NHS England

Setting up a HIU Service

Contents

About National High Intensity Use

The service comprises a High Intensity Use lead that proactively makes contact with the most frequent attenders of the local A&E to find out how the local health and social care system could better meet their needs.

The objectives of the service are to:

Measurable

- Identify those at greatest risk of A&E attendance and non-elective admissions.
- Proactively work with a rolling cohort of people who access healthcare more than expected, using a truly personalised approach.
- Reduce A&E attendances and avoidable non-elective admissions of individuals within this cohort.
- Reduce 999 calls of the people worked with, as a natural by-product.

More difficult to measure but essential

- Form robust networks of community health, social care, mental health and the voluntary sector to work with individuals' part of the service, creating true integrated working.
- Provide 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, resulting in an A&E attendance, admission or 999 call.
- Improve communication and partnership working between those involved in the individuals' care 24/7.
- Identify patterns and 'causal factors' that may lead to high intensity use of services and take action to better support people before this occurs.
- Empower individuals to self-manage, feel confident and reconnect into their communities if they wish to.
- Drive equality and patient voice.

The principles of the service are to:

1. **Identify.** The top 50 people who make most high intensity use of A&E are identified utilising A&E data systems. Some additional clients are selected due to their vulnerability as opposed to chronically high use of health services.

2. **Personalise**. The individuals are contacted directly, usually by a phone call from the HIU lead. The calls focus on the individual's issues, identifying, de-medicalising, de-criminalising and humanising their needs to uncover the 'real' reason for attending A&E or an admission.

3. **De-escalate**. Many individuals use health care frequently due to an escalation in their social, emotional, financial, or family issues, an unmet need. Competent de-escalation is facilitated by offering immediate access to an appropriate one-to one coaching support service (the HIU lead).

4. **Discharge**. Discharge from the project to community or voluntary support services takes place when the individual requires on-going support but not at the intensity or specialism of the HIU lead. Many individuals, following initial support from the HIU service are discharged without the need for follow up but this needs to be done skilfully, mindfully, and delicately. Many are reconnected to their community with renewed friends and purpose. The word 'discharge' is not used with individuals as people hear 'rejection'. So, connecting individuals to the community without immediate relapse requires consideration.

5. **Manage relapse**. Once supported by the service, individuals often begin to feel more positive, decrease their dependency and improve their personal outcomes. Relapse can occur when individuals begin to feel isolated again or feel they can no longer cope with a change in situation. They may begin attending A&E again but more usually, individuals instead contact the HIU lead directly who picks up their issue and helps them navigate through the difficult time rather than feeling the only option is to reattend A&E.

6. **Quality of intervention**. Higher quality more personalised and effective interventions will create robust connections and positive outcomes for individuals and deliver financial savings to the system with increased pace.

Key success factors

Based on national feedback, there are five key success factors that are viewed as critical to the delivery of the desired outcomes:

1. **Select the right person for the role** – you need someone with high emotional intelligence, resilience and a natural ability to problem solve creatively.

2. Provide your High Intensity Use lead with **training, ongoing support and coaching** to prevent burn out and to sustain successful outcomes over time. It also allows the programme to run efficiently with reduced effort required by the ICB at the beginning.

3. **Give them freedom to act and freedom to innovate** – concentrate on the outcomes you want rather than being prescriptive about how they will be achieved. Be brave - the right person will guide the way.

4. **Commit for a minimum of 18 months** – you will need this time to attract the right candidate to implement the approach and to sustain later cohorts.

5. **Source an automated, independent evaluation method** that allows you to demonstrate quantitative and qualitative outcomes so you can evidence success.

HIU Processes to Consider	
Making the case for change/commissioning the service	
	Business case Your local system may require business case to gain approval for the HIU service. The NHSE central team can provide support with the following: • Sample Business Case • Privacy Impact Assessment • Equality Impact Assessment
Employing Organisation	
	Data sharing Have you got a data sharing agreement that can be adapted for use? Agreements across different organisations will be needed, for example between A&E providers, ambulance service, social care, police, GP practices and the High Intensity Use service. The NHSE central team can support you with the following: • Consent form • Information Sharing Agreement between host and acute • Privacy Impact Assessment
Communications and engagement with stakeholders	

Communication of the new service with a number of groups and other local services will help the service lead introduce the service and create the buy-in and support required. Involve your communications colleagues early in the process and develop joint communications across your health economy so the new service is communicated consistently and in line with the ethos of the service.	
	Communication about the service Who do you anticipate the service will interact with on a day to day basis? How will you communicate with them about the new service? Would it be of benefit for them to help co-design the service? Services you may need to engage with include: • A&E • GP practices and the wider primary care team • Mental health services • Drug & alcohol services • Social services • Third sector – faith and voluntary • Community services (community matrons, respiratory teams, falls team etc.) • Ambulance service • Jobs centre • Housing Data analytical services from the Business Intelligence team at the Acute Trust who will be responsible for providing and evaluating changes in activity.
Evaluation and monitoring Regular monitoring of how the client group is accessing services is vital to identify changes to service use. Be clear about your starting point and what you want to achieve. But don't over measure - it can get complicated.	
	Logic Model Develop a logic model to provide clarity on the expected inputs, outputs, and outcomes to aid evaluation of the service and understanding of whether it is meeting its aims. The central team can provide you with a sample logic model.
	Ongoing Monitoring How will you regularly monitor how much contact the worker's current cohort of clients has with A&E?

