High Intensity User Service, Service Specification
Version: 0.9 Updated
Date: 19.04.2023

Service/ Care Pathway/ Cluster	**High Intensity User Service**
Commissioner Lead	**NHS City and Hackney**
Provider Lead	**Homerton University Hospital NHS Foundation Trust, East London NHS Foundation Trust, Tavistock and Portman NHS Foundation Trust, Volunteer Centre Hackney**
Period	**2022 ongoing (recurrent funding)**
Date of Review	**Reporting on Service Delivery to City & Hackney Psychological Therapies & Wellbeing Alliance (Quarterly)**

1. Purpose

1.1. Introduction

This document sets out the service specification for the High Intensity User Service, delivered jointly by Homerton University Hospital NHS Foundation Trust, East London NHS Foundation Trust and Volunteer Centre Hackney. The service was initially commissioned on a pilot basis for a one-year period in 2019-2020. The core service is now commissioned on a recurrent basis. The specification details the collective responsibilities of all providers as well as specific detail on the expectation and contribution of each organisation, which will be recurrently funded from April 2022 onwards.

1.2 National context

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 (nationally). NHS England / RightCare have set out and recommended the introduction of a High Intensity User (HIU) service which offers a robust way of reducing frequent user activity primarily to the Emergency Department (ED) and non-elective admissions but can also contribute to reducing other avoidable unscheduled care contacts. The High Intensity User (HIU) service was initiated by NHS Blackpool CCG and has since been rolled out in a number of other CCGs. The Implementation Team within NHS RightCare have undertaken evaluation of effectiveness across 4 CCGs. It is shown to offer robust way of reducing frequent user activity to LAS/999, NHS 111, ED, GP contacts and hospital admissions.

1.3 Local Context

City &Hackney (C&H) has the highest rate per GP registered population of frequent attenders at EDs in North East London and has one of the highest rates in London. Additionally, C&H has the highest number of frequent callers with the London Ambulance Service.

1.4 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	√

1.5 Locally Defined Outcomes

- Effectively manage, coordinate and signpost High Intensity Users of the local ED, within the CCG footprint, liaising with LAS & 111.
- Establish, utilise and coordinate multi-agency and existing professional services to negotiate a reduction in ED attendance of High Intensity Users in C&H, and ultimately a reduction in High Intensity Users.
- Safely manage and coordinate the chaotic and demanding nature of the patient group through the use of multi-agency support and the volunteer sector.

1.6 Aims and objectives of the service

The objectives of the service are to:

Measurable:

- Identify High Intensity Users across ED, working with Frequent Caller managers for LAS and 111
- Proactively manage a rolling cohort of High Intensity Users using a truly personalised approach.
- Coordinate, signpost and oversee identified High Intensity Users.
- Reduce inappropriate use of health services including ED, LAS and 111 for cohort of patients under the service

More difficult to measure but essential:

- Work in conjunction with other High Intensity User Services in London e.g. Royal London Service to ensure a consistent approach in management of High Intensity Users across North East London
- Form a robust network of multi-disciplinary professionals working in healthcare and outside of healthcare, including Local Authority, Police and Third Sector to manage patients, that addresses mental health, physical health and social need as part of an integrated approach.
- Provide a service driven by positive patient reported outcomes.
- Act as a conduit to negotiate and de-escalate issues before a crisis occurs, such as a situation which has historically led to a destabilisation of their condition and resulting in a 999 call / ED attendance.
- Improve communication and partnership working between those involved in patient care 24/7.
- Assist other providers to identify patterns and ‘causal factors’ which trigger relapse behaviours in former High Intensity Users.
- Assist the navigation of patients towards community resources that support their journey and feel more connected to their local area.

- Empower patients to self-manage and both utilise and contribute to assets within their community to enable them to reach a position where they can reduce inappropriate contact with urgent care services.

- To support patients to flourish through sustaining and reconnecting with families and friends, improving well-being, reduced feelings of both loneliness and isolation, improved confidence and to feel less dependent on a health professional. Patients will be supported to do this via the befriending service, for example.

1.7 The service philosophy / principles

- The service should complement and work with any other agencies that the user could be under the care of e.g. GP, Social Care

- Most High Intensity Users appear to have a degree of psychological causation behind their behaviour, however, most do not have a formal mental health diagnosis and are often not known to mental health services.

- The team will offer case management and where appropriate direct intervention, including psychological, emotional, social and practical support, to people who are frequent attenders at HUH ED or frequent users of LAS or NHS 111 services in partnership with LAS & 111 Frequent Caller Managers. The frequent attending or calling may have a psychological or psycho-social causation however the cohort does not need to have a mental health diagnosis in order to be treated under the service.

- The service focuses on the individual's issues, identifying, de-medicalising, de-criminalising and humanising their needs to uncover the individuals own personal and unique reason for calling 999, 111 or attending ED.

- Many individuals use healthcare services frequently due to an escalation in social, emotional, financial or family issues; in essence their unmet needs. The High Intensity User Service will be competent in de-escalation by offering fast access to appropriate support either within the service or via referral to relevant services to address their unmet needs.

