# PRJ-1252 – Lewisham High Intensity User Service

# Pre-Market Engagement

# Draft specification requirements

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# Introduction

People who frequently attend A&E make up less than 1% of England’s population but account for more that 16% of A&E attendances, 29% of ambulance journeys and 28% of hospital admissions and costs the NHS approximately £2.5bn per year.[[1]](#footnote-1) High usage of A&E services is closely associated with deprivation and inequalities and users typically have a range of both medical and non-medical needs[[2]](#footnote-2).

The 2019/20 NHS operational planning and contracting guidance set out that all health systems in England must implement a high intensity user service.

Based on the NHSE HIU model of care framework and principles, the HIU programme helps some of the most vulnerable people in our society, while saving NHS resources through reductions in A&E attendances, 999 calls, and non-elective admissions.

The Lewisham High Intensity User (HIU) service will deliver a dedicated service providing a one-to-one coaching approach, targeting people who use healthcare more than expected specifically targeting high users of 999, NHS111, A&E and hospital admissions supporting the most vulnerable patients in community to flourish, whilst making the best use of available resources.

The service will contribute to the wider High Intensity User Programme and is designed to take a multi-disciplinary approach to proactive case management, support prescribing priorities and deliver both routine and urgent care 'in-hours'.

# Aims and objectives.

The aims of the service are to:

* Effectively manage, co-ordinate and signpost frequent attenders at A&E
* Reduce frequent attenders’ activity on A&E department and calls made to London Ambulance Service (LAS).
* To explore the underlying reason for frequent attendances to A&E and signpost and make referrals to the appropriate agencies that can support individual needs.
* To engage / reengage people with local community services.
* Effectively manage and co-ordinate the chaotic and demanding nature of the patient group through the use of multi-agency support and the voluntary sector
* To provide support to identified patients linking to end of life pathways where appropriate.

The objectives of the service are to:

* Identify those at greatest risk of multiple attendances and admissions at A&E services.
* Proactively manage a dynamic rolling cohort of High Intensity Users, using a truly personalised approach
* To provide support to ensure patients are empowered to take ownership of their health and well-being, linked with primary care whilst decreasing their dependency upon A&E services.
* Refer to/utilise existing community and admission avoidance services.
* Provide a service driven by quality with positive, measurable outcomes.
* Improve communication and partnership working between those involved in patient care.
* To implement a patient centred and holistic approach to care, facilitating appropriate clinical treatments as well as solutions to underlying issues (including social care).
* Work closely with the acute provider and London ambulance Service (LAS) ensure approaches to patient care are coordinated.
* Empower patients to self-manage to enable discharge and to support the transition from negative to positive contributors of society.

Key outcomes

* Reduce (avoidable) attendances to A&E department.
* Reduce (avoidable) admissions to A&E department.
* Reduce ambulance conveyances.
* Provide high quality and personalised interventions.
* Promote self-care and health and well-being of patients (health coaching)
* Minimise inappropriate use of resources.
* Patients to have a positive experience of the service.

# Service Outline

# **Service Description**

The focus of the work will include identification, early intervention and effective management of patients frequently attending A&E and referred to as High Intensity Users. Following identification, the community-based team will make direct contact with each patient and undertake an assessment using an agreed assessment process to identify the reasons for frequent A&E unplanned attendances/admissions. This may include a range of complaints; social issues combined with alcohol dependency, mental health, criminal justice and potentially some extremely complex medical presentations. The vast majority of interactions may involve addressing a combination of a range of factors in order to reach the desired end.

Following the assessment, a process of support should ensue with concordance underpinning changes in behaviour. The service lead should act as an advocate for each of their caseload, guiding them through the complex journey and multifaceted approach which has resulted in their frequent attendance at A&E department, signposting to relevant partner agencies and supporting patients during this process. Whether the reason for calling is clinical, social, mental health addiction, loneliness, or a combination of any of these factors, the service should identify and adapt the support to meet the need and signpost at the earliest opportunity.

# **Proactive management**

The provider will;

1. Identify frequent High Intensity Users working in partnership with the Trust and GP practices.
2. Ensure patients who attend A&E are known to the practice are identified and patient data accessible to the service lead to be managed.
3. Work with the Trust, LAS and GP practices to identify a maximum number of patients.
4. Ensure these patients will be managed over a period of time depending on the complexity of their needs before being discharged.
5. There will be an on-going evaluation of the service, a six-month lessons learnt report and continuous learning will continue to shape service.

The patient cohort will be refreshed on a quarterly basis in order to proactively identify any patients at risk of becoming high users of urgent care services. This may result in an increase in the baseline. Any new patients will be identified in partnership with the Trust and GP practices (rolling cohort of patients).

# **Patient Cohort**

The service will support approximately 120-140 patients per annum who frequently attend or are at risk of multiple A&E attendances/ admissions or contact London Ambulance Service (LAS) services. Patients are identified by the acute provider and LAS.

**Inclusion Criteria:** HIU of A&E/ 999 services aged 18+ registered with a Lewisham GP

**Exclusion Criteria**; Patients with sickle cell disease, age above 70, children under age 18, care home patients etc or not registered with a Lewisham GP.

## Key stakeholders

The Proactive Management High Intensity Users Service will interconnect health and social care through establishing robust working relationships with:

* Primary care across 34 GP practices - General Practitioners, Practice Managers, Practice Nurses, Practice Pharmacists
* Acute Provider - Lewisham and Greenwich NHS Trust
* Lewisham community/social care service provider
* Neighbourhood Care Networks
* Other clinical and voluntary groups as required.
* Carers and Carer organisations
* Out of Hours providers Ambulance Services
* Mental Health services Drug and alcohol services
* Third Sector

The relevant service/s will be engaged dependent upon the needs of the patient and then used to discharge the patient from the service. The majority of patients will require a combination of the above to align in order to sustain the positive behaviours demonstrated throughout the period that the patient is engaged with the HIU service.

## Workforce

It is anticipated that this service will be provided by a team of professions across a range of different disciplines, providing compassionate and non-judgemental health coaching with understanding of Lewisham services available to support patients.

This HIU team will consist of a mixed workforce of both medical and non-medical staff who will work collaboratively with key services and stakeholders to support, manage, and treat a patient’s health and social needs.

# Key Performance Indicators (KPIs) and Contract Reporting

The Contractor shall supply the following core reports to the Commissioner:

* **Quality Report**, which shall provide information on incidents, complaints, and other quality measures, on a quarterly basis in line with agreed reporting timetables;
* **KPI Report** which shall provide contract performance information in accordance with an agreed reporting timetable (reporting deadlines to be agreed with the Commissioner upon contract mobilisation). The KPI Report will provide details of activity against plan and exceptions;
* **Minimum Data Set Report** which shall include data conforming to the Nursing Homes Minimum Dataset. This should be submitted in accordance with the reporting timetable;
* **Safeguarding Report:** This should be submitted in accordance with the reporting timetable.

# Contract and Finance

The new contract has an annual value of approximately £170,000 and will be delivered on an NHS Standard contract for a duration of 3 years + 2 year optional extension equating to a maximum contract value of £850k (£510k + £340k).

1. [hiu-summary-report-final.pdf (redcross.org.uk)](https://www.redcross.org.uk/-/media/documents/about-us/hiu-summary-report-final.pdf) [↑](#footnote-ref-1)
2. [NHS England » High Intensity Use programme](https://www.england.nhs.uk/high-intensity-use-programme/) [↑](#footnote-ref-2)