  The service will be delivered 5 days per week, generally 9am-5pm with no weekend work required as it’s not a crisis service.  **Referral Sources**  Referrals are not generally recommended; rather a list to be generated by the BI team at the hospital which is sent monthly to 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.  **Identifying the Cohort**  Individuals with High Intensity Use are primarily identified through data by way of an automated list generated by the receiving hospitals’ A&E department.  A monthly list of the top 250 people (using the eligibility criteria and thresholds commissioned for) who visit the department the most in the previous 3-month period will be identified and referred to the HIU lead to identify, consent, connect and work with. If there is more than one receiving hospital in the ICB footprint then a list of top 250 individuals should be produced from each.  Each HIU Lead typically has a rolling caseload of 12- 15 HIU clients, identifying and working with a ‘new’ cohort of 15 clients each quarter from the list. This is by far the most efficient and manageable method of supporting the most vulnerable people without burning out the HIU Lead.  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 (depending on what is commissioned) * People who live in the (ICB footprint or are registered with a (ICB) General Practitioner   **Location**  The role is community-based assertive outreach so a lot of time in the community. The rest to be agreed, with flexible working hours including working from home.  **Exclusion criteria**   * Individuals aged 17 and under (depending on what is commissioned) |
| **4 Applicable local standards**  Safeguarding  The Provider shall adhere to the (ICB) 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 (ICB) 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.  Governance  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. |

1. British Red Cross ‘Nowhere else to turn’ Exploring high intensity use of Accident and Emergency services Nov 2021 [↑](#footnote-ref-1)