- Once supported by the service, the individual often begins to feel more positive, decrease their dependency on urgent care services and improve their personal outcomes. Relapse can occur when individuals experience further adversity or begin to feel isolated again or feel they can no longer cope with a change in situation. Therefore reconnecting the patient to their community and friends is key for sustaining improvements made, particularly when the patient is 'discharged' from the service.

- 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.

- The service brings together multiple providers and creates a single integrated team.

- Delivery of interventions should be fluid and not operate on a tiered approach; there is not one linear pathway which a patient will follow and interventions can be offered simultaneously to support each individual patient.

- With the exception of interventions offered by the third sector which may span a longer timeframe, the service provides a brief intervention(s) to a patient with the aim of reducing inappropriate use of urgent and emergency health services.

- The service works on behalf of the system, accepting referrals for High Intensity Users that meet agreed thresholds from Homerton ED, London Ambulance Service and 111.

2. Service Scope

2.1 Service Entry Criteria

2.1.1 Inclusion Criteria

The High Intensity User service is aimed at patients who frequently attend Homerton ED or frequently call 999 or 111. The following thresholds will be used for entry into the service:

- HUHFT ED 5+ attendances within one month / 10+ attendances within a year (excluding wound care and sickle cell pain). The patient will meet the threshold as soon as they reach 10 attendances; a full year does not need to have passed before the patient is eligible for the service.
- City and Hackney LAS 5+ calls within month / 12+ calls within 3 months
- City and Hackney 111 6+ calls within 3 months

The HIU Service will liaise on a monthly basis with the LAS Frequent Caller Manager to ensure joint working and care planning for patients who are also known to LAS.

Patients are prioritised according to intensity and spread of use across health care services.

Patients are likely to have a range of complaints including social issues combined with substance misuse, mental health difficulties, involvement with criminal justice (as victim or perpetrator or both), potentially alongside complex medical presentations with or without medically unexplained symptoms. The patient does not need to have a mental health diagnosis to access the service.

Homerton ED high intensity users do not need to be registered with a C&H GP Practice or live in City and Hackney in order to be accepted into the service.

LAS and 111 frequent callers can be either registered or resident population of City and Hackney.

2.1.2 Exclusion Criteria

Patients whose reason for frequency of attendance / calling is time-limiting e.g. nausea/vomiting from pregnancy.

Patients below the age of 18.

2.2 Geographical population served

City and Hackney.

2.3 Service description

The service will provide the following functions.

2.3.1 Screening

The ED (HUH) will provide a list on a monthly basis of their High Intensity Users to the service. The service will conduct a brief desk-based screening exercise to assess whether the patient meets the entry criteria set out within this service specification.

Where the patient is accepted into the service and is registered with a C&H GP, the GP must be informed that patient is under the service and the service should request for relevant information on an agreed template from the GP Practice. The GP is incentivised to provide all appropriate information under the High Intensity User GP Incentive Scheme.

Where the patient is not accepted into the service the reason is recorded.

2.3.2 Assessment

Upon entry into the HIU service patients will be assessed in order to ascertain the best course of action for the specific patient. An initial assessment may include:

- Comprehensive case notes review conducted to understand patient's usage of services, this should include the following systems: EPR, RiO, HIE, UCP
- Liaise/consult with professionals involved in patients care to gather further information (e.g. care coordinator, consultant, police, LAS), and other EDs in other local boroughs where considered relevant
- Every patient should have UCP checked to see whether a UCP care plan already exists
- Contact High Intensity User patient by phone and assess their need using a personalised approach to try and uncover their understanding of why they are attending ED.
- Engaging patients when they present in ED or are inpatients on medical wards

During the assessment the service will aim to understand:

- The nature of the difficulties which the patient is experiencing
- The patient's own understanding of their difficulties and rationale for using emergency services
- The patient's readiness to engage and with what services

The length and type of assessment for each patient will vary. The service may need to meet with the patient face-to-face on a number of occasions.

2.3.3 Action Plan

Each patient under the service will have an action plan created which details the activities to be undertaken for the patient while under the service. The action plan is a 'live' document and so will be updated by the service as work with the patient progresses. Each active patient is discussed in a 2-weekly referrals meeting attended by all service providers. Updates are shared with the patient's GP.

Decision on the pathway or interventions considered most appropriate for the patient can either be taken by the HUIS team collaboratively or where a patient's assessment is more complex, taken for discussion and agreement with the wider service at a monthly MDT meeting. The interventions offered to the patient may develop during the patient's pathway as they become more ready to engage or the understanding of their difficulties evolves.

The vast majority of actions plans agreed may involve addressing a combination of a range of factors in order to reach the desired end. Therefore the patient may work collaboratively with the service on a number of different interventions, either simultaneously or one after another.

2.3.4 Case Management and Care Planning

Each patient under the service will be allocated a case manager depending on the nature of the work to be undertaken with the patient. This will either be the HIUS Lead (HUH) or the Care Planning & Navigation Nurse Practitioner (ELFT). The patient group may have issues around trust so it is preferable to work with a designated person to begin with before being referred to interventions within the service or outside agencies.

