SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**QVV/0272**
Service	High Intensity Use (HIU) service
Commissioner Lead	NHS Dorset Urgent and Emergency Care
Provider Lead	British Red Cross – Head of Contract Development
Period	01/04/2022 – 31/03/2025
Date of Review	01/04/2024

1. Population Needs

1.1 National/local context and evidence base

A small number of patients are known to generate a disproportionately high percentage of A&E attendances and hospital admissions. According to national data, 0.67% of the population are associated with 29% of ambulance arrivals, 16% of A&E attendances and 26% of admissions from A&E, with an estimated cost to ambulance services and acute trusts of £2.5bn each year. The demand that this group of patients place on today's ambulance and unscheduled care services is immense. It can also seriously impact upon the availability of emergency ambulances within our communities.

These people are vulnerable and potentially in high-risk groups that, particularly during this pandemic and recovery, have an unmet need that is not supported. These people have differences in the care that they receive and opportunities that they have, to lead healthy lifestyles, resulting in health inequalities. These inequalities can involve differences in:

- Wider determinants of health, for example, quality of housing or homelessness and employment
- Behavioural risks to health, for example, smoking or drug taking
- Quality and experience of care, for example, patient satisfaction and how viewed by services
- Access to care, for example, availability of service to support emotional and social needs
- Health status, for example, life expectancy and prevalence of health conditions, such as mental health

High Intensity Use (HIU) service is a successful NHS England & Improvement (NHSEI) programme to address the needs of vulnerable individuals who use healthcare more than expected. An independent evaluation of the NHS England HIU programme, operating in Stockport, evidenced reductions in activity across A&E attendances of up to 58%, non-elective admissions of up to 67% and up to 71% in ambulance conveyances. The minimum reduction in activity across the country is 40% in year 1, using this approach.
The 2019/20 NHS Operational Planning and Contracting Guidance stated that CCGs yet to implement a High Intensity User support offer for demand management in urgent and emergency care, will be required to establish a service.

As the data and learning set out in Appendix 1 evidences, there is a need to commission a HIU service to collaborate with these individuals to understand their unmet needs and provide the emotional/psychosocial support as opposed to the traditional medical model.

2. Outcomes

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 Local defined outcomes

Supporting these people through alternative services such as a HIU Service will allow more time and a personalised care approach to be able to be responsive to the patients need. It will also help reduce the financial impact, health inequalities and improve system resilience and recovery in an already over stretched health system.

Key Outcomes:

- Reduce frequent use of ED services (attendances and non-elective admissions)
- Reduce frequent use of 999 services (see and convey)
- Improve quality of life for patients whilst having a positive experience of the service.

Secondary Outcomes:

- Reduce frequent use of NHS 111 calls
- Reduce frequent use of General Practice primary care appointments

The by-product of this reduction in service pressure, is that the flow through ED reduces that increases ED capacity, positively impacting on handover delays, reducing compassion fatigue with NHS workers, reduce waiting times, improving population health, and narrowing the inequality gap. Patients will feel listened to and support to get their needs met in the right place, first time.

3. Scope

3.1 Aims and objectives of service

The aim of the service is to support individuals who are accessing emergency services on a regular basis through taking a person-centred approach to identify and work through their unmet social needs that may be exacerbating physical and mental conditions.

The objectives of the scheme are:

- Identify those at greatest risk of 999 calls, A&E attendance, and non-elective admissions.
- Proactively manage a rolling cohort of High Intensity Use individuals using a personalised approach in the form of health coaching and care co-ordination to help the individual in accessing the services and support that they need.
- Support individuals to flourish through sustaining job opportunities, reconnecting with families and improving well-being.