	Can you develop a facility that allows the worker to see the active list at all times, re-run the report for updates and search for clients by name to review their activity? It is recommended that a list of the Top 50 A&E attenders is identified every three months on a rolling basis. This ensures clients are current and also provides a relevant baseline for evaluation every three months, post intervention by the HIU lead. It is difficult to measure 'what hasn't happened yet' so until the service is running for long enough to evaluate 12 months pre and post intervention, then the three month method is a good starting point under the assumption that their pre intervention activity would have remained constant if no intervention had taken place i.e. neither increased nor decreased.
	Ongoing Evaluation How will the service evaluate performance and report on progress? It is helpful to produce a quarterly board report that provides information on both quantitative and qualitative outcomes. Qualitative outcomes could include self-harm reductions and case studies of real client stories. Clients are often invited to present to the ICB or at events to help lower the stigma associated with this group.
Recruitment / Sourcing the team Getting the right person in the role is one of the key success factors. This role is not dependent on having someone clinical in post to achieve the results – rather the person employed having the right skills and attributes.	
	Advert How can you make the job appealing to someone with high emotional intelligence, resilience, and a natural ability to problem solve creatively? Focus on the attributes and skills of the person, rather than a particular clinical or non-clinical background. Where can you promote the role to find the right person? Possible places to advertise include the voluntary sector, social care, local hospital, drugs & alcohol services, council services such as housing. Leave the advert as wide as you can to attract the widest possible field.
	Information governance Once obtained, consent needs to be kept refreshed and up to date as time goes by, as circumstances and levels of data sharing may change. All IG processes need go through the local data protection office within the ICB or Acute Trust.
	How Individuals will be identified

	Concentrate on the past three months' highest A&E attenders to use as preliminary baseline data. Do you have good links with hospital Business Intelligence to identify the Top 50 HIU attenders at A&E? Do you have other sources of intelligence about vulnerable clients? Key data that is needed at this stage includes: name, NHS number, warning flags and phone number. How will future cohorts be identified, when and how?
	Location Where will the worker be based? Is there a host location where there will be sources of everyday support? HIU services across the country are based in a variety of host provider settings. The most successful being the voluntary sector, social enterprises, Community Interest Companies or Community Providers. Hot desking and home working are options for some of the week but the worker will be out visiting clients/ services for a large proportion of the days. Freedom and flexibility for this role are key to successful outcomes and to meet the needs of the clients. National peer support is available for the HIU leads to tap into, which is beneficial.
	Equipment Mobile phone. Laptop or computer.
	Documentation How will the care provided be recorded? Is bespoke documentation needed? How will it be shared with others involved in the clients' care (as appropriate)? Does it need to be?
	Communication with the individual's GP How will you inform the individual's GP that you are working with their patient? Is there an opportunity to have electronic access to health records?
	Hours of operation What hours will your service operate? Nationally, the service is 37.5 hours a week and hours are flexible dependent on what the clients need. Generally, the service operates on weekdays between 9am – 5pm. Out of hours on-call telephone contact is not usually part of the HIU Lead's contract although some 'maintenance', remote contact may be beneficial

	as part of a flexible working approach (see out of hours contingency support below).
	Out-of-hours contingency support It may be useful to utilise an established out-of-hours provision for this client group, some of whom have unpredictable behaviours that require an element of out-of-hours support so the HIU lead can remain 9-5. Is there a local out-of-hours provider, e.g. volunteer provision, Silverline, crisis team, mental health helpline, Samaritans, that could provide additional support out of hours? Some make outgoing calls to clients to support the role of the HIU lead. Is there a local Mental Health Helpline, a service that is free to the caller (even from mobiles) and operates evenings and weekends?
	Discharge and ongoing support Many individuals, following initial support from the HIU service are 'discharged' without the need for follow up. The term 'discharge' is not used with the cohort and it is more like the HIU lead gradually 'walking backwards' once individuals are embedded properly into the community or issues resolving. Experience has shown that talk of discharge instigates feelings of being rejected by doing well if they are discharged. Keeping the individual's 'open at a distance' also gives the opportunity for immediate re-referral into the service if they relapse, rather than having to reattend A&E in order to regain support. Experience with existing services has shown that, on some occasions, after about three to six months support, clients can relapse which could lead to A&E attendance reoccurring. Right from the outset, the cohort are informed of the possibility of relapse and, the support of the HIU lead, as well as and open and honest conversations, can prevent a potential relapse or if they do then it has less impact than before. They are picked up immediately and worked with again until stability ensues which tends to be a shorter time than before.
Support to the worker Working with this cohort of individuals can be extremely demanding and exhausting, particularly if only one worker is employed, so there needs to be consideration to how to prevent the worker from overload. Adequate training, regular supervision and coaching sessions are an essential part of maintaining the worker's good health, as well as successful results.	
	Clinical supervision

	Who will provide clinical supervision to your worker (if they are working as a clinician)? Do you have someone in the organisation or will you need to source this from elsewhere?
	Coaching Would the worker benefit from coaching to support them in the role? 1:1 coaching for the HIU lead is recommended from the start of the contract or 'buddying' support with other HIU leads across the country with whom they can share learning, experience and how to overcome challenges faced.
	Training What training will be needed and how will it be provided? In order to provide clear direction, maximise success and begin working with clients as soon as possible, training is recommended in the fields of: • learning the techniques used to change the behaviours of complex behaviours • staff resilience to prevent burnout • how to identify and connect with essential services • how to deliver telephone coaching to clients

Conclusion

This resource pack was developed to offer support to ICB's and other areas interested in setting up a HIU service. It is not intended to be exhaustive or prescriptive.

If you have experience to share regarding a similar service or following the use of this pack, please do let us know so we can learn from each other.

For more information email **england.improvementdelivery@nhs.net**