Case Management will vary from patient to patient depending on need. Case Management may be hands on, regular direct patient contact, to monitoring progress and use of services, signposting, referring on and setting protocols with ED. This will include liaison with professionals/other agencies involved in the patient's care delivery.

The case manager will act as an advocate for each patient, guiding them through the complex journey and multifaceted approach which has resulted in inappropriate 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 case manager will identify and adapt the support to meet the need.

The case manager will act as a central and familiar point of contact for the patient, providers delivering the HIU service and organisations delivering care to the patient outside of the service. This will pull services in the same

direction and increase chances of sustainability of any progress made with the patient. The case manager will monitor and keep track of the patient from entry into the service until the patient is 'discharged', regardless of which intervention(s) the patient is receiving.

Care planning is central to service delivery and where clinically possible every patient receiving intervention from the service should have a plan of care agreed with the patient. A plan of care may range from a short liaison which puts them in touch with the right service for their needs to an engagement plan / protocol with ED on how the patient should be managed on attendance at ED or a detailed care plan which includes crisis planning. The service will establish what type of plan of care they deem to be appropriate for the patient.

2.3.5 Interventions

It may not be required for all patients to receive intervention from the service. For some patients under the service actions taken may only include the service liaising with agencies and professionals already involved in the patient's care or signposting/referring patients to services which may benefit the patient, including the voluntary sector.

For some patients the service will also create an engagement plan / protocol on how the urgent and emergency care service should manage the patient if they arrive at ED or call 111 or 999.

The timeframe from assessment and action plan being completed, to the patient starting an intervention should be recorded and reported on by the service.

Service Intervention	Description	Duration	Provider
Engagement Plan / ED Protocol	A plan set out with ED on how the patient should be managed on arrival in ED	N/A	HUH / ELFT
Cognitive Behavioural Therapy / Motivational Interviewing	Focus particularly on anxiety/panic related presentations or other psychological symptoms that are linked to emergency presentations and poor adherence to treatments. Joint sessions with ED, specialist teams in the community and ward staff to improve communication and engagement, encourage a collaborative approach between clinicians and patients and facilitate onward referrals and sign posting. Part of the intervention may have a preparatory function, increasing patient's readiness to accept other accounts of what is causing/maintaining their physical health symptoms so that are more likely to engage with intense psychological treatments.	Up to 6-8 sessions	ELFT
Community Supporters Project Manager (Befriending Peer Support)	The volunteers will aim to reduce social isolation and loneliness of the patient. Trained volunteers offer a crucial social lifeline and confidence boost to socially isolated HIUs through one to one weekly visits. The visits usually last between 1-2 hours with the patient and volunteers encouraged to not only engage in conversation with the patient but to find local activities, groups or events and share these experiences together. This person could be in need of support in one or more of the following areas: • Social Isolation • Loneliness • Confidence building • Physical health		Volunteer Centre Hackney

	• Mental health • Limited English • Integration into the Hackney community e.g. refugees, migrants, asylum seekers • Supported volunteering Volunteers will meet with the person they are matched with, to share local activities, work towards agreed goals and build meaningful connections in the community. The role can be fairly short term or long term but will depend on the person they are supporting. The roles and tasks are varied and decided together with the person that they are working with but will be governed by their needs, e.g. helping someone get out into the community, engaging in local groups and activities, practising communication skills, building confidence. The volunteer may help the person to attend health care appointments where appropriate or join a patient in their home for a home visit with a health care professional. Some volunteers depending on the hours they can commit may be able to provide telephone support to patients in between sessions. If appropriate, the volunteer could support the person they're visiting to develop their own skills and to also start volunteering. The emphasis on the support is to enhance the quality of a person's life by supporting and promoting their welfare, personal development and capacity for self-determination. Referrals into the Befriending Intervention will need to be made by the case managers and a referral form will need to be completed which covers a risk assessment of the patient.		

2.3.6 Referral to GP Proactive Care Practice Based Service and CMC

The Royal College of Emergency Medicine Best Practice guideline on Frequent Attenders in the Emergency Department covers primary care involvement. It states that some patients who attend frequently may have struggled to engage with primary care. Others can be helped by a more assertive approach from their GP, for example a regular appointment with their GP which may pre-empt ED visits. It advises that case management of frequent attenders and care plans should involve GPs wherever possible.

From April 2019 High Intensity Users have been supported in Primary Care under the Proactive Care Practice Based Service. The Proactive Care Practice Based Service aims to provide more personalised support to patients to help them better manage their health, and with the patient's consent the GP can create UCP care plans which can be viewed by the wider urgent care system. The High Intensity User service will be expected to consider which patients under their service would benefit from Primary Care involvement and the creation of a UCP care plan, liaising with the patient's GP.

When a patient is under the Proactive Care Practice Based Service, the GP practice is expected to undertake a minimum of 2 appointments with the patient during the year. The practice can use these appointments flexibly so that these are joint appointments with the High Intensity User service if the HIU think this would be beneficial.