- Help navigate the complexities of the health and care system to overcome barriers so they can take control of their own well-being.
- Advocate for the individual to drive equality and have a voice.
- Empower individuals to self-manage to enable discharge and to switch them from negative to positive contributors of society.
- Function as a conduit to negotiate and de-escalate issues before a crisis occurs.
- Coordinate, signpost and oversee other identified High Intensity Use.
- Function as the 'glue' between clinical services for individuals who would otherwise fall through the gaps or do not meet service criteria.
- Provide training and support to other providers to ensure individuals are empowered to take ownership of their health and well-being whilst decreasing their dependency upon unscheduled care services.
- Link with social prescribing services to ensure people can access holistic support in their community before their needs escalate and facilitate a 'step up' to and a 'step down' from this High Intensity Use service.
- Form robust network of community health, social care, mental health, and police to manage individuals, creating true integrated working.
- Improve communication and partnership working between those involved in individual care 24/7.
- Provide a service driven by quality with positive human outcomes observed.
- Assist other providers to identify patterns and 'causal factors' which trigger relapse behaviours in former High Intensity Use to shape future commissioning of service and/or demand/capacity planning.

3.2 Service description/care pathway

The service will be based upon the NHS RightCare model where 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 individual shall be:

- Contacted and assessed using a personalised approach to uncover the 'real' reason for calling 999 or attending ED. This may reveal a range of complaints; social issues combined with alcohol dependency, mental health, criminal justice, and potentially extremely complex medical presentations.

The NHS RightCare model focuses on understanding individuals with this unmet need and support them by: De-medicalising *(the issues);* Decriminalising *(the activity) and* Humanising *(the people involved).* The most powerful and innovative element of the NHS RightCare model is that there are no restrictions on any individual. They are not told they cannot call 999 or there is a belief that their presentations are disingenuous. Through providing one-to-one attention and active listening, the root cause of why their dependence on unscheduled services is established.

The service shall:

- Work with a rolling cohort of patients who attend A&E, call 999 and or admitted more often than expected. Individuals will be identified by the HIU lead through using ED and 999 data sets and will managed within 12 months before discharged from the service into sustainable, robust, mainstream services.

- Provide to any person who meets the eligibility criteria:
    - Unscheduled care activity more than expected, experiencing crisis and chaotic lifestyles
    - At risk of becoming a High Intensity Use on the emergency response system.

- 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

- By exception and where capacity, can accept referrals for eligible individuals from both primary and secondary care healthcare professionals.

- Accept referrals by e-mail, phone, or face to face.

- Respond to all referrals within two working days.

- Investigate the issues involved, collating background, contact the individual by telephone and manage accordingly. Individuals deemed vulnerable will take priority and be contacted within 24 hours of referral.

- Have a service lead who proactively makes telephone contact with the identified individuals to find out how the local health economy could better meet their needs. Individuals will need to sign an individual data sharing agreement upon commencement of working with the service to ensure the Information Sharing Policy & Privacy Statement approved for the service will be adhered to.

- Contact patients through face to face or telephone consultation. The lead will function as an advocate for the individuals, 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 service lead will identify and adapt the support to meet the need. The service may need to undertake case reviews for complex individuals and connect with other services to ensure project success. The principles of the service will be to de-escalate issues by one-to-one coaching and support services stepping down or even stepping out when appropriate, rather than making endless referrals to already saturated services.

- Discharge individuals or transfer care at a time when another service is accepting of the referral and can provide sustainable ways of moving the individual on (for example, GP practice – social prescribing, volunteer sector, community services, mental health, and peers' groups). The service will provide updates and discharge summaries to professionals of interest, for example, primary care, secondary care, ambulance trust and or referring professional via updating the relevant system direct or sending electronically to a named person to update relevant systems. All individuals 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).

Interactions may involve addressing a combination of a range of factors to reach the desired end. The service lead will anticipate individual need during the week for the weekend by identifying those in most need and will contact the individual either out of hours or at the weekend if it is felt they require motivating through this period. Therefore, the service will be delivered 5 days per week within flexible hours to suit the needs of the individuals with out-of-hours on-call telephone contact as required. This may require weekend and weekday evenings on-call work.

The individuals may have issues around trust so may prefer to collaborate with a designated person to begin with before referral to mainstream services. Even once referred on to other providers, the lead may need to maintain connection with the individual to function as a central and familiar point of contact so to pull services in the same direction and increasing chances of sustainability. The service lead will collaborate with individuals to develop a bespoke exit strategy to reduce the dependency on the service lead in order to increase capacity to take on the next cohort of eligible individuals and to promote independence and esteem.

The Provider shall:

- Interview and appoint the right person (s) for the HIU lead role(s).
- Provide staff with behaviour change training for complex individuals and staff resilience training to prevent burnout.
- Provide regular supervision and mentoring to the service leads.

The provider will mobilise the service from 1st April 2022 until 31st July 2022 and start the delivery of the service in August 2022. The mobilisation period will include:

- Stakeholder engagement with UHD to work through information governance, business intelligence and case review requirements
- Recruitment and Training of staff
- Internal project set up, with programme delivery manager, evaluation team, IG team and IT/infrastructure team. (HIU product specific support)
- Preparation for the service launch event to include stakeholder engagement with interdependent services, for example, Help and Care – social prescribing, SWASFT Frequent Caller team and Mental Health teams.

3.3 Population Covered

People who live in the NHS Dorset footprint or registered with an NHS Dorset General Practitioner.

3.4 Any acceptance and exclusion criteria.

High Intensity Use will primarily be identified through data gathered from Dorset Emergency Departments and South Western Ambulance Service Trust (SWAST). The definition of High intensity use of the ambulance service is individual contact to the ambulance service five or more times, relating to individual episodes of care in a month or twelve or more times, relating to individual episodes of care in 3 months. The definition for emergency department, high intensity use is five or more attendances in the last 12 months, with activity within the last 3 months. Individuals with highest use from all three Dorset EDs and SWAST will form the cohort. The service lead will identify, seek consent, connect, and collaborate with these individuals.

Each HIU Lead typically will have a rolling caseload of 15-20 HIU individuals, identifying and working with a 'new' cohort of 14-15 individuals each quarter. By having a fixed cohort for each quarter should provide stability to all and ensures a steady, predicable, controlled outcome and expectation from the outset.

Although this is not primarily a referral/push service model, exceptions may be made by the HIU lead in discussion with referring professional and individual fulfilling eligibility criteria.

Eligibility Criteria

- Aged 18 years and over
- People who live in the NHS Dorset footprint or registered with an NHS Dorset General Practitioner
- High intensity use of Dorset ED departments (as defined above) and conveyed by ambulance
- High Intensity use of SWAST ambulance service (as defined above)

Exclusion Criteria

- Individuals aged seventeen and under
- Self-referral
- Individuals on an End-of-Life Pathway
- Individuals in clinical mental health crisis

Although not excluded, individuals with a history of violence will be managed via a discreet process which ensures the individual and service lead do not meet alone or without a chaperone. Staff safety and well-being is priority, and any meetings will take place within the GP practice, community centre or public place with other staff on site. If the provider has reasonable grounds and justification not to engage with an individual, the rationale will be recorded and communicated as appropriate.

3.5 Interdependence with other services/providers

The project will interconnect with Health and Social Care through establishing robust working relationships with:

- NHS Dorset
- A&E Multi – Disciplinary Teams
- Dorset Integrated Urgent Care Service
- Ambulance service and Frequent Caller Team
- Primary Care Networks, GP Practices, and their non-clinical roles 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

The list is not exhaustive. The relevant service will be engaged dependent upon the needs of the individual and then used to discharge the individual from the service lead. The majority will require a combination of the above to align to sustain the positive behaviours demonstrated.

4. Applicable Service Standards

4.1 Applicable national standards (e.g., NICE)

To apply national best practice standards, (e.g., NICE guidance) to all interventions undertaken.
Behaviour change: general approached (PH6) Overview | Behaviour change: general approaches | Guidance | NICE

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g., Royal Colleges)

Competent bodies include CQC; Professional bodies e.g., GMC, NMC; Public Health; NHS England, Royal Colleges.

Health Education England and Skills for Care: Person Centred Approaches, and Care Navigation: A Competency Framework Health Education England Health Coaching – Quality Framework

4.3 Applicable local standards

Safeguarding

The Provider shall adhere to the NHS Dorset 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 Dorset 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 that is relevant when working with specific groups. The aim is to support good practice in information sharing by offering clarity on when and sharing information legally and professionally to achieve improved outcomes. The Provide

shall use this guidance and disseminate to all staff as the basis for information sharing regarding 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 NHS Dorset. 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 acting 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 as 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. Location of Provider Premises

The Provider's Premises are located at:

To be agreed, with flexible working hours including working from home.

Appendices

Appendix 1

Within the South Western Ambulance Transformation Strategy and Plan, a HIU scheme is a key priority for ICB's to implement to support reducing the demand on SWAST. This has been localised and agreed as a key priority in the Dorset Urgent and Emergency Care transformation plan with governance through the UEC Delivery Board and Group. The outcomes of the HIU service with support and align to the Dorset Integrated Care System (ICS) objectives to:

- Improve efficiency and help close financial gap
- Improve the quality of services, particularly reducing safety and harm risk
- Improve outcomes for people in Dorset, reducing health inequalities
- Aid system recovery

As shown in table 1, in Dorset there are 1,995 individuals who have high intensity use of Emergency Departments (ED) in the last 12 months. This equates to 14,590 ED attendances and 5,613 emergency admissions. Forty-two of these individuals have attended ED more than twenty times in the last 12 months, accounting for 1,391 ED attendances and 288 emergency admissions.

Table 2 shows 804 high intensity use of ED individuals have arrived by ambulance on five or more times in the last 12 months. This equates to 6882 ED attendances and 3523 emergency admissions. Ten of these individuals have arrived by ambulance more than twenty times in the last 12 months, accounting for 394 ED attendances and 133 emergency admissions.

Table 1: High Intensity Use of Emergency Department Services in Dorset (All arrival modes) (10/1/2021 to 09/01/2022)

Category	Total number of individuals	Number of ED attendances	Number of emergency admissions
Individuals with 5-10 ED attendances in the last 12 months	1775	10,779	4,586
Individuals with 11-19 ED attendances in the last 12 months	178	2420	739
Individuals with 20+ ED attendances in the last 12 months	42	1391	288
Total	**1,995**	**14,590**	**5,613**

Table 2: High Intensity Use of Emergency Department Services by Ambulance Arrival in Dorset (10/01/2021 to 09/01/2022)

Category	Total number of individuals	Number of ED attendances	Number of emergency admissions
High intensity ED use individuals with 5-10 ambulance arrivals in the last 12 months	729	5399	3017

that arrived by ambulance (on at least one attendance)			
High intensity ED use individuals with 11-19 ambulance arrivals in the last 12 months	65	1089	373
High intensity ED use individuals with 20+ ambulance arrivals in the last 12 months	10	394	133
Total	**804**	**6882**	**3523**

As well as individuals having high intensity use of the ambulance service through conveyance to ED as shown in table 2; the ambulance service also has high intensity use individuals calling and or treated on scene.

As at May 2022, South Western Ambulance Service NHS Foundation Trust (SWAST) have 156 distinct callers in Dorset that are aged 18 years or more and have contacted the ambulance service five or more incidents in a month or 12 or more incidents in 3 months. These 156 distinct callers have generated 1024 calls of which:

- 406 were a call only (no incident)
- 125 resulted in a hear and treat outcome
- 348 resulted in a see and treat outcome
- 145 resulted in a see and convey outcome