Where a patient under the HIU service has a UCP care plan, the service will add a High Intensity User Alert and provide additional details on the UCP care plan where appropriate. The service will inform the GP practice of any additions made to the UCP care plan.

2.3.7 Bi-Monthly Multi-disciplinary Meeting

The HIU service will run a monthly collaborative multi-disciplinary forum in which the case managers of the service will bring complex patients for discussion with the aim that an MDT discussion would progress the management of the patient. Its membership should include:

- ED Clinical Staff
- Psychological Medicine (HPM) Clinical Staff
- London Ambulance (LAS)
- 111 (LAS)
- GP
- City & Hackney GP Out of Hours Service (Homerton)
- Paradoc (Homerton)
- The Tavistock and Portman NHS Trust
- Relevant ELFT services
- Learning Disabilities Team ((London Borough of Hackney)
- Metropolitan Police
- Substance Misuse Team (Homerton)
- Turning Point
- Integrated Independence Team (Homerton)
- Mental Health Crisis Line
- Telecare
- Volunteer Centre Hackney
- Primary Care
- City & Hackney Neighbourhoods Team

The HIU service MDTs are held on MS Teams to enable members to attend remotely and thereby increase likelihood of attendance.

2.4 Service composition and roles

The table below shows the staffing for the High Intensity User Service.

Provider	Staff / Input	Staffing (WTE) for Pilot	Expected Activity within HIUS (p/a)	Staffing (WTE) for ongoing Service	Cost
HUH	High Intensity User Service Lead	0.4	N/A	0.4	Band 8a
HUH	Data Co-ordinator	0.4	N/A	0.4	Band 5
ELFT	Care Planning & Navigation Nurse Practitioner	1	80 patients	1	Band 7
ELFT	Assistant Psychologist	0.6	30 patients	0.6	Band 5
VCH	Befriending & Peer Support Co-ordination	0.6	20 – 25 patients	0.6 w/t eq	(removed*)
	Volunteers	N/A		N/A	(removed*)
	*commercially sensitive				
				Total	**(removed)**

The staff roles are as follows.

2.4.1 High Intensity User Service Lead

The role of the HIU Service Lead includes:

- Oversee and lead a multidisciplinary team and maintain a strategic oversight of the whole High Intensity User Service.
- Lead the screening and assessment process.
- Oversee reporting and allocation of interventions within the HIU Service delivered on a quarterly and annual basis.
- Work in conjunction with GPs, ELFT and VC Hackney to maintain oversight of the whole pathway.
- Responsibility for overseeing patient caseloads and supporting staff to manage theirs.
- Will ensure high standards of confidentiality, data quality and ongoing engagement with partnership agencies/ stakeholders to ensure they work within HUH & ELFT IG policies
- Lead the multi-disciplinary team and ensure that the service complies with external and internal regulatory requirements.
- To liaise proactively and appropriately with the Trust senior management team, commissioners, GP practices and other HIU services to develop improvements to the service ensuring the pathway functions at a high standard.
- Where appropriate, the HIU Service Lead will also hold a small caseload where the predominate need is for physical health support.
- Manage updating of CMC care plan with High Intensity User Alert where plan is created
- Participate in the Pan-London HIU Meeting as required

The HIUS Service Lead will be employed by Homerton and will be part of the Emergency Department (ED) team.

2.4.2 Care Planning and Navigation Nurse Practitioner

The role of the Care Planning and Navigation Nurse Practitioner includes the following:

- Participate in the screening assessment of high intensity service users to be managed under the service.
- During assessment of patients undertake accurate formulations of mental state, risk and need of these patients, taking into account medical, psychological and social factors and referring on to other disciplines or other agencies as appropriate.
- Co-ordinate the active case management of patients following screening and assessment and maintain an overview of patients while they are under the HIU Service.
- Create personalised care plans and / or management care plans for patients where appropriate and ensure that care plans are appropriately disseminated to all relevant parties
- Offer appropriate psychological, emotional, social and practical support to patients on the caseload.
- Provide expert mental health advice on the management, treatment and diagnosis of patients to acute hospital clinicians and where appropriate liaise with other professionals involved in the care and treatment of the patient to ensure care is coordinated.
- Chair and facilitate the HIU Service meetings which will determine the pathway and interventions for more complex patients under the service, with support from the HIU Service Lead if necessary.
- Liaise with HIU Service Lead regarding planned absence from role – annual leave / training etc. to ensure support to service is adequately managed

The Care Planning and Navigation Nurse Practitioner will be employed by ELFT and will be part of the Homerton Psychological Medicine (HPM) team.

2.4.3 Assistant Psychologist

The primary purpose of the role is to provide a brief psychological intervention to clients who have been identified as “frequent attenders” or “high intensity service users”.

The current clinical process is as follows:

Screening: A monthly meeting is held with the Care Planning and Navigation Nurse Practitioner and HIUS Team Lead to identify any patients who appear to present with symptoms that might benefit from a brief psychological intervention. These are allocated to the AP for further screening. The AP examines the patient’s notes and takes a history of any physical and/or mental health issues. The AP then makes a provisional decision on whether the patient might benefit from psychological input, which is fed back to the Nurse Practitioner or HIUS Lead.

Assessment: The patient is then contacted by phone or seen face-to-face if they are in the ED. The AP makes three attempts at contact during which time they also contact the patient’s GP to update them on the patient’s presentation, obtain collateral information and seek support with contacting the patient. If there is still no contact, a discharge letter is sent to the patient and their GP, and the HIUS Lead is informed. If contact is made with the patient, the AP offers an introduction to the service and books an assessment appointment (ideally face-to-face in their GP practice but otherwise on the Homerton site or via phone/video consultation). The assessment explores current difficulties, reason for attendances to ED, unmet needs and hopes for current and future psychological support. The assessment process may take more than one session, depending on the level of severity and complexity of individual difficulties. From this, a formulation is developed and shared with the patient, and there is an exploration of potential services to which the patient can be referred.

Allocation / Onward referral: If the case is deemed to be more complex, then the patient is referred to the HIUS Nurse Practitioner or the HIUS Lead. Less complex patients are offered a set of six to eight weekly 50-minute psychological intervention sessions with the AP.

Psychological intervention: The patient is offered six to eight sessions of psychological intervention, primarily adopting a Cognitive Behavioural Therapy (CBT) framework (although other models may be considered based on the needs of the patient and competencies of the AP and their supervisor). The interventions provided are usually focused on supporting patients living with health anxiety, mild-moderate depression, pain management and/or managing a long-term health condition. Assertive communication skills training and the development of an action plan may also be developed as alternatives to visiting ED as a first option. Patients are discussed weekly in clinical supervision with a Band 8a Clinical or Counselling Psychologist within ELFT. In between sessions, there may be liaison with other services involved in the patient’s care. In addition, the patient may be referred to third sector organisations or the neighbourhood teams in City and Hackney for immediate or follow-up practical support (e.g. for social stressors that may have an impact on mental and/or physical health). Regular updates are giving to the HIUS team in fortnightly referral meetings, and notes are written on HUH EPR and RiO after every contact or attempt to contact the patient.

If the patient disengages during intervention, the AP will make three attempts to contact them. If there is still no contact after these attempts, they will be moved to the “holding phase” where attendances to ED will be monitored (see below). They will also be sent a letter summarising the involvement of the HIUS in their care and a clear care plan.

Post-intervention monitoring (holding): The patient is moved to a “holding phase” when the intervention is completed (this can be in less than eight sessions where mutually agreed with the patient) or where they have disengaged from the HIUS. This is a 12-week period in which their attendances to ED are monitored on a monthly basis by the HIUS. If there is no reduction, there will be another attempt to see them face-to-face in the ED. The patient can also contact the HIUS if they experience any difficulties with following their agreed care plan.

Post-monitoring phase: At the end of the twelve weeks, the patient will be contacted by phone to arrange a final session. This session is used to collect patient feedback on their experience of HIUS, and to review their physical and psychological wellbeing. If the patient does not respond to the attempted contact, they will be contacted by letter. They will then be discharged from HIUS.

The assistant psychologist will be employed by ELFT as part of the Homerton Psychological Medicine service and will be supported and supervised by a Clinical Psychologist or equivalent within HPM.

2.4.4 Data Coordinator

The Data Coordinator will be responsible for all administration within the service and the co-ordination, gathering and entry of data from relevant services and professionals in order to track the patient from entry into the service to the point of discharge. They will also monitor the patients' use of urgent care at specific points post-discharge in order to assess the sustainability of outcomes.

The Data Coordinator will map urgent care use of the cohort of the patients that the service is working with against interventions delivered.

In summary the post will be responsible for:

- Organisation of monthly MDTs
- Maintaining a contemporary database of HIU patients, monitoring and recording outcomes at each stage of their pathway through the service
- Responsibility for recording interventions for patients in the HIU Service
- Monitoring the effectiveness of the HIU Service against the performance indicators
- Collecting and collating feedback from HIU patients to measure the effectiveness of the service

The Data Coordinator will be employed by HUH and will report to the HIUS Lead.

2.4.5 Befriending / Volunteering Project Manager

The Project Manager will be responsible for running a programme where volunteer befrienders are matched to High Intensity Users. The aim of the project is to help reduce isolation, which is potentially a major contributing factor to the patients' "overuse" of ED and to re-engage them with the community.

The role will be responsible for recruitment, training and support of volunteers and will be responsible for the careful matching of volunteers to patients. The role also involves providing ongoing emotional and practical support to the patients, as they form a trusted relationship with them, and liaising with statutory services as required.

Over the course of a year, the Project Manager will aim to recruit, train and support at least 20 specialist volunteers and match these volunteers to at least 25 patients.

The Project Manager will be responsible for measuring success of the project and will provide information on a monthly basis to the Data Co-ordinator to include as part of measurement of the whole service. The Project Manager will make monthly contact with all the volunteers and patients to ensure they are both satisfied with the relationship and gather verbal updates on activities and progress.

Screening: The Project Manager will first have a full discussion with the HUH-based clinical HIUS Team on the current health situation of the patient. This will cover all safety or risk management concerns, and steps taken by all parties to mitigate these. They will then contact the patient to arrange an initial assessment time with the patient. This will offer space to allow the patient to explore their current situation, identify where they feel they are currently and ways they can see themselves taking control of some parts of their life supported by a befriender. The Project Manager will encourage the patient during the initial assessment to reflect on social activities and interests that they may be keen to pursue but need support to do so, and to focus on their health and well-being. They will then discuss time preferences for contact from the befriender and any other matters that are relevant to the match. Finally, the patient and Project Manager will jointly create an action plan for the coming weeks when matched. They will make at least 3 attempts to make contact with the patient, after which an update will be reported to the HUH-based HIUS team for noting on the person's record & all other appropriate actions.

Volunteer Recruitment and Training: The role will be responsible for volunteer recruitment, which includes an application form, interview, references and an enhanced DBS check. The project manager will also ensure that the volunteers receive weekly contact and monthly therapeutic supervision, as well as bi-monthly group meet-ups with other volunteers. The recruitment interview will explore the volunteer's current life, activities and interests (employment, studies, leisure and other supporting roles), their reason for volunteering, as well as their personal

and professional experiences supporting people with mental or physical health conditions, how they feel they can help and what support they may need to achieve this. The Project Manager will introduce the service, the aim of the project and the volunteer role explaining its aims (i.e. to help the patient build confidence and gain independence) and they are made aware of the various health conditions that patients may have. A DBS check will be made and the volunteer invited to attend training.

The training consists of:

- Causes of isolation
- Building a relationship
- Role of the volunteer
- Communication and listening skills
- Support needed by our patients
- Safeguarding
- Boundaries
- Beginning, middle and end of the relationship

Matching Process: The Project Manager will be responsible for carefully matching the volunteer to the patient under the HIU Service, taking into account interests, personalities, availability and geographical location. Following both the patient's initial assessment, the volunteer interview and post-training completed paperwork, the Project Manager will then send a patient profile to the volunteer. This profile will include relevant personal details e.g. age, current home environment, family relationships, bereavement and health conditions, if relevant. It will also detail their interests, what support they may need and any sensitive issues not to be brought up unless by the patient.
If the volunteer agrees they can support this patient, they will suggest times to meet.

Ongoing Support and Supervision: Their suitability is assessed after the first two weeks, with both parties contacted by the Project Manager. The volunteer is then contacted every two weeks for feedback which is fed back to the HUH-based HIUS team. Ongoing support is given to both the patient and the volunteer with the latter invited to attend monthly therapeutic supervision to share their experiences with other volunteers. Equally, ongoing contact is maintained with the patient, with any arising health or care matters investigated and reported to statutory services.

Case Reporting: Full updates on every case will be reported at fortnightly referral meetings and monthly MDT meetings. This will include updates on all attempts at contact made, ongoing discussions and support needed by the patient and feedback from the volunteer on conversations held. Once matched with a befriender, each patient will stay on the HIUS active list for a minimum of 2 months before being closed.

2.4.7 Befriending Volunteers

Trained volunteers offer a crucial social lifeline and confidence boost to socially isolated High Intensity Users through one-to-one weekly visits and telephone calls. They will build a trusting relationship to explore worries and overcome fears and barriers together. They will offer a space for the patient to explore previous activities they may have put aside due to mental and physical health conditions, or may not have tried.
Volunteers will meet with the person they are matched with, talk on the phone or online to share activities, work towards agreed goals and build meaningful connections in the community. The role can be fairly short-term or long-term but will depend on the person they are supporting.

The roles and tasks are varied and decided together with the person that they are working with but will be governed by their needs, e.g. helping someone get out into the community, engaging in local groups and activities, practising communication skills, building confidence, building on the action plan created during the patient's initial assessment.

The volunteers will be trained to focus on exploring what the patient's day currently consists of and what things could they focus on to help support their well-being such as healthy eating, cooking, sharing recipes, enjoying an online exercise class, craft kits and mindful colouring and puzzles which we have sent out to patients' homes.
Volunteers will be responsible for providing records of time spent on visits to the Project Manager monthly and what they have noticed has changed or improved in relation to their patient's unique situation e.g. being able to use public transport if they had not done this before or going shopping for the first time if identified as a goal. This feedback will focus on the relations, topics of conversation, how the patient is currently feeling and activities they are focusing on relating to well-being. They will also raise any concerns that the Project Manager will explore.

3. Service Delivery

3.1 Location of service

The HIU service administrative base will be within the Homerton. The service will have fortnightly meetings as a whole team led by the HIUS Lead. These meetings should have attendance from the HIUS Lead, Care Planning & Navigation Nurse Practitioner (ELFT), Assistant Psychologist (ELFT) and the Data Coordinator (HUH). Where possible a Clinical Psychologist from HPM should attend.
The wider bi-monthly MDT meetings will take place at the Homerton.

Generally, interventions will be offered within HUH if patient is in attendance at ED or an in-patient, otherwise offered away from secondary care and wherever possible in primary care or in the community. Where appropriate and absolutely necessary a home visit will be undertaken.

If a home visit is needed, under the organisation's lone working policy, the first visit may be conducted with an additional member of staff. An assessment at the first home visit can then be made as to whether two individuals would need to be present for any future home visits for the specific patient.

Befriending can take place in various locations across the borough including at Volunteer Centre Hackney, local libraries, cafes, parks or people's homes (once assessed by VC Hackney Project Manager) as well as over the phone.

3.2 Days/ hours of operation

The service will typically operate from 9am-5pm Monday to Friday.

However, some volunteers may be able to offer support to patients out-of-hours and check in with the patient during the weekend. Some volunteers may even be able to make out-going calls to patients to the support the case managers when they are not working.

3.3 Whole System Relationships

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

- CCG
- Emergency Departments
- 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
- London Ambulance Service
- 111
- Learning Disabilities
- North East London High Intensity User Groups / Frequent Attender Services

The list is not exhaustive. Beyond the core team within the HIU service there will be a need to engage other organisations in a patient's pathway. The relevant service will be engaged dependent upon the needs of the

patient. Some organisations may be used to discharge the patient from the service. The majority will require a combination of the above to align in order to sustain the positive behaviours achieved.

It will be vital to have robust relationships with other High Intensity User Services and Frequent Attender Groups and liaise with the leads from these services regularly to check the attending patterns of patients under the service at other EDs. There may need to be care plans/protocols which are agreed across North East London or with other EDs where the patient frequently attends.

3.4 Entry and discharge processes

Patients will enter the HIU service through meeting one or more of the following thresholds:

- HUHFT ED 5+ attendances within one month / 10+ attendances within a year (excluding wound care and sickle cell pain presentations)
- City and Hackney LAS 5+ calls within month / 12+ calls within 3 months
- City and Hackney 111 6+ calls within 3 months

The HIU service is essentially a time-limited service, which aims to move people along a pathway to reduce dependency on inappropriate use of the urgent care system. From the start each patient will require a bespoke exit strategy to reduce the dependency on the service in order to increase capacity to take on the next cohort of eligible patients and to promote independence and esteem. Discharge should be considered as soon as they are taken on i.e. the initial formulation and plan should contain details of how/when person would be discharged. Readiness for discharge from the HIU service will be monitored by the case manager in collaboration with team members. A decision for discharge from the service will be made collectively by all HIU service providers involved in the patient's care. A patient may be discharged from the service but still receiving befriending support.

Patients who have been under the service and have received the maximum number of appointments of each intervention will need to be discharged from the service with a plan in place. They will then be in a 12-week "holding phase" whereby their attendance is monitored and HIUS work can quickly re-commence if needed.

The Case Manager should write to the GP to inform the GP of the patient's discharge plan.

Once a patient has been discharged from the service, at 3, 6 and 12 months post discharge from the service, the Data Co-ordinator will record and report on levels of ED attendance of the patient. This will measure whether outcomes delivered under the HIU service are sustained.

4. Reporting and Performance Indicators

4.1 Reporting

The service should produce a quarterly and yearly report that provides information on both quantitative and qualitative outcomes. Case studies of real client stories should be presented alongside quantitative data collected in order to show outcomes achieved which cannot be seen via quantitative data collected. These reports will be produced to the City & Hackney Psychological Therapies and Wellbeing reporting templates.

Data will need to be collected and reported on at patient level and aggregated. In addition to KPI reporting, the service should report against the following measures on a quarterly and yearly basis:

- Number of patients accepted into the service
- Number of patients that met the threshold not accepted into the service and reason
- Breakdown of number of patients accepted into the service by primary presentation
- Average wait time from acceptance into the service to start of first intervention including referral to partner services
- Average duration of care under the HIU Service (excluding befriending which may continue post-discharge)

- Number of open cases under the service in total and broken down by organisation
- Average length of each intervention (duration and number of appointments)
- Number of discharges from the service
- Number and percentage of patients that relapse and meet the threshold of the service within the year
- PREMs (Patient Reported Experience Measure) number of patients which completed questionnaire and feedback (service PREM to be used & collected by HIU Data Coordinator)
- PROMs (Patient Reported Outcomes Measure) number of patients which completed questionnaire and feedback (PROM to be selected relevant to clinical intervention & completed by clinician providing intervention)
- Number of wider MDTs held and number of patients discussed
- Level of frequent attendance for each patient 3, 6 & 12 months post-acceptance into the service

4.2 Evaluating success

The HIU programme focuses on several main criteria against which to measure success; some qualitative and some quantitative. Qualitative measures include tracking progress of anxiety/depression/functioning using CORE-10 scores to ascertain when someone is flourishing as part of the intervention. Measuring a client's wellbeing is at the heart of the programme. Case studies, clients' willingness to act as advocates of the programme (perhaps by speaking at high level or local events) or being part of the interview process as the programme expands, are all hallmarks of a successful programme. The ethos of this work is that 'when clients flourish, the savings follow', so developing ways of lowering the stigma associated with this group by integration into the community are fundamental to demonstrating success.

Qualitative measures which involve cost savings include: ED attendances, non-elective admissions and mental health bed days, as well as 999 and 111 calls. Quarterly reporting is the ideal timeframe and standard across all HIU sites.

NHS RightCare suggests a target of a minimum of 20% reduction in ED attendances. This allows the service to work with more complex patients where the intervention is not immediately seen. Higher targets do not allow for patients who may be difficult to engage or other unforeseen difficulties. For example, one patient with extremely high attendances may affect the attendance reduction of several other patients who the service has successfully worked with.

5. Governance

5.1 Governance

Each Service Provider is responsible for its own governance. Each Service Provider shall identify Governance and Regulatory Leads in each of the areas set out below. That individual will respond in the first instance to all relevant queries. The Service Provider shall be permitted to change the individual acting as Governance and Regulatory Lead on prior written notification to the CCG.

Lead	**Role**
Provider Nominated Individual	Service Provider lead for all contractual queries
Information Governance lead	A representative from the senior level of management to coordinate relevant Information Governance work programme

Caldicott Guardian	Role to oversee the arrangement the use and sharing of patient information - championing confidentiality and advising on options for lawful and ethical processing of information. Must not be the same person as the Senior Information Responsible Officer
Senior Information Responsible Officer	An executive who is familiar with and takes ownership of the organisation's information risk policy, acts as advocate for information risk on the Service Provider's Board
Emergency Officer	Service Provider lead for ensuring the organisation is prepared for a major incident and business continuity plans are in place
Safeguarding lead	Service Provider lead for ensuring safeguarding policies are in place within services that are provided
Mental Capacity and Deprivation of Liberty Lead	Service Provider lead for ensuring there is a safe system which safeguards vulnerable children and adults, including adults who lack mental capacity.
Prevent Lead	Service Provider lead for prevention of terrorism by safeguarding and protecting vulnerable individuals.

5.2 Reporting of Incidents and Serious Incidents

The High Intensity User Service Lead must notify the CCG and the HIUS Service Lead of any SI and/or relevant incident that fall within the scope of the HIU Service within 2 days of that SI taking place.
The High Intensity User Service Lead will also coordinate and report on the status of each SI investigation, any recommendations and, where required by the CCG, final investigation reports in line with the NHS SI guidance.
NHS England's Serious Incident Framework sets out the types of incidents that can be considered to be SIs (please note there is no definitive list) and how these should be managed, including notification to the CCG.

5.3 Investigations of Serious Incidents

In the event of a Serious Incident or Never Event at one of the Service Providers, each Service Provider shall manage it in accordance with local procedures and in line with the provisions in the Service Contracts. The 2015 Serious Incident Framework ("2015 SIF") sets out the types of incidents that can be considered SIs and how these should be managed, including notification to the CCGs.
In the event of an SI taking place where more than one Service Provider is involved, the Service Provider that identifies the SI should alert the CCG and the Alliance Board in order to initiate discussions about subsequent action. The Service Providers shall ensure that all organisations and agencies involved work together to undertake one single investigation and the Serious Incident Framework will be used to determine if there needs to be a lead organisation for the investigation. Where a Service Provider or a number of Service Providers felt that one of the other Service Providers should lead the investigation, and they cannot reach an acceptable agreement, the CCG would arbitrate and decide which Service Provider would lead in terms of putting together the RCA report and signing it off. The CCG will be the final arbiter of which Service Provider will lead.
In complex and rare cases the CCG might undertake the investigations in accordance with the 2015 SIF or nominate a different Service Provider organisation. This might be where the relevant patient received care from multiple providers including care beyond the Service Providers subject to this Alliance Agreement.

5.4 Reporting of Incidents and Serious Incidents

All Patient Safety Incidents and Serious Incidents that occur as part of the work that fall within the scope the Alliance, as defined by the Service Contract, must be reported to the Alliance Board along with a status of each SI investigation and, where required by the CCG, final investigation reports in line with the 2015 SIF. The CCG will determine when a serious incident report is relevant to the Alliance Board and this will be shared where the learning can be regarded as relevant to more than one organisation/the Service Providers as a whole.
All Serious Incidents must be fully investigated within the timeframe set out in the guidance to ensure that lessons are learnt are shared and changes to procedures can be implemented in a timely manner.

5.5 Extract from Serious Incident Framework

Serious Incidents in the NHS include:

1. Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    a. Unexpected or avoidable death of one or more people. This includes
        i. suicide/self-inflicted death; and
        ii. homicide by a person in receipt of mental health care within the recent past (see Appendix 1);
    b. Unexpected or avoidable injury to one or more people that has resulted in serious harm;
    c. Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:—
        i. the death of the service user; or
        ii. serious harm;
    d. Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
        i. healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
        ii. where abuse occurred during the provision of NHS-funded care.
    e. This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information).
        i. A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information;
        ii. An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare