The Strategy Unit.

Qualitative Evaluation of the High Intensity Use Service

Report for NHSE/I Clinical Improvement Evaluation Team

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1. Executive Summary

The High Intensity Use (HIU) services, of which there are around 100 in England, are focused on supporting people who use a significant amount of urgent and emergency (U&E) care resources compared to the average population. HIU caseworkers provide service users with intensive, tailored support to identify and address the reasons for their high U&E use. They also build awareness and confidence in service users to use non-medical support alternatives, such as voluntary and community sector services (VCS). This customised support is intended to reduce avoidable activity on U&E services. Local HIU services are supported by the national programme team and a resource pack which details the design *principles* and the *key success factors* that can act as enablers of the service.

The NHS Strategy Unit was commissioned to undertake a qualitative evaluation of the HIU service; a case study approach was used to explore how five sites (East Kent, Kernow, Southport & Formby, Stockport and Chelsea & Westminster) delivered their HIU services. This report is the output of the case study qualitative evaluation, providing an executive summary with recommendations (section 1); describing the context and design of the HIU programme (section 2), methods (section 3); a synthesis of findings across the case studies (section 4); the conclusions, recommendations and a logic model for future action (section 5). There are also three appendices, of which appendix C contains the individual case studies.

It was clear from all accounts (service users, national leads, HIU teams and local stakeholders) that HIU services were successfully implemented and well received. Numerous examples were provided of how HIU services made the service user and their needs visible; how professionals across health and care as well as VCS were able to collaborate together with, and on behalf of, the service user to provide holistic support. Together they were able to have the intended outcome: service users were supported to become more confident and independent in accessing community services, to make positive changes in their personal lives, resulting in their reduced use of U&E services as a natural by-product.

There was some expected variation in HIU service delivery across the five case study sites, but broadly they followed the principles set out in the RightCare resource pack. The overall findings suggest that identifying service users using referrals from other linked services such as hospital psychiatric liaison teams provided a better experience for staff. This was because the HIU team were able to take into consideration the assessment of clinicians and engage in discussions with them as to the best approach to support for the service user. This method of identifying service users also reduced the risk of individuals not engaging with the service if they considered the contact by a HIU lead to be a cold call. This was found, in some instances, to be the experience of HIU teams who identified potential service users through A&E attendance lists.

In conclusion, the findings of this qualitative case study evaluation, which assessed the experience of five HIU teams and their service users, demonstrated that the service was valued by all participants. Some improvements to the service model have been suggested for the national programme team to consider as well as good practice reiterated; overall there is much support for the continued rollout of the service.

Recommendation 1: The primary route of identification of HIU service users should be via referral through other services. The use of A&E lists to identify service users still has merit, especially in identifying individuals that may not be known elsewhere.

Recommendation 2: HIU teams should consider the number of service users expected to be supported at any given time, and the complexity of their support needs. This should be translated into the number of caseworkers and their caseload, recognising that the service is flexible in offering support; frequent, albeit minimal, contact from several service users could overburden caseworkers.

Recommendation 3: Person-centred approaches to supporting service users to reduce their dependency on U&E services should focus on developing coping strategies for individual triggers, especially out-of-hours. Caseworkers also need to identify the relevant community agencies and support the service user to build trusting relationships with other professionals to reduce U&E dependency and improve overall wellbeing in the long-term.

Recommendation 4: There is merit in being explicit with the service users as to the time-period of support, and this could be a flexible offer (as already practiced by some case studies), tailored to the service user need and progress made over time.

Recommendation 5: The overall findings across the principles of de-escalate, discharge and relapse highlight their interdependencies. As such HIU services should approach this as a process, centred around the individual service user rather than three discrete principles.

Recommendation 6: Although case studies did not uncover examples of support for caseworkers to be lacking, HIU host organisations should provide a well signposted support infrastructure, such as mental health and wellbeing support for team members

Recommendation 7: A wealth of experiential knowledge is being built up by HIU services as to how different types of service users can be supported, often innovatively. Whilst these are shared informally through HIU networks a more formal typology of service users and the ways in which they can be supported in the community should be developed and shared widely as a resource.

Recommendation 8: National support is required to secure local funding commitment for the HIU service. The current development of ICSs provides an opportunity to promote the integrated and collaborative service offer of the HIU services and their effective use of the VCS. A further updated resource pack should provide HIU teams with guidance on how to engage and work with commissioners and ICSs.

Recommendation 9: The HIU national programme team should commission an independent mixed methods evaluation to assess the impact of the HIU services nationally. As part of quantitative evaluation approaches HIU services should be provided with additional guidance for data collection, sharing and analysis that can be used for local purposes and inform national understanding.

2. Background

2.1 Introduction to the High Intensity Use service

The High Intensity Use (HIU) service has been designed to support the needs of people with often complex lives who use a significant amount of urgent and emergency (U&E) care resources compared to the average population. This is primarily through accident and emergency (A&E) attendances but also includes ambulance conveyances, non-elective admissions, and other unscheduled care.

HIU services in England are typically commissioned within health and care systems (i.e. STPs/ICSs) to operate within their geographic area and provide support to service users through a one-to-one coaching approach, taking time to unpick issues and challenges in their lives in order to find a way forward. Part of this is working with individuals to help them to navigate and access local health (and other care services) according to their needs. The support includes the provision of bespoke tools to manage their overall wellbeing and facilitating the use of local voluntary and community services (VCS), and personalised approaches to reducing dependency on U&E services.

The number of HIU services in England has been growing since a pilot service, launched in Blackpool in 2014, '*demonstrated that an approach of empathy and coaching rather than enforcement had the potential to reduce the number of 999 calls*' (NHS RightCare 2015, [p. 3]). The pilot showed that, in the first fifteen months of operation, A&E attendances from the target group of service users reduced by 93 percent and 999 calls reduced by 89 percent. This suggested a potential for HIU services to support people with unmet needs and free-up capacity for front line resources to reduce the cost burden from regular use of U&E care.

As part of the 2019/20 NHS Operational Planning and Contracting Guidance, all health systems in England were required to implement a HIU service. As of March 2021, there are over 100 live HIU services, representing approximately 80% coverage nationally. Rapid evaluations of a cohort of HIU services, commissioned by NHSE and conducted in 2017 and 2018, have demonstrated an impact on reducing U&E attendances and reconnecting individuals with their communities.

2.2 The design principles and key success factors of a HIU service

In 2017, NHS RightCare published a resource pack (updated in 2021) to support local health and care systems to establish a HIU service. This guidance incudes an outline of the six principles (Table 1) which should underpin an effective HIU service, setting out how service users should be identified, supported, de-escalated, discharged, managed for relapse and defining the quality of the intervention.

The HIU delivery model is expected to be tailored to the local context, with the resource pack offering some suggestions for common features of the service, including:

- Appointing a HIU service lead, whose role is to proactively make contact with the most frequent attenders of their local A&E;
- Working with a network of health, social care, VCS and other public services to provide a suite of support options available to service users and advocate on their behalf with these services when required;
- Providing tools and guidance to service users in a bespoke way, led by their needs and interest, to help them to self-manage and reduce their reliance on U&E care.

Table 1: The principles of the HIU service (reproduced *from* NHS RightCare *(2021)*)

Principle	Description
Identify	Each HIU Lead identifies 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 or as a preventative measure, as opposed to chronically high use of health services. This group may be referred into the service by concerned partners as having called 999 or presented to A&E fewer times in comparison to others but presented with high-risk episodes of self-harm or homelessness.
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, calling 999 or an admission.
De-escalate	Many individuals use health care frequently due to an escalation in their social, emotional, financial or family issues and unmet need. Competent de-escalation and co-ordination of needs is facilitated by offering immediate access to an appropriate one-to-one coaching (the HIU lead).
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.
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 re-attend A&E.
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.

The resource pack also described five key success factors to support the design and implementation of local HIU services (reproduced here as Table 2):

Table 2: The key success factors of the HIU service (reproduced *from* *NHS RightCare* *(2021)*

Key Success Factor	Description
Select the right person for the role	You need someone with high emotional intelligence, resilience and a natural ability to problem solve creatively.
Provide your High Intensity Use Team with training, ongoing support and coaching	[This is] 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 CCG at the beginning.
Give them [the HIU lead] 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.
Commit for a minimum 18 months	You will need this time to attract the right candidate to implement the approach and to sustain later cohorts.
Source an automated, independent evaluation method	That allows you to demonstrate quantitative and qualitative outcomes so you can evidence success.

2.3 The purpose of this evaluation

The NHSE/I Clinical Improvement Evaluation Team commissioned the NHS Strategy Unit to complete an evaluation of the HIU service, conducted through five case studies selected to illustrate different operational models. Section 2 describes the methodology in more detail. The purpose of this approach is to learn from the variation in design and delivery of HIU services in England; to understand and reflect how they have adopted the 'design principles' and 'key success factors' for a HIU service shared by NHSE/I and make recommendations for improvements to the HIU service.

The main body of this report focuses on the synthesised findings across the case studies. A detailed summary of findings by case study site is provided in Appendix C. Findings (Section 3) are structured by the principles and key success factors for HIU services outlined above, to understand the different models of delivery and how systems have tailored the guidance to different contexts, from the perspectives of staff and service users.

3. Methodology

3.1 Summary of data collection methods

This qualitative evaluation involved semi-structured interviews with stakeholders and service users and document review, for five case study sites with established HIU services. The sites were selected by the national RightCare HIU programme team at NHSE/I. For wider context, the project team also interviewed the national HIU Programme Lead and the HIU and Social Prescribing Product Lead for the British Red Cross.

3.1.1 Semi-structured interviews with stakeholders and service users

Table 3 provides a list of participants in the interviews by case study site.

Table 3: Interviewees by case study site

Case study site	No. of stakeholder interviews	No. of service user interviews
Chelsea and Westminster	4	2
East Kent	2	1
Kernow	4	2
Southport and Formby	4	2
Stockport	5	2

Interviews were carried out under conditions of anonymity. The topic guides (stakeholder and service user) are included as Appendices A and B. Interviews lasted between 30-60 minutes; they were recorded with consent. Recordings were transcribed and transcripts coded with the assistance of qualitative data management software (NVivo 12). A coding framework was developed for the purpose of analysis, taking account of the 'principles' and 'key success factors' for HIU services (as outlined in Section 1). Where quotations from these interviews are used, individual participants are not identified. For ease of reading, quotes from professionals are highlighted in amber boxes, quotes from service users are in blue boxes.

3.1.2 Document review

In addition to the interview data, documents regarding local HIU services (such as performance reports) were requested from case study sites, and these have been reviewed for additional context.

3.1.3 Qualitative data analysis

To address the challenge of comparing case studies when the model of HIU service delivered differs slightly we adopted a realist approach to qualitative data analysis. This approach is often described as 'what works, for whom, in what circumstances, and why'? More formally it is described as establishing the outcomes (both subjective, such as patient wellbeing, professional stress; and objective such as service activity) that are realised (or not), based on the mechanisms employed in the implementation (that is both the resources within the HIU scheme e.g. time, skills, personal engagement and the reason for their use) in a specific context (refers to the environments, characteristics and behaviours of service users and professionals). This analytical approach and the reporting of the principles and key success factors in section 3 followed the methodology set out by Dalkin et al (2015).[1] As part of the analytical process the theory implicit within each of the principles was identified (stated according to the relevant principle in section 4.2), this allowed the findings to be tested against those theories. We did this specifically for the principles as this allowed for comparison of the delivery model at each case study site.

3.1.4 Ethics

All interviews were conducted to the Strategy Unit's high ethical and governance standards, which are in line with best practice. This includes:

- Protecting and promoting the dignity, rights, safety and wellbeing of participants, patients and staff involved through informed consent.
- Conducting all work in accordance with the UK Framework for Health and Social Care Research code of conduct.
- Applying the highest practical standards of handling patient identifiable information according to the 7 Caldicott Principles and 7 GDPR Principles.

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[1] Dalkin, S.M., Greenhalgh, J., Jones, D. *et al.* What's in a mechanism? Development of a key concept in realist evaluation. *Implementation Sci* 10, 49 (2015)

4. What works, for whom, and why

This section provides a summary of the findings from the evaluation.

Section 4.1 summarises the host provider and remit of the HIU service at the five case study sites, and findings relating to the importance of stakeholder engagement in designing local models. It describes how the five HIU services have been designed and implemented.

Section 4.2 provides an overview of how HIU services have been delivered and experienced by both HIU teams and service users. This is reported in the context of fulfilling the 'principles' of a HIU service: *identify; personalise; de-escalate; discharge; manage relapse; and quality of intervention.*

Section 4.3 describes the experiences of case study sites in delivering the HIU service using the enablers of 'key success factors', as set out in the NHS RightCare resource pack: *select the right person for the role; provide training support and coaching; give freedom to act and innovate; commit for a minimum of 18 months; and source an independent evaluation*.

Fuller accounts of the HIU services in each of the five case study sites are provided in Appendix C.

4.1 HIU design and implementation

4.1.1 Key features of the case study sites

The key features of the five HIU case study services at the timepoint the study took place are summarised in Table 4. In line with national guidance, all services are hosted by a local VCS organisation. Reflecting the intended tailoring of services to the local context, there were differences in how service users were identified or referred, and the numbers of service users supported at any one time.

Table 4: Summary of five case study sites

HIU service	Service provider	Service remit	HIU team
East Kent	British Red Cross	Service users are approximately 90 of the most frequent U&E care attenders per year at East Kent Hospitals University NHS Foundation Trust, with an additional focus on 18-25 years cohort.	HIU Lead and 1 caseworker
Kernow	Volunteer Cornwall in partnership with Pentreath and Cornwall Mind	Service users are approximately 140 of the most frequent U&E care attenders per year at Royal Cornwall Hospitals NHS Trust and Derriford Hospital in Devon. Also separately commissioned to support the discharge of mental health patients from Cornwall Partnership NHS Foundation Trust.	HIU Lead and 5 caseworkers

Southport and Formby	Sefton Council for Voluntary Service	Service users are approximately 50 of the most frequent U&E care attenders and referrals from the hospital alcohol liaison team (HALT) team per year.	HIU Lead and 3 caseworkers
Stockport	British Red Cross	Service users are 50 of the most frequent U&E care attenders per year at Stockport NHS Foundation Trust.	HIU Lead and 1 caseworker
Chelsea and Westminster	British Red Cross	Service users are solely referred from the local Psychiatric Liaison team following an A&E attendance at Chelsea and Westminster hospital (case numbers vary – dependent on referral numbers).	HIU Lead, 1 caseworker and 1 part-time caseworker

The three British Red Cross (BRC) case studies are amongst 16 HIU services delivered by the BRC across England, whereas the Southport and Formby (S&F) and Kernow models are delivered by local VCS organisations in this area only. All models of delivery are closely based on the pilot Blackpool service that formed the basis for the NHS RightCare resource pack described in Section 1. Chelsea and Westminster is unique in that it is a Mental Health commissioned service, focussed on patients referred from A&E to Psychiatric Liaison (and then onto BRC) and working preventatively, as per the needs of that local system.

Although all HIU teams are led by an HIU lead, other team member job titles vary across the case studies. For ease of reference, the term 'caseworker' (adopted by Kernow and Southport and Formby) is used here to describe all HIU team members who support service users directly.

4.1.2 The support offer available to HIU services

In addition to providing 'principles' and 'key success factors' for HIU services, the NHS RightCare resource pack provides practical guidance relating to implementation timescales, commissioning and establishing the service, as well as service tools such as client consent forms and information sharing agreements. All case study sites have made use of the resource pack in designing and implementing their services, although BRC have subsequently developed their own bespoke resources, tailored to the multiple system offers they now deliver.

> *"We used the standard service specification [for a HIU service]. It's in the RightCare pack. We followed that process and we just basically used all the materials in the RightCare pack and then adapted them."*

Case study sites have also benefitted from consultancy support from the HIU Lead (HIUL) to support their implementation. The HIUC is the founder of the original Blackpool service and was brought into the NHS RightCare national programme team to provide expertise to local systems who expressed an interest in establishing their own service. Their role includes presenting the HIU service model at various NHS conferences in England – events which were referenced as the catalyst for local service development by participants in the case studies.

The HIUC and national programme team have supported CCGs and other key stakeholders to access and present RightCare data showing the prevalence of high intensity use of U&E services in their areas, to build the business case for implementing a HIU service locally. The HIUC has also presented the model to local stakeholder boards and teams across England where requested.

Post-employment, the HIUC additionally provides consultancy and training support to local HIU services when commissioned to do so. This includes:

- Support in interviewing for HIU team members
- Coaching and mentoring the HIU team
- Support for initial service user engagements
- Attendance at stakeholder events

Case study sites reported the value in this support in helping them to establish their service:

> *"[The HIUC] was very helpful in assisting me at the beginning… So I had some sessions with her before I was even working face to face with the clients and then subsequently when I was actually working with the service users I had regular [mentoring] sessions with her. [These were] really useful because obviously [there were] some things that I was struggling with at the time.., it was really [helpful] being able to ring [the HIUC] and have sessions with her."*

4.1.3 Stakeholder engagement

The importance of system stakeholder engagement in developing a HIU service was emphasised across the case study sites. It was required to: gain local buy-in for the service; establish system networks for supporting the service user cohort; and manage expectations of the service – for instance reaching shared understandings of the remit and role of HIU caseworkers.

> *"[We held] a launch day at the beginning of the service and… lots of agencies and organisations were invited to that launch day to hear about the project, which was excellent because everyone there contacted you instead of you having to contact them. [Community services] were there, mental health teams were there, all of those sorts of people attended the launch day and those [are] probably still the people that we are most in contact with today."*

> *"We did a very big stakeholder event to try and get everybody in the room to say what we're doing, we're supporting these people and we want you to know about it but at the same time we had to be a bit clear about what it was we were doing and why. We had to be really*

> *clear., we are a service that supports high intensity user of 999 and ED so no primary care., no district nursing services…"*

4.2 Delivering against the HIU service principles

As described in Table 1, there are six guiding principles for a HIU service. The sub-sections below each describe:

- The principle as stated in the RightCare resource pack;
- The theory implicit in the RightCare resource pack for the principle. These were elicited in the analytical phase of the qualitative evaluation by the project team, to test whether the principles were delivered as intended, whether any modifications were made, and to what effect;
- The findings across the principles. These are drawn from a synthesis of professional and service user accounts.

4.2.1 Identify

Principle

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. This group may be referred into the service by concerned organisations as having called 999 or presented to A&E fewer times in comparison to others but presented with high-risk episodes of self-harm or homelessness.

Theory

People who can be supported to reduce use of A&E services can be identified through reviewing A&E high intensity use lists and through a subjective assessment of vulnerability by HIU teams and other services.

Findings

Service users described that prior to their engagement with the HIU service, their experiences with social isolation (not limited to the pandemic), their poor awareness of which services to access, and lack of knowledge about how to access them, led them to use U&E services instead. Their accounts revealed that in the absence of appropriate support and to manage their anxieties and frustration, they defaulted to U&E services as a place of safety and security.

> *"When I have an episode of depression, panic and I didn't know who to talk to, what to do, or couldn't get through to the crisis team, the only place I felt safe with was if I had an ambulance person or seeing people in A&E made me feel secure".*

The delivery of the principle of 'identify' was through two modes of identifying HIU service users as described below:

1. *Identifying service users from A&E attendance lists*

Reflecting the principle, the most common mode of identification of potential users across the case studies is by accessing business intelligence data which identifies people with frequent A&E use. These lists are received by the HIU service directly from the hospital, at agreed regular intervals. The usual practice at case study sites is for a list with contact details of the top fifty frequent attenders, to be received on a quarterly basis.

The combined experience of HIU services using these lists as a mode of identification is that there is an initial investment in time for the HIU team to filter through the accompanying information, to identify those that would most benefit.

> *"Because we can only work with a small number of people, you need to take the time [to review the lists] … The interventions that you're going to offer are very intensive and can make such a big difference…. So, it's really important to take the time to pick the right people."*

The information contained within the lists has improved over time as services become more embedded and HIU teams identified what additional data they need to inform their ability to identify potential people more easily. For example, in Stockport, two lists were requested to provide more personal and attendance related information:

> *"We asked for 12 months data, and we asked for 12 weeks data. I got a list of anybody who had attended more than 5 times in the preceding 12 weeks, but I also had an overview of a 12 month period as well. So I get their name, their age, their NHS number, details of their presentation so which day they attended, what time they attended, how they got to ED, so whether they were on foot, by an ambulance, by the police or whatever. What the presentation was, so it's coded and then a very small narrative about the outcome so whether they were discharged, whether they were admitted, whatever happened to them."*

Detailed information also allows the HIU team to plan the caseload for the team. Case study sites had found that it was more appropriate to manage the HIU team caseload to account for the complexity of service user need, rather than simply a function of number of staff available and assigning a set number of service users to each caseworker. As a result, HIU teams were managing caseloads for each time-period by first identifying the level of support required for that cohort and then ensuring a case mix for each caseworker. For example, East Kent reported:

> *"We aim to take on between about 20 and 25 [people] every 3 months. We divide HIUs into 3 sections so very high attenders, medium and the lower end that are maybe 6 to 15*

> *attendances in the last 3 months, so that would be the lower end.... If we happen to have 5 service users who actually need a lot more support, we take them on into the next quarter, and if we feel able, in order to meet the numbers, we'll maybe take up a lot on the lower spectrum, or if we've only got lower ones we'll take up more in the high, so it is really varied."*

One of the initial aspects of the role is connecting with potential service users once identified from lists of frequent A&E attenders. Service users interviewed confirmed that the initial call from the HIU service was often unexpected. Nonetheless, the first encounter with caseworkers was described to be relaxed, friendly, and informal. Service users reported that they were given the opportunity to discuss their conditions and the underlying reasons for U&E services use, with caseworkers putting them at ease by their manner and offer of support.

Service users are usually not informed in advance that their details may be passed to the HIU team and that they may be contacted by them and, as a result, can be hesitant to engage.

> *"You're cold calling these patients, they're not expecting the phone call because there's no referral process, so, sometimes, you'll be met with, 'How have you got my number? Where have you got this information from?' And other times, they're quite happy to carry on with the conversation and accept the intervention, so to speak."*

Service users interviewed confirmed that the initial call from the HIU service was often unexpected. Nonetheless, the first encounter with caseworkers was described to be relaxed, friendly, and informal. Service users reported that they were given the opportunity to discuss their conditions and the underlying reasons for U&E services use, with caseworkers putting them at ease by their manner and offer of support.

> *"When I was first contacted by the HIU worker they said they could help in the way that if I need support in getting out and about, going through to appointments, really it's support around what I need. So, they'll be basically person-centred".*

2. *Identifying service users through referrals from other services*

The second method to identify potential service users is through live referral from other services. For example, the Kernow HIU team is commissioned to support the discharge of patients from the community mental health trust and the Southport and Formby team accept referrals from the local HALT. HIU teams reported that these services provide appropriate referrals as, in their experience, HIU service users often have a mental health and wellbeing issue; and are likely to self-medicate with alcohol.

> *"So although people appear to be presenting as a physical health problem or because of alcohol, the thread that runs through virtually everybody is either a mental health or psychological well-being issue."*

The HIU service at Chelsea and Westminster is unique amongst the five case studies: it takes referrals exclusively from the hospital psychiatric liaison team. This liaison team takes referrals from A&E when an individual presents (this could be a first attendance), and then in discussion with the HIU team handover the person to the service. The HIU team then make contact with the potential service user, sometimes when the person is still in hospital.

The three case study sites that accepted referrals from other services felt that their HIU service benefitted from collaboration with them, in not only identifying the most appropriate service users together but in increasing the chances of engagement as there was less cold calling involved. Service users were made aware of the HIU team and, with the handover from a trusted clinician, there was reported to be more acceptance of support from HIU team members.

> *"It's so nice to just be able to go into the other room and talk to the person who's referring. That seriously cuts down on time, makes it efficient. I think it also helps the service user, the fact that the person they initially met is introducing them to someone that they know."*

Another positive feature for the HIU team in using this approach to identification is that in the handover and introduction, the first stages of consent for support and information sharing is initiated. This makes the process of engagement more efficient for the HIU team and makes the most of a short window of opportunity with the service user.

*"One of our KPIs is that contact made by a member of the Red Cross within 24 hours of point of referral. And I wasn't always sure, I always thought that that might be too long, I wasn't sure whether that was. But what I've realised is that, often that is probably the right time, and actually sometimes, they'll make contact but they won't see them again for another 24 hours. Or, because we've seen them in such a point of crisis, actually 24 hours, 48 hours is enough time for someone to sit down and go, 'OK, what are the other issues that you've got? "*Service users who engaged are usually prioritised over those who are more ambivalent about receiving support, as case study sites linked higher engagement with higher likelihood with changed behaviour (leading to reduction on A&E attendance).

> *"When we take those referrals that are a bit weak, they're not too fussed about whether they have support or not, they will fall to the bottom, because you've got these people that really want help, really need help, and they're in regular contact. They're very engaged."*

Summary

Case study sites described two main routes to identifying service users, as shown in Figure 1. The use of an A&E high attenders list with limited information requires the HIU service to identify appropriate service users and contact them. On the other hand, filtering for eligible service users from live referrals from an overlapping service meant service users were identified on the basis of collaborative discussions and benefitted from managed handover processes; this provides a better experience for staff (and presumed for service users as well).

Independent of the mode of identification, case study sites were in agreement that most service users had mental health and wellbeing support needs, and within this spectrum some were likely to be more complex in their support requirements, many requiring care co-ordination. Our analysis uncovered a more nuanced feature of identification: staff delivering HIU services needed to ensure a case-mix of service users in order to better manage their caseload.

Figure 1: What works in identifying HIU service users

4.2.2 Personalise

Principle

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, calling 999 or an admission.

Theory

The HIU lead uncovers the non-medical reasons for a person's use of emergency services, allowing the HIU caseworker to personalise their support to reduce the use of U&E services.

Findings

A personalised approach was delivered through the ways in which caseworkers made and maintained contact with the service user and developed a trusting relationship with them. It was further developed through identifying appropriate support services in the community and enabling the service user to access these alternatives.

1. ***Making contact by phone***

Some of the challenges associated with the first contact being a 'cold call' were discussed above (Identify principle). Case study sites confirmed that the first contact, usually by telephone, was critical in establishing trust with a potential service user and understanding their individual reasons for high use of U&E services. This first conversation therefore focuses on the HIU team member getting to know the service user and exploring what support is required. Where possible, a caseworker might be allocated after this first conversation; to match experience with the service user needs and to ensure the best possible rapport.

The first conversation is also the opportunity for the HIU team to go through a checklist to discuss consent to being supported by the team, safeguarding and information sharing – the caseworker then gains explicit consent may also gain permission in writing at the first face-to-face meeting for data sharing with other services.

> *"We're really careful about the language we use [during the first call] and the terminology that we use and we try and keep it as basic as possible and just have a really honest conversation with them from the beginning over the phone, and then we say, 'with your permission can we just come out and have a little chat about that further?"*

Service users highlighted the importance of maintaining contact by phone or other method, even after face-to-face support is initiated. It became even more meaningful during lockdown periods in the pandemic. This level of support offered some service users their first experiences of a professional committed to understanding their life challenges.

> *"Slowly I started to understand that they're here to help, they're here to listen to you, to hear what you have to say, and find a solution. She texts me, asking about my situation, how I'm doing, what I'm doing. It's good, knowing someone cares about your situation."*

2. *Working face-to-face*

Following initial consent and agreement to work together, caseworkers usually meet the service user face-to-face, dedicating time to discuss unmet social needs more specifically. Case study sites reported that during these initial conversations it was important that caseworkers described the: remit of the HIU service; scope of the support that could be provided; and boundaries or routines for contact.

Face-to-face support was agreed to be an important feature of the service. This often meant that caseworkers visited service users in settings that were familiar to them, including their own homes. This was easier for HIU teams that covered a smaller geography, such as Stockport, but more challenging for those who had a larger catchment area, such as Kernow and Chelsea and Westminster. Over time, as caseworkers moved into the support phase and built service users' confidence to interact with heath and care professionals and use services more appropriately, they would attend routine appointments if it was needed.

> *"It's one of the biggest barriers to engaging with people, them not being able to travel to you or travel to an appointment. If we can go to them in their home, especially older people. Just working in a very person-centred way, going the extra mile to make that engagement, I think that's massive, letting people know we care."*

Service users described how the frequency of contact with their caseworkers, and the duration and location of their meetings, were agreed based on their individual needs. Caseworkers were reported to go beyond service users' expectations.

> *"My caseworker was amazing. She wouldn't just come for an hour, she'd come for a couple of hours, and I was really impressed. We'd usually have the meeting in an open area over lunch or something".*

3. *Providing a personalised support offer*

Case study sites described a bespoke, personalised approach to support, emphasising that there was no 'one-size-fits-all' approach. HIU teams' ability to deliver personalised support was characterised by caseworkers as being able to provide whatever was required.

> *"Whatever they want. That's the offer. It's what is it that will help keep you well? What is it that is making you feel that you need to go to ED all the time? That's where people go, 'really? Are you serious?' That's the beauty of the offer, is that it's absolutely human-centred. Not even just person, it's human-centred. It brings us back to being a human."*

This approach was very well received by service users and they identified it as a central feature of an effective approach to improving their individual wellbeing.

> *"The support worker cheers me up, we have a laugh. They make me feel like someone's bothered about things, they are very understanding".*

Recognising that service users may previously have had poor relationships with health and care professionals, HIU teams described how it was important that the caseworker began the support process by listening patiently to the service user, providing reassurance that the support would be non-judgemental and would not be removed before the agreed time-point/outcome.

> *"We work with you regardless of whatever your condition, whatever your issue. We don't go away. We're not going to judge you, we're not going to tell you what you should be doing. We're only going to offer some solutions alongside you. We're not saying you should be doing this, we're actually respecting that person and we just point out how it could be made a bit easier for yourself, how you can help yourself a bit more and what support is there should you want it. We're not making anybody do anything. We're giving you the options."*

Service users confirmed the trust and rapport built with their caseworker, describing their ability to speak freely and without judgment. As a result, HIU caseworkers became the service users' first port of call.

> *"If I have any problems, then the only person that knows right now is my support worker. If I have any problems, then I will call her. That is the only person that I can trust, and I know she can help me."*

Demonstrating the personalised support offer, the ability of the caseworker to identify the services most relevant to their needs, and then supporting access, was highlighted by service users.

> *"I didn't even know services like this were out there. When both my parents died, it was a very bad patch. You can't signpost yourself because you're not well enough to know what's available, you're not in the right frame of mind to go looking. So, you need somebody to come in and tell you what they see and what you need. And for me I thought my life was over. But that's stopped now."*

Service users described HIU how caseworkers had advocated for them, liaising with other professionals to ensure that their perspectives were recognised and addressed.

> *"She sorted things out that I couldn't really do myself, people would listen to her, but they wouldn't listen to me. She understands me fully and how I feel. She puts me in touch with other services, we have a good conversation. I couldn't fault it at all. I hope it doesn't go. I know I can't have her forever."*

Diverse examples of personalised support were provided by HIU teams and service users, including:

- Meeting for informal conversations or talking regularly on the phone
- Liaising with GPs and pharmacists to manage medications and co-attending healthcare appointments
- Acting as an advocate for patients in engaging with clinical services.
- Signposting (and supporting referrals) to specialist local services (community support groups, befriending services, mental health services, social prescribing, alcohol specialist services, NHS responder relief and crisis prevention)
- Identifying and enrolling in community activities of interest, such as classes for art, fitness, music and gardening
- Applying for benefits, housing and support for managing money
- Supporting access to IT equipment and signposting to services to improve digital literacy
- Securing accommodation
- Building confidence to access employment opportunities.

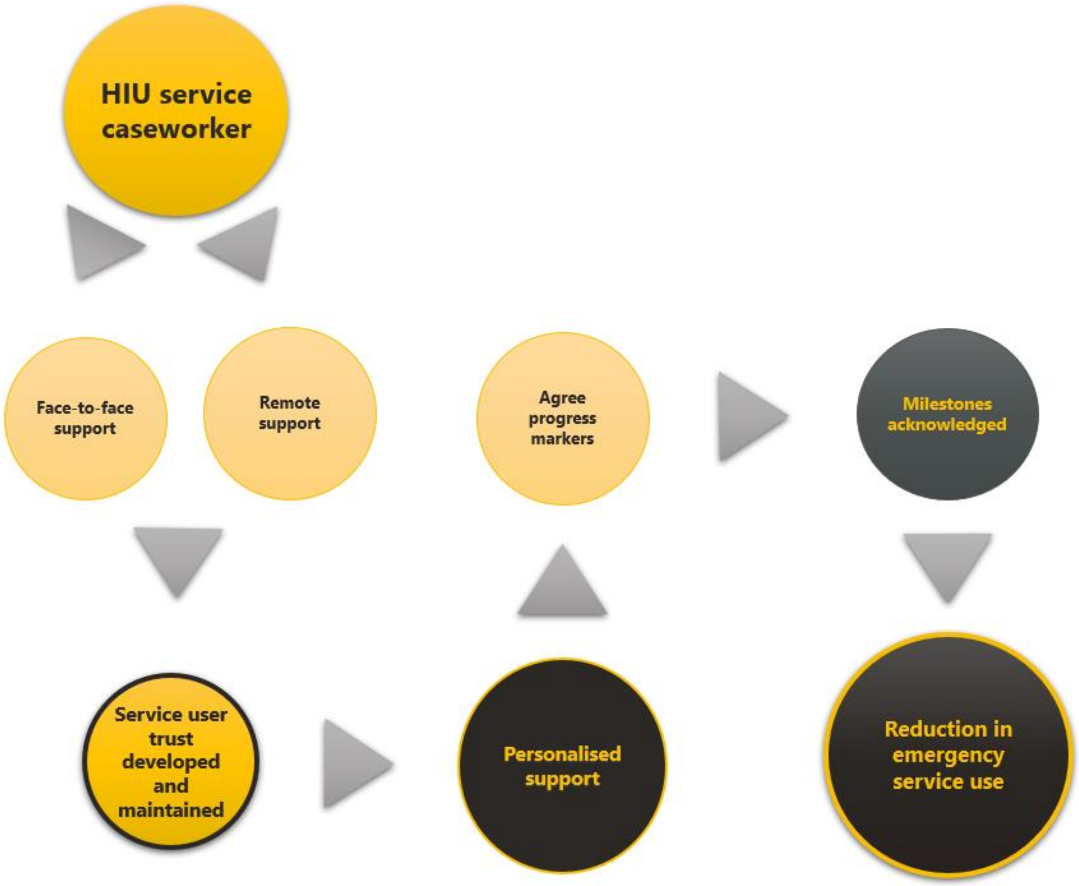
To support and recognise progress, caseworkers set personalised goals with service users. This provides individual motivation and personalised reward.

> *"We give them (service users) little rewards based on whatever motivates them. [The HIU lead is] very good at identifying what are the things that people value in terms of things in their life that are important to them. It might be that as they make progress, [they say], 'let's go for an ice cream and sit on the beach where you used to go as a child and watch the sun go down as a reward for not calling the ambulance at all this week'… Little steps and milestones each time that they can aim for and making sure we give them lots of positive feedback and encouragement and every so often little rewards."*

Summary

As Figure 2 illustrates, caseworker support, which is tailored to the individual, begins with developing and maintaining trust through patiently listening to the service user and responding in a non-judgemental way. The experience of HIU teams is that support needs to be delivered on a regular basis during the agreed period, using both face-to-face and remote engagement. Having gained service user trust, the caseworker can progress to supporting the individual primarily by connecting to other support services and VCS, building service users' awareness of alternative and more relevant options available to them. In the offer of personalised support, and the provision of a bespoke offer, it is important to agree progress markers and acknowledge the achievement of these in small but significant ways for the service user. With the knowledge of alternative options in the community and the confidence to access them, HIU service users can be supported to reduce avoidable use of U&E services.

Figure 2: What works to personalise support



4.2.3 De-escalate

Principle

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 timely access to an appropriate one-to-one coaching support service (the HIU lead).

Theory

An individual crisis that results in regular U&E service use can be prevented if service users have access to direct and immediate skilled coaching support that takes a holistic approach to addressing their needs.

Findings

The principle of de-escalate was delivered through caseworkers providing flexibility in the timing and type of support provided; and the early involvement of other support services to provide a holistic model of care.

1. *Flexible support*

In addition to identifying alternative forms of support and helping service users to access it (as described above in ‘personalise’), caseworkers provided flexible and phased approaches to manage individual triggers and prevent an escalation.

> *“We're not nurses or doctors, we're not psychologists or anything like that, but we've got the time to give to people. I think that's the key thing that, under no fault of their own, the NHS and things don't have because they're so busy. We've got the right expertise and the right amount of flexibility to help them recover and I think that's the big difference. “*

It was clear from service user accounts that the limited availability of health and care support outside of regular working hours led to a higher risk of inappropriate use of (out of hours) U&E care.

> *“Outside of those times, is a problem. They have the crisis team, but the phone lines are always busy and when you're desperate, you start feeling worse, and then you go to A&E because nobody's picked the phone up.”*

Service users stated that the ability to contact their caseworker directly and to receive responses from them in a timely way was one of the key supportive features of the service; and that this reduced their risk of escalating to a crisis.

> *“If I've got any problems or issues, I've got a contact number that I can always phone up, and I can always text or they'll phone me back.”*

The frequency of contact between caseworkers and service users varied, based on the individual and stage of their journey from initial crisis management: it could range from twice a day to once a fortnight. HIU services reported the need to set some ground rules, for example which hours of the day to contact; however, within this, caseworkers offered as much flexibility as possible, dependent on service users’ needs. This accessible, personalised relationship was central to providing de-escalation support.

> *“We get a lot of people, when they call us, they say, 'I need to go into A&E.' You ask them, 'why are you going into A&E?' 'There's nothing else I can do. I haven't got any physical symptoms or anything, but I just feel rubbish and I want just to talk to someone.”*

One of the challenges for HIU teams in offering this flexibility was the availability of other support services: they usually only operated standard hours (Monday to Friday, 9am to 5pm). Thus, there was a risk that if caseworkers were the only accessible service, service users became dependent on them. To prevent this, caseworkers planned ahead, focussed on strengths and established boundaries, equipping the person with ways to self-manage triggers.

> *"I have to remind them, 'Look, if you need to call an ambulance, you call it, don't think that I'm here to tell you not to, but what we're trying to look at is other things.' And for those people, they know their pathways really well - if they ring 10 times a day - which can happen, then we might say, for next week, the next time this happens, whatever the trigger is that makes them pick up the phone and ring, let's talk about some techniques that you can use to do that and I want to see if you can just call me 5 times instead of 10 times next week."*

There were examples provided of creative solutions to support service users out of hours; for instance, some service users were given journals and encouraged to write about escalations and anxieties, including reflections on how they feel and reasons for attending A&E. These journal entries could then be discussed with their caseworker at an appropriate time.

> *"I think that's really helpful for them because even though they weren't able to talk to someone, they were able to write down exactly what they were feeling and they knew that we'd be reading that and that we'd be talking to them eventually, so it's kind of a bit of de-escalation for that time. Don't get me wrong, it doesn't work every time, but that's just one of the tools we use in order to help our service user."*

Service users also described other ways they had been supported by caseworkers to manage their wellbeing independently and to de-escalate a crisis, such as through meditation apps or occupying themselves with activities they enjoy when experiencing anxiety.

2. Working with other agencies to provide holistic support

Delivering the de-escalate principle requires HIU teams to have a good knowledge of local VCS care services and to build relationships with them and other agencies, to advocate on the behalf of service users and provide appropriate referrals. This includes the police, out-of-hours mental health support, telephone support services and community groups aligned with the service user's interests.

> *"For me, it depends on the person, everyone's really different. I can give lots of information and advice to people about the right services to use at the right time, mental health lines, support lines, it could be the Samaritans. Having those conversations with people and seeing how they feel about using those services, if they've used them before what their experiences are of them, if they haven't used them before trying to answer any questions about them, give some information about them."*

Following initial support to access the relevant services, the service user is encouraged – and often supported (see 3.2.2) – to access these services independently.

> *"I think this has given them the knowledge of actually what's out there and what they actually need. It might be that you get someone into a rehab programme then you know you can step away because they've got that alcohol support. So you're now able to problem solve yourself and you're able to access the services without being anxious about ringing them up. You've got those relationships, you no longer need to be ringing me to do it, you're now doing it."*

One of the challenges for caseworkers was in managing expectations of both service users and other agencies; they had to make clear that the HIU service was not a crisis service, nor was it staffed by clinically trained individuals who could treat service users for a physical or mental health crisis. Instead, they were a team that provided service users with the support and tools to prevent a crisis and reduce avoidable use of U&E care services.

> *"I'm really clear with them, I'm not a CPN (community psychiatric nurse), I'm not a medical professional, I'm a bloody good listener and I can do the things I can do, but don't hold your risk of suicide."*

To support other health and care professionals when service users did escalate to a crisis, caseworkers developed individual care plans, outlining the user-centred approach to be followed by healthcare professionals in the event of a crisis. Service users reported the difference that this had made to their care and thus their use of U&E services.

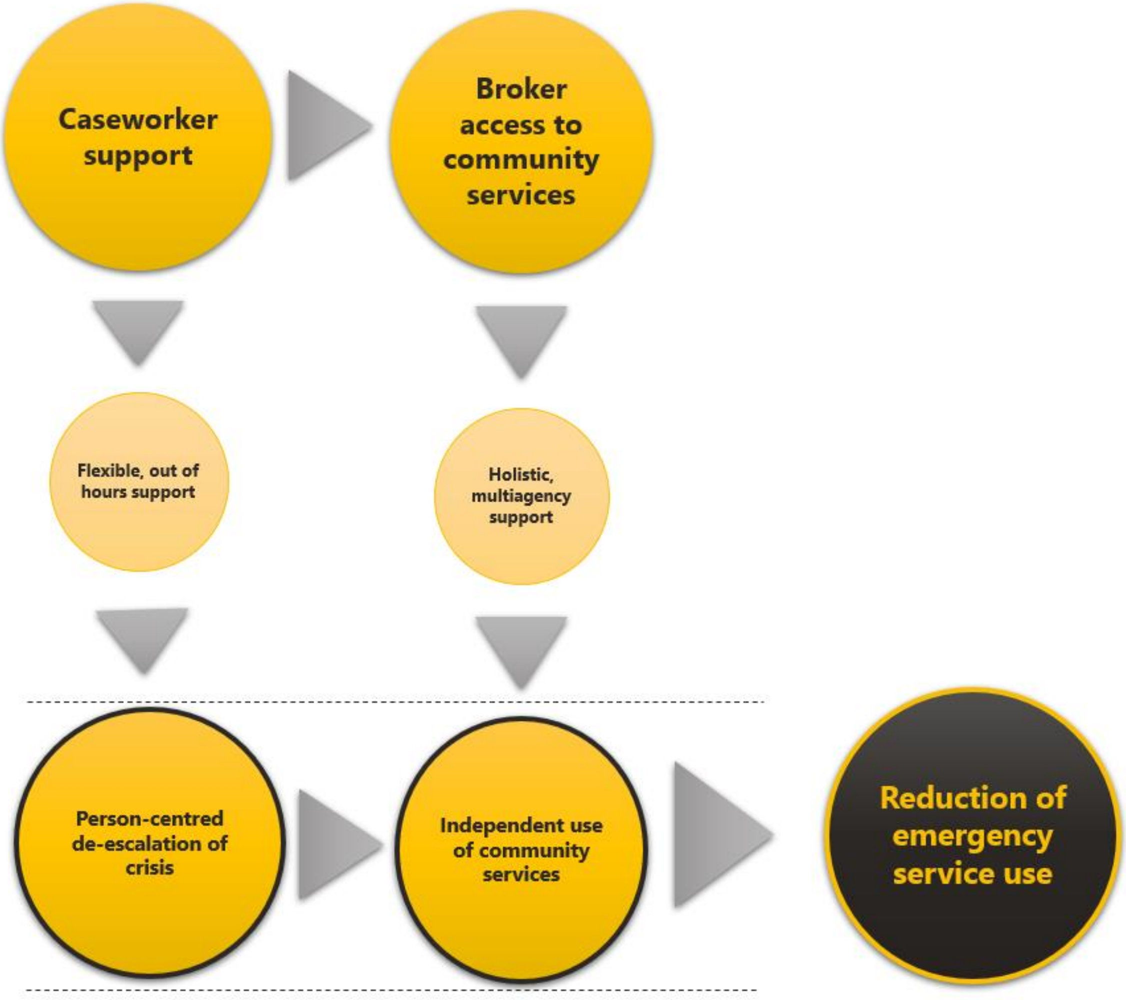
> *"So if I have that care plan sorted out, at least I've got it documented to say, if I'm out of hours with the symptoms, this must happen, I've been asking for that for a long time and it wasn't until I spoke to the HIU worker that they started to get things sorted for that".*

Summary

There were two main resources identified by case study sites to deliver the principle of de-escalation: flexible caseworker support and holistic support through other agencies. Caseworkers needed to first work with the service user to identify the triggers for their avoidable use of U&E services and then develop strategies to deal with them. Key to effectiveness was providing tailored support to the service user to de-escalate and manage a crisis out of hours, in hours.

In order to manage de-escalation over the long-term and in the future absence of HIU team support, caseworkers also brokered access to community services (including voluntary care support) as relevant to the service user; and encouraged service users to use these independently, once their familiarity and confidence grew. Over time, this was reported to reduce both the dependency on U&E services and the caseworker.

Figure 3: What works to de-escalate



4.2.4 Discharge

Principle

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.

Theory

HIU service users that are reconnected to community or voluntary support services in a supported, considered transition can be discharged from the service without risk of immediate relapse.

Findings

The need to sensitively manage discharge from the HIU service was described across the case study sites, although there were variations in how this was approached. Some teams were explicit with the service user from the outset as to how long to expect support from the HIU team, to mitigate the risk of creating dependency. Chelsea and Westminster, for example, acknowledged that their support duration was shorter than others'

> *"I know that other HIU services typically can be 6-12 months of work... I think our average is about 30 days. When we start working with people, we don't go into it completely open-ended, we actually go into it the other way, thinking this is going to be quite a refined 6-week piece of work. It might extend a little bit, but approaching a piece of work thinking, 'I'm going to work with you for 6 weeks,' is very different to, 'I'm going to work with you for 12 months.' You can do very different things in that time period, so I think ours is slightly more short and focussed, opposed to the longer-term, really long HIU pieces of work."*

Progress during the allocated time was reviewed with the service user; if both the caseworker and service user agreed that more support time was required, the service was flexible in providing this.

> *"The closing, how does it normally go? I've tried, halfway through, to be like, 'we're about halfway through, we have another 3 weeks. How do you think the support is going? What more would you like from the support?' Just so that we make sure we're on the same page, rather than having that chat at the end and realising we're not on the same page and that's the end. I think that is really important because it's completely led by the service user."*

Other sites had set similar target timescales for the period of support, which they had moved away from as the service developed and users' needs were better understood. In these services, the approach provided was described to be independent of time constraints. The rationale for this was that the service user could experience the intensive support in the initial engagement period, with a managed, reduction in support by the caseworker as the service user become more linked in with other community services, without any anxiety that the support was going to be withdrawn.

> *"What we wanted to do was do the high-intensity aspect of it from the very beginning, so that we're doing a lot of contact with them in the first couple of weeks, get everybody around them that they need, whether that's the GP support, social care support, alcohol teams, whatever it is they need, we do all of that within the first couple of weeks. We then take a baby step backwards and don't contact them as often as possible, but only when we feel that's the right time to do so...So it's about stepping away in a manner in which they don't feel like they're being left on their own."*

Reflecting the guidance principle, case study sites rarely mentioned discharge to the service user: there was no formal acknowledgement that service users were being 'discharged' from their services. Instead, service users were informed that they were able to manage independently, making use of community services. The caseworker would emphasise that the service would remain available and provide a phone number to contact the service if they ever needed to.

> *"But I wouldn't ever discharge anybody, we don't talk about discharge because they freak out if you say you're going to discharge them, unless I know they've got some kind of mental health support or the housing office is on it or the GP's now seeing them more regularly. But we always leave it that if they want to ring us, they can ring us."*

This was also reflected in the service user interviews:

> *"I'm doing really well myself but [my caseworker] knows that I know that she's only a phone call away if I'm relapsing again. And even if I don't phone her for 2 or 3 weeks, she'll phone me to check in to see how I'm doing, just to make sure I'm okay."*

Of the nine service users interviewed only one mentioned discharge (this person was supported by the HIU service for a fixed six-week period). All other service users expressed their desire for continued support from their service; they were aware that HIU support would eventually and gradually come to an end, and this was anxiety provoking for some.

Whilst there was some acceptance by HIU teams that their inability to acknowledge a formal discharge was the nature of the service and the service users it supported, it presented some challenges for managing caseloads (see also the findings for 'identify' at 3.2.1) if the service users discharged did recontact caseworkers and required intensive support again.

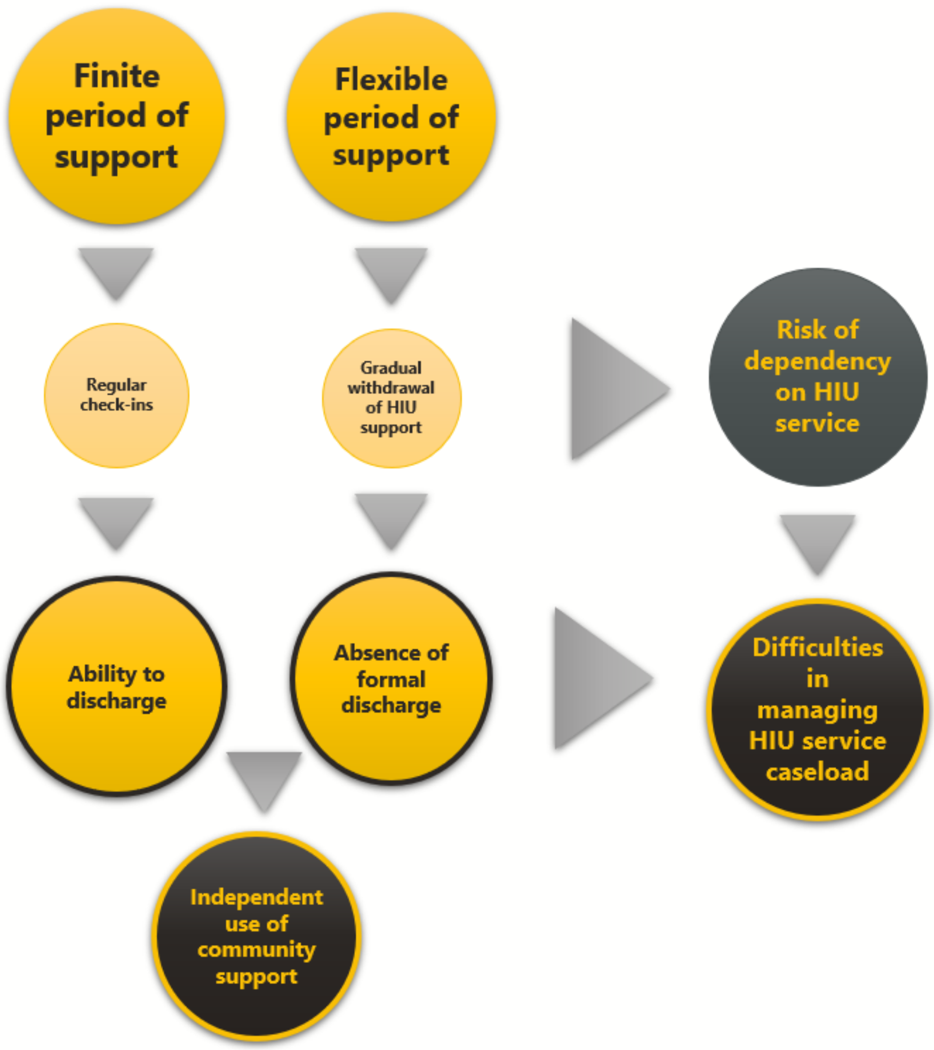
> *"I mean that's the goal obviously, for people to make the changes with the support and then have the resilience to go off into the sunset and hopefully we don't see them again, the reality is that doesn't always happen."*

Summary

There were two ways that case study sites approached discharge from the HIU service as shown in Figure 4. The first was to be explicit with the service user that the support being provided was over a specific time period and focused according to the goals agreed. Following regular check-in by the caseworker as to the progress made, the period of support could be extended according to the needs of the service user. The other method of discharge was deemed to be more user-centred by not being time-bound nor formally discussing a discharge process with the service user.

The inherent challenge when the support period was not explicitly discussed with the service user was that HIU services could not fully remove people from their caseload, and this had implications for their time and resource if service users relapsed (see next section).

Figure 4: What works in the discharge process



4.2.5 Managing relapse

Principle

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.

Theory

Changes in services users' lives and their inability to cope may cause them to fall back on emergency services; and these previously established behaviours can be prevented by recontacting the HIU service.

Findings

Case study sites reported that their approach to managing relapse was closely linked to their approach to discharge: by reducing engagement rather than having a stated discharge end point meant that service users could be quickly re-engaged and supported if they relapsed.

> *"That's one of the things with the [service users], they're never wholly discharged. They can always pick up the phone and ring."*

Service users acknowledged their risk of relapse after their intense support period from the HIU service had ended, but they were reassured that they would be able to recontact their HIU caseworkers if they needed to.

> *"I'm almost there [not needing the service] now, I know that [the HIU worker is] only a phone call away if I'm relapsing again. And even if I don't phone them for 2 or 3 weeks, they'll phone me to check in to see how I'm doing, just to make sure I'm okay."*

As part of the discharge process, HIU services described the need for caseworkers to agree relapse plans with service users, ensuring that they were not left in a position where they did not know who to ask for help.

> *"I would say.., our big focus is to make sure that they [service users] know where to find information, that they have confidence and feel in a place that if they are in a bad situation, they know who are the people to contact, so that it doesn't ever get to that dire situation which they just have no idea where to turn to."*

HIU teams also understood that if the service user did relapse, it may not be appropriate for their service to respond first.

> *"Depending on the nature of the crisis, sometimes that's not for us, that's a time when we just need to - we certainly wouldn't close them - take a step back and let appropriate services kick in."*

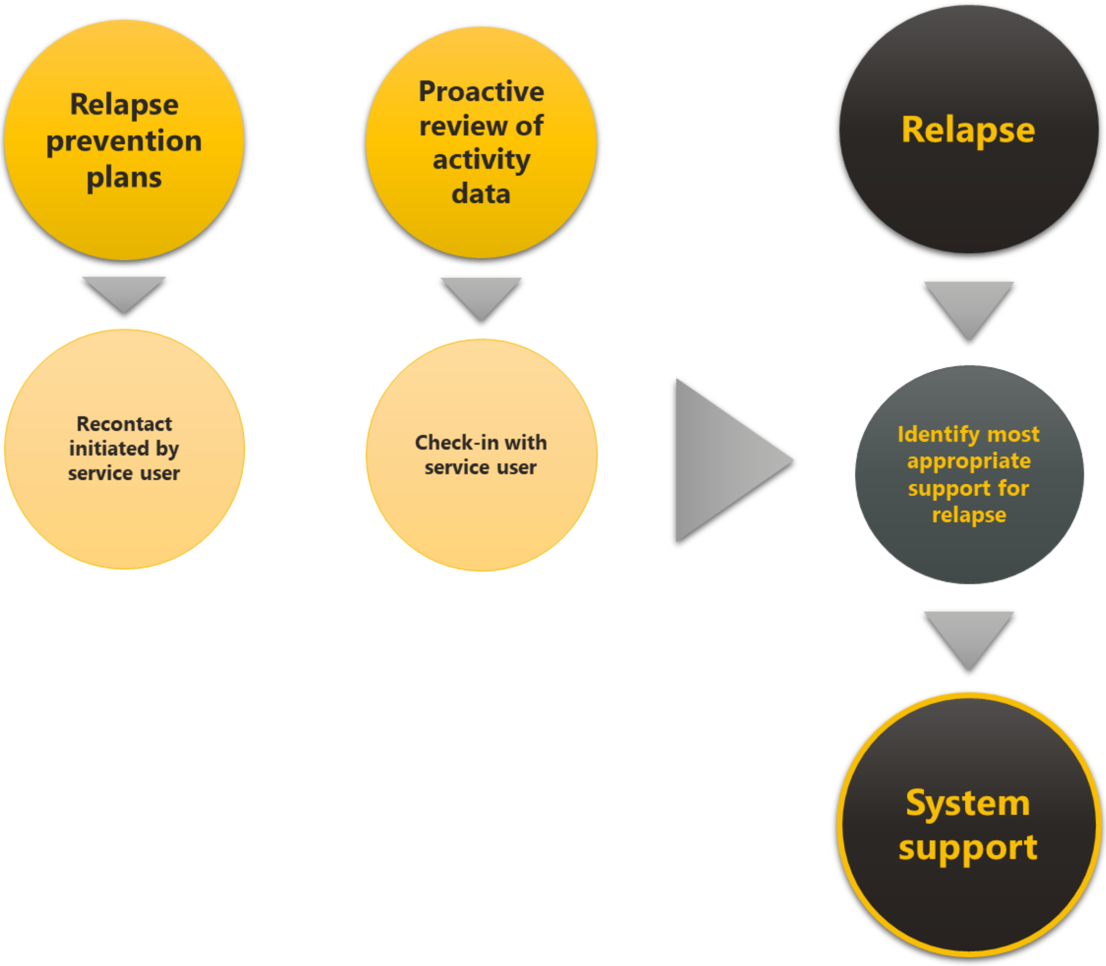
Some case-study sites monitor U&E attendances at their partner hospitals and/or HIU team members attend multi-disciplinary team (MDT) meetings at hospitals to inform discussions of people with high use. Through these means they are proactive in contacting a service user if they identify a risk of relapse through increased attendances.

Relapse data is not routinely collected by all HIU teams or their partner acute trusts, but relapses are perceived to be rare. A one-off analysis by the Chelsea and Westminster HIU service had found that a small minority (approx. 5%) of service users they had previously supported had been re-referred back to the psychiatric liaison team at a later date. A closer examination of some of these individuals identified some unique aspects which had resulted in their re-referral, such as language issues and supported accommodation needs.

Summary

HIU services reported that in their experience the risk of relapse into full crisis was low for service users they had supported. This was attributed to the relapse prevention plans they had put into place at the point of discharge, which usually meant that the service user would recontact their caseworker if they felt the need to. HIU services also reviewed any A&E activity data for changes in attendance for previously supported users, pooling knowledge with other professionals if there was a risk of relapse. This can lead to the HIU team re-contacting the service user to understand the reasons for increased A&E attendance. In the rare event of a full crisis, HIU teams will explore with other professionals who is best placed to support the service user in the initial period of the relapse and re-initiate their support when the physical or mental health crisis had passed.

Figure 5: What works in managing relapse



4.2.6 Quality of intervention

Principle

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.

Theory

Through the personalised interventions offered through the HIU service, users will benefit from high quality support that enables them to more effectively use services that are appropriate to their needs. Their lower use of U&E services will benefit the system through cost savings.

Findings

Service users reported that the HIU service had provided them with holistic support, centred around their needs. They described how, because of this support, they were more confident, independent and optimistic about their future.

> *"I have a bit more confidence in myself, I've got something to aim for. Because beforehand, I didn't have any confidence. It's about learning again. It's like learning to ride a bike. Some people don't know the support is there."*

There was a consensus across staff at case study sites that their service offered "*well-rounded*", "*invaluable*" and the "*missing link*" support to individuals who often had nowhere else to go. It was important for HIU service staff that they were able to offer their service users parity of esteem: that their mental health and wellbeing issues were placed on equal footing with physical health needs.

> *"I think we've had a few quotes back from people that we actually get done what we say we're going get done, we finish it off, we refer where we need to, we get them the support and if we don't know, we'll find out."*

For some service users, interaction with the HIU team - more specifically the quality of support provided by their caseworker - meant that they could now confidently resume usual activities and improve their own wellbeing.

> *"Before I saw the support worker, I wasn't going out at all, I've got nowhere to go really. But now I can get on buses etc. We went out for meals together and that gave me the confidence to go and socialise on my own."*

Caseworkers were reassured, through feedback from service users, that they as an individual, rather than the HIU team, made the difference.

> *"It's funny because you'll get little presents or little comments or quotes that you don't realise sometimes how much you are doing for someone until they something like that, that you've just been amazing or you don't realise what you're doing for me or how much you've helped me. You don't realise yourself sometimes because it just seems like something simple that you've let them access or you've given them support for or you've just been there and sat there."*

The personalised approach provided by caseworkers included sharing knowledge of the service user with other professionals, so that they could also support the user in a more sensitive and personalised manner.

> *So, I've got one chap who as soon as men interact with him, he just can't cope and he shuts down, so now the ambulance crews have notes that actually he responds to females. And we feed that back in a really good way and we always get consent for that, but it helps the people when they go into hospital or on the ambulance if they go again and it also helps the team…This chap that I work with, he's so horrendous in hospital, he so aggressive and shouty. This is a chap that holds a door open for me, gets a seat out for me, he's so kind and gentle but they never see that."*

Other successes reported by HIU teams included: managing addictions including alcohol, overcoming agoraphobia, addressing stress-related pyromania, supporting people to leave abusive relationships, providing respite to carers of the service user. The perception was that these personalised interventions had been cost-effective for the system; but at a service level, success was measured in getting service users to the "*right place in their life.*"

> *"I think it's just more personalised, so it really is the qualitative feedback that's been the greatest thing. Although we were focussed purely on reducing cost and resource in A&E, and ambulances, we've found out that actually the quality of this intervention and the quality of the support that we've given is massively appreciated by a small cohort who just haven't had this type of service before."*

This was confirmed by service users who described how they had achieved stability in their lives through the HIU service, which in turn had led them to use U&E services less frequently.

> *"I would literally put it [going to hospital less] down to the support, what the service can do and how it can help a person in reaching their goals and getting targets done. For me, it's been emotional and physical support. It's helped push me in the right direction".*

There were also benefits reported in terms of staff experience. Staff described how much they enjoyed their roles. Working effectively meant building a valued network of professionals; within which they then felt they were recognised as skilled practitioners – "*relevant*" and a "*safe pair of hands.*"

> *"I do think the working relationships with the stakeholders have also been a really good outcome, getting phone calls and letters and emails to us and the CCG in support, really good feedback in terms of, '[I] can't believe what you've done with this patient, they're like a different person since we've seen them.' Little things like that are just incredible to receive and it's really important that we receive things like that as well for future commissioning."*

HIU services reported that there are some risks for teams and staff that do not have a healthcare background, especially when engaging users with complex and significant support needs. On occasion there is a tension to manage for the team: if they don't work with the individual, who does?

> *"It is a bit of a gamble for charities, voluntary sector organisations, because you're taking on clients that the public sector has been unable to support. You're almost like 'where do you go if you can't help them? What do you do then?' You feel a sense that you're the last resort for some of these individuals and if you can't help them, then there really is nowhere else for them to go.....Some of the people need more intensive help and support than any of us can*

> *provide. You just have to accept that but that's a really uncomfortable place for a charity to be because of the level of risk you're holding."*

Four of the five HIUs submitted case studies of service users they have worked with, describing the personalised interventions that were offered (described in the Personalisation principle 3.2.2) and supplementing these with feedback collected from service users both formally and informally. These were used by HIU services as evidence that their services were having the intended positive impact on the lives of the service users. Success for the HIU services is defined as achieving a good outcome for the service user, collaboratively. The case studies that were developed by the research team for this evaluation echo the findings of those submitted by the case study sites.

> *"So just build a good network around you, a supportive network as you go, recognise the real heroes and stars within the services that you bump into, and work collaboratively. So, work with the drug and alcohol. I know sometimes, people say you're double counting, because, which service wins? I don't care which service wins, as long as the people are winning, and as long as the people keep winning. Be challenging, be robust, be funny."*

The benefit of collaborative and coordinated support for the service user was clear from service user accounts:

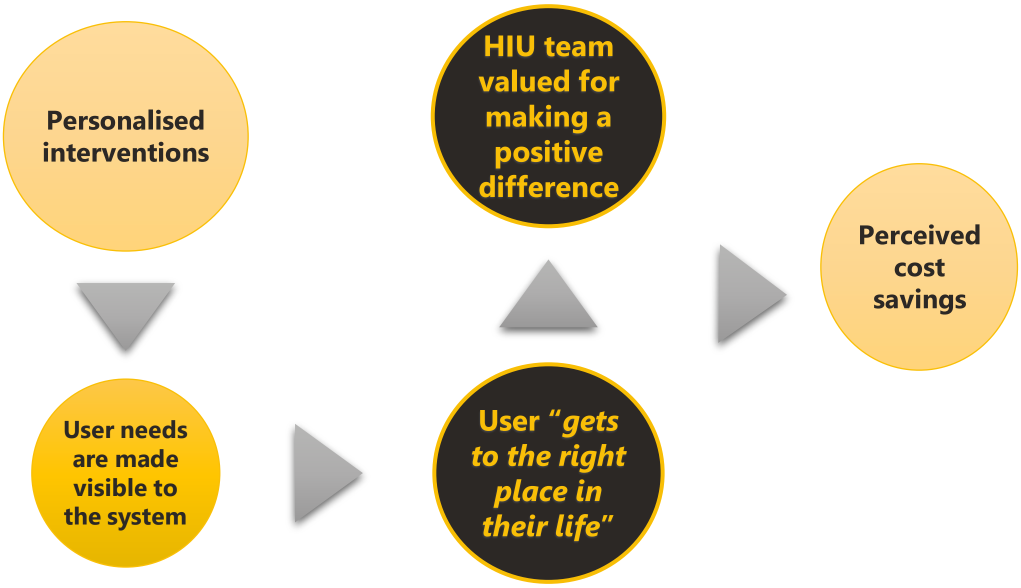
> *"She knows I've got fibromyalgia, so she tried to sort that out. She knew that I needed to go right to the mental health for my DBT, she sorted that out for me too. I've got somebody from the befriending service who phones me up. I've got somebody else that phones me from {VCS service] So, they're doing teamwork, working together with me. I'm also with the alcohol services as well, they phone every 2 weeks just to check in on me, and that's helpful. So, they're all helping me in different ways. They're communicating together".*

Summary

Case study findings make clear that the personalised interventions delivered by the HIU team are having the intended effect of better connecting service users to community support. There were numerous accounts of how the work of the team made the service user and their needs visible, often through the most simple of human interactions, such as providing a space for listening without judgement. As the more detailed service user accounts developed for this evaluation (Appendix C) also make clear, this was the key step to effective support. The quality of these personalised interventions was deemed to be improved through sharing (with consent) the person-centred approach with other professionals, allowing them to adapt their own approach and collaborate in the support of the individual.

The quality of the intervention was also being described in terms of staff experience. Team members viewed their roles positively and were further empowered in their work by the appreciation of colleagues in the health and care system.

Figure 6: What works in delivering a quality intervention



4.3 Key success factors in delivering HIU services

This section describes how the case study sites have addressed the five key success factors for delivering a HIU service set out in the NHS RightCare resource pack (1.2, Table 2 above).

4.3.1 Select the right person for the role

The recruitment process for the HIU teams was led by the HIU host organisation, often supported by the HIU Champion. HIU leads have come from a variety of backgrounds including mental health; sexual health; charities and education. What makes a person suitable to work in a HIU service was described by both service users and professionals as requiring strong empathy and interpersonal skills – for instance, emotional intelligence and active listening skills.

> *"You can train them to do the technical bits but..., it really comes down to..., understanding human relationships at an emotional level, not at a theoretical level. It's not about understanding the psychology behind that person's behaviour. It's being able to empathise and get alongside them and convince them that you are there to help and support them. This is a group of individuals who have often been written off by the system, as put in the troublemaker box or too hard to solve box. If you can't persuade those people that you can help them, they won't engage with you and then you're not going to be able to make any progress. It's got to be the right person."*

HIU caseworkers act as a mentor, advocate and critical advisor to service users, dependent on their needs across the support period. This diversity of skills was reflected across the case study interviews.

> *"[You need to be] able to work under pressure, you have to be able to respond calmly in a crisis, because they can happen all the time… Every day is completely different. Everyone you work with, each service user, is completely different and I'm regularly faced with scenarios that I never faced before and you have to be able to transfer your previous skills, knowledge, understanding, previous instances that have been similar… I think rolled into that is a really important understanding of safeguarding, understanding risk and what needs to be escalated. Again, you just never know what you're going to face but you have to be able to take those principles around risks and safeguarding, and apply them to situations day-to-day."*

4.3.2 Provide ongoing coaching and support

As described in section 3.1.1, all case study sites have engaged with the national programme team and the HIUL in the design and initial set-up of their services. Case study hosts also have their own support programmes in place for their HIU teams.

As they have multiple HIU services, BRC have an established training model for their HIU teams. The HIU Lead and community connector roles are provided with training from the outset, both in relation to BRC processes as well as more specific training related to the service such as how to support people living with trauma. CVS have provided their teams with training around suicide, as this is a topic they have to deal with in their work. Volunteer Cornwall do not provide a formal training programme for their service and the HIU lead was reliant on oversight from the HIUC when taking up the post. As they have grown their team, the Kernow HIU lead has provided informal development for new caseworkers.

There is also a national network of HIU services, coordinated by the HIUC that meets regularly to share learning. BRC have their own network for their sixteen services. This has been reported as particularly useful for soliciting advice from experienced colleagues.

> *"I think generally the biggest thing whenever we {HIU teams} talk to each other or connect with each other, it's normally around case studies and around 'I have this service user and do not have a clue what to do with them'… It's really handy to be able to talk to other HIU workers and say 'have you ever had any experience of this? What did you do?' Because our job is very outside of the box it's very handy to get those little random suggestions that can just trigger what you think you are going to help them with."*

4.3.3 Give HIU teams the freedom to act and innovate

Across the case studies, HIU leads and their teams described how they had been empowered to design the service and their offer as fits the context, within the parameters of the guidance for the model. Being free to develop the networks and relationships that will benefit service users is seen to be essential to the success of the service. Leads explained how having this autonomy enabled them to develop a service that was tailored to local need.

> *"My boss said I'm the only project that I ask for forgiveness rather than permission. And... they just had to let me go... the amount of trust in me is how I work best. If I make a wrong decision I'll hold my hands up... You need to be left to crack on, because not everyone will agree with what you do, but I don't agree with everything my clients want, but if that's right for them, good for them, and give it a go."*

The support of the lead commissioner for the HIU service was also reported as vital to the success of the service. This includes championing the service with NHS colleagues and navigating barriers, such as accessing data and engaging clinical teams.

> *"Where it's gone wrong is, when you have not one person fighting for the model, you do need the commissioner to be absolutely on board."*

Some services have been able to access enablement funds to support their service users to take part in social activities, supply them with furniture to improve their living standards, or provide phones to call services. Both service user and caseworker accounts suggested that HIU services had been most successful when they reconnect service users with their hobbies and interests. To this end, all HIU services had developed strong relationships with healthcare, social care and community teams in the local area to facilitate direct access for service users to services or activities most suited to their needs or interests.

HIU teams described one of their roles to be a 'community connector'; that is, they used their experience and knowledge to reconnect clients with the community. Aptitude in this role required the caseworker to be motivated to understand the service user's story and identify something that interests the service users (see also 'personalise' above) and the ability to be creative and 'think outside the box'.

> *"There was one lady who loved flower arranging, didn't have any qualifications in it, but loved flower arranging and had previously used to go and arrange the flowers at church. So that was one thing the connector managed to get her into and there was a short introductory course, so she had to attend that, and she had to go in person, so she met people, felt comfortable about being in that situation and then she went on and paid for a course herself and got qualified, then got a proper job in a florist. They're some of the things that the connector can do... ...it's about knowing where to look and what's in the community."*

As highlighted in section 3.2, HIU teams rely heavily on the networks of VCS organisations to provide their service users with the social network and support for their wellbeing. In areas where VCS presence is strong and diverse, this is a vital tool for success. However, some case study sites reported that the pressures on the VCS sector in their area was a limiting factor and that a lot of social services are under pressure. In Chelsea and Westminster, for example, the service takes referrals from across London as their referral criteria is a person who has attended Chelsea and Westminster Hospital. This means it is more difficult to build up connections with community services within a specific geographic area. The freedom to act and innovate could often be beyond the control of the HIU team.

4.3.4 Commit for a minimum of 18 months

Although a key success factor for the services is stated to be an 18-month commitment, case study services had found it difficult to secure this level of funding. Most have been funded for an initial 6-12 months with short-term extensions agreed. Case study sites had not lost funding; but at the time of interviews, none had secured long-term commitments. These short-term funding arrangements pose a risk to the future of the services and their staff.

> *"The big challenges really have been finding continuation funding year on year because it's been funded up to now with bits of money left over and underspends in other budgets. So, each year we get towards the end of the year and we don't know if we're going to be able to carry on into the next year. They'll say we've got £40,000 left in this budget, so we'll put that into HIU, that'll keep you going for another 6 months... It's been several cliff edges that we've had in funding terms."*

Service users were also keen that the HIU service continued to be funded to allow others to benefit as they had.

> *"If the service ended because it couldn't be funded, I would cry. It's a service connected with the NHS, but it's mainly I'm heard, and it's not just about myself. I have heard it's made differences to [many] people. It needs to stay because of the way it's worked."*

The HIU services engaged in this study were also ambitious and keen to develop the preventative aspect of their service by engaging a wider cohort of people with high use, such as people frequently attending GP services. They also wanted to provide a bespoke service for target groups such as younger people, older people, or those with addictions. The inability to secure this longer-term funding was perceived by HIU teams to be a missed opportunity for HIU services to build on their current service momentum and be considered within Integrated Care Systems' planning.

4.3.5 Source an automated, independent evaluation method

A challenge for HIU services in monitoring or evaluating is that as largely non-NHS organisations, they can find it difficult to access NHS data such as patient activity. The process for receiving patient level data from the relevant acute trust to identify potential service users requires sign-off by the local Information Governance (IG) lead. For some HIU services, the local interpretation of IG guidelines to allow for this has delayed access to data. Mitigating actions have included providing HIU teams with NHS email addresses and submitting a business case to the provider outlining the need for patient-level data.

Although the case study sites are required to submit performance reports that include performance and activity data to their CCGs, they have not yet been independently evaluated (although this has taken place in other services outside our sample). The performance reports provided by case study sites demonstrate some variances in how the impact of a HIU service is reported. Four of the five case study sites (no data was available for Chelsea and Westminster) have demonstrated an overall reduction in U&E attendance for those who have engaged with the HIU service. Reporting methods, however, are variable across the sites. For example:

- BRC (East Kent and Stockport) report service use by those who have engaged with the HIU team in terms of A&E attendance, non-elective admissions and ambulance conveyances in the period 3, 6, 9 and 12 months pre and post, whist also evaluating multiple wellbeing and strength based outcomes;
- Volunteer Cornwall (Kernow) look at activity over a 12 month period pre and post engagement;
- CVS (Southport and Formby) look at activity over a 12 month period pre and post engagement and compare this with those who did not engage the service.

The CVS model showed that even without HIU service engagement, service use reduced but that for those that did engage, this reduction was much more pronounced. The table below presents their findings for the average cost of CVS service users' (patients) A&E attendances and admissions before HIU intervention and during/after, forecast over 12 months to estimate annual avoided costs. The control group (non-CVS patients) are assessed in the same way. The CVS method is provided as an example in table 5 below.

Table 5: Summary of estimated annual cost avoidance for HIU's receiving interventions from CVS compared to those refusing support

	CVS (42 patients)	Non-CVS (52 Patients)	Difference	%
A&E Attendances	-£52,653	-£34,860	£17,793	-8%
Admissions	-£440,540	-£292,013	£148,527	-12%
Total	**-£493,193**	**-£326,873**	**£166,320**	**-11%**

When considering these savings, it is important to remember that these do not then translate into cashable savings (reduction in expenditure); Southport and Formby A&E does not reduce capacity as a result of HIU activity, but uses that capacity in a different way. One participant suggested clinician time saved might be a more appropriate measure:

> *"It's real, time, isn't it? The cost, everybody goes, 'Yes, oh you've saved £400,000. Where? Where's the money? Where's the actual money?' It's not real money, whereas time saved of 40 hours a week of somebody going in, you can cost that, I suppose, but that's 40 hours that they could spend on somebody who actually did need to be seen."*

The figures provided by the case studies also do not take into account the running costs for the service. Based on this study, the cost of running a HIU service - with a HIU lead and one caseworker - is c. £100,000 per annum. This cost may vary however, dependent on the level of support and infrastructure offered by the service provider to the HIU team.

5. Conclusions and Recommendations

This section summarises the main findings of the qualitative case studies and provides recommendations for service improvement.

It was clear from all accounts (service users, national leads, HIU teams and local stakeholders) that HIU services were successfully implemented and well received. Numerous examples were provided of how HIU services made the service user and their needs visible; how professionals across health and care as well as VCS were able to collaborate on behalf of the service user to provide holistic support. Together they were able to have the intended outcome: service users were supported to become more confident and independent in accessing community services, to make changes in their personal lives, resulting in their reduced use of U&E services.

There was some expected and welcomed variation in HIU service delivery across the five case study sites, but broadly they followed the principles set out in the NHS RightCare resource pack. The overall findings suggest that identifying service users using referrals from other linked services such as hospital psychiatric liaison teams provided a better experience for staff. This was because the HIU team were able to take into consideration the assessment of clinicians and engage in discussions with them as to the best approach to support for the service user. This method of identifying service users also reduced the risk of individuals not engaging with the service if they considered the contact by a HIU lead to be a cold call. This was often the experience of HIU teams who identified potential service users through A&E attendance lists.

Recommendation 1: The primary route of identification of HIU service users should be via referral through other services. The use of A&E lists to identify service users still has merit, especially in identifying individuals that may not be known elsewhere.

The experience of the case studies was that service users had a range of mental health and wellbeing support needs, with some users having more complex needs. This resulted in HIU caseworkers having to define their caseload of service users as a function of the intensity of support required rather than the number of people they supported.

Recommendation 2: HIU teams should consider the number of service users expected to be supported at any given time, and the complexity of their support needs. This should be translated into the number of caseworkers and their caseload, recognising that the service is flexible in offering support; frequent, albeit minimal, contact from several service users could overburden caseworkers.

Key features of the personalised support offer of HIU services were found to be attentiveness to the accounts provided by the service user, especially during the first remote and face-to-face contact. Exercising non-judgemental attitudes and patience when listening to the service user developed a relationship based on trust. Once a rapport is established and the service user engaged with the service, caseworkers maintained regular contact as agreed with the service user. Through this regular contact the caseworker-built service user awareness of other community agencies and the ability of other VCS services to support them. The experience of HIU services is that caseworkers needed to broker the introduction to other services; service users often lacked the confidence or had developed mistrust of other professionals that first needed to be overcome.

Delivery of personalised support then went hand-in-hand with caseworkers identifying with the service user the anxieties that triggered use of U&E services regular, and then developing tailored strategies to manage these and de-escalate from a potential crisis. Supporting service users to independently manage anxieties out-of-hours was particularly important, given that most other services did not operate out-of-hours.

Recommendation 3: Person-centred approaches to supporting service users to reduce their dependency on U&E services should focus on developing coping strategies for individual triggers, especially out-of-hours. Caseworkers also need to identify the relevant community agencies and support the service user to build trusting relationships with other professionals to reduce U&E dependency and improve overall wellbeing in the long-term.

Our findings suggest discharge was the most challenging of the principles to deliver. Being explicit with the service user that the support being provided was over a specific time period was perceived to pose a risk of disengagement or relapse by HIU services that offered support that was not time-limited or where a discharge process was never discussed. The inherent challenge when the support period was not explicitly discussed with the service user was that caseworkers could not fully remove people from their caseload, and this had implications for their time and resource.

On the other hand, HIU services that were clear from the outset that their support offer was time-limited argued that this created less dependency in service users and could be used to plan support and assess progress over time. It also meant that caseworkers could manage their caseloads more effectively. Transparency around the time-bound support offered by the HIU service was not linked to disengagement from the service by those services that practiced it.

Recommendation 4: There is merit in being explicit with the service users as to the time-period of support, and this could be a flexible offer (as already practiced by some case studies), tailored to the service user need and progress made over time.

Success of the HIU service can also be assessed through relapse rates in service users following discharge (formally or informally): case study sites reported that the risk of relapse into full crisis was low for service users they had supported. This was partly attributed to the ability of the service user to recontact their caseworker if they felt the need to; in effect the caseworker then de-escalated the service user before they relapsed into a crisis use of U&E services.

Recommendation 5: The overall findings across the principles of de-escalate, discharge and relapse highlight their interdependencies. As such HIU services should approach this as a process, centred around the individual service user rather than three discrete principles.

With respect to the key success factors, it was clear from all accounts that the right people had been selected for the role, that in addition to providing empathy and critical friend support, they were resilient, professional and flexible with their time.

Recommendation 6: Although case studies did not uncover examples of support for caseworkers to be lacking, HIU host organisations should provide a well signposted support infrastructure, such as mental health and wellbeing support for team members.

Support from their host VCS agency and coaching and mentoring from a network of more experienced colleagues was regarded as facilitative especially when it came to providing more innovative support for service users.

Recommendation 7: A wealth of experiential knowledge is being built up by HIU services as to how different types of service users can be supported, often innovatively. Whilst these are shared informally through HIU networks a more formal typology of service users and the ways in which they can be supported in the community should be developed and shared widely as a resource (not limited to HIU services).

HIU services were to an extent dependent on the strength and diversity of the VCS in their local area, the relationships built up by caseworkers within this sector and their ability to easily and effectively access their services for their service users. This made HIU services that covered a larger geographical area or operated on short-term funding disadvantaged in their ability to build the necessary sustainable relationships with the relevant community agencies. The inability to secure a commitment to funding had implications for sustaining service user support, team existence and improving the service offer.

Recommendation 8: National support is required to secure local funding commitment for the HIU service. The current development of ICSs provides an opportunity to promote the integrated and collaborative service offer of the HIU services and their effective use of the VCS. A further updated resource pack should provide HIU teams with guidance on how to engage and work with commissioners and ICSs.

The financial savings reported by some HIU services to date were not consistently derived and appeared not to be recognised by all local stakeholders. HIU services limited access to activity data due to data sharing and IG challenges can impact on their ability to monitor or evaluate progress. Notwithstanding this, more robust local monitoring and comparative evaluation methods are still warranted, such as a quasi-experimental[2] approach, for example, a retrospective matched cohort study which uses data to match people exposed to the HIU intervention with similar people who were not. Further qualitative evaluation should also include as participants, U&E staff and wider system stakeholders such as commissioners and other VCS representatives

Recommendation 9: The HIU national programme team should commission an independent mixed methods evaluation to assess the impact of the HIU services nationally. As part of quantitative evaluation approaches HIU services should be provided with additional guidance for data collection, sharing and analysis that can be used for local purposes and inform national understanding.

In conclusion, the findings of this qualitative case study evaluation, which assessed the experience of five HIU teams and their service users, demonstrated that the service was valued by all participants. Some improvements to the service model have been suggested; overall there is much support for the continued rollout of the service.

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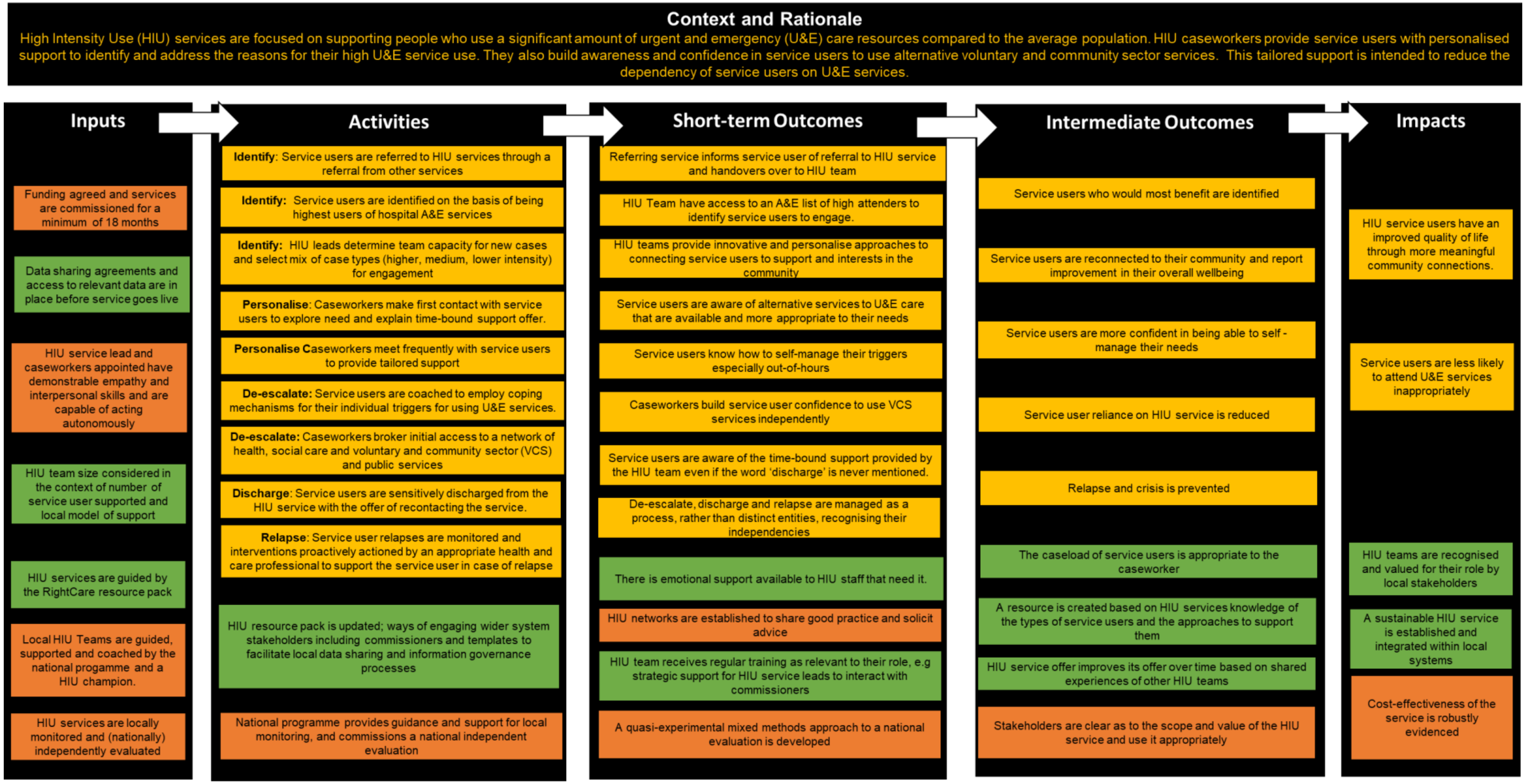
[2] Further detail on the quasi-experimental methods can be found in evaluation resources such as the MDSN Evaluation Guide or the Magenta Book

5.1 Logic Model



Context and Rationale

High Intensity Use (HIU) services are focused on supporting people who use a significant amount of urgent and emergency (U&E) care resources compared to the average population. HIU caseworkers provide service users with personalised support to identify and address the reasons for their high U&E service use. They also build awareness and confidence in service users to use alternative voluntary and community sector services. This tailored support is intended to reduce the dependency of service users on U&E services.

Inputs

- 🟧 Funding agreed and services are commissioned for a minimum of 18 months
- 🟩 Data sharing agreements and access to relevant data are in place before service goes live
- 🟧 HIU service lead and caseworkers appointed have demonstrable empathy and interpersonal skills and are capable of acting autonomously
- 🟩 HIU team size considered in the context of number of service user supported and local model of support
- 🟩 HIU services are guided by the RightCare resource pack
- 🟧 Local HIU Teams are guided, supported and coached by the national progamme and a HIU champion.
- 🟧 HIU services are locally monitored and (nationally) independently evaluated

Activities

- 🟨 **Identify**: Service users are referred to HIU services through a referral from other services
- 🟨 **Identify:** Service users are identified on the basis of being highest users of hospital A&E services
- 🟨 **Identify:** HIU leads determine team capacity for new cases and select mix of case types (higher, medium, lower intensity) for engagement
- 🟨 **Personalise**: Caseworkers make first contact with service users to explore need and explain time-bound support offer.
- 🟨 **Personalise C**aseworkers meet frequently with service users to provide tailored support
- 🟨 **De-escalate:** Service users are coached to employ coping mechanisms for their individual triggers for using U&E services.
- 🟨 **De-escalate:** Caseworkers broker initial access to a network of health, social care and voluntary and community sector (VCS) and public services
- 🟨 **Discharge**: Service users are sensitively discharged from the HIU service with the offer of recontacting the service.
- 🟨 **Relapse**: Service user relapses are monitored and interventions proactively actioned by an appropriate health and care professional to support the service user in case of relapse
- 🟩 HIU resource pack is updated; ways of engaging wider system stakeholders including commissioners and templates to facilitate local data sharing and information governance processes
- 🟧 National programme provides guidance and support for local monitoring, and commissions a national independent evaluation

Short-term Outcomes

- 🟨 Referring service informs service user of referral to HIU service and handovers over to HIU team
- 🟨 HIU Team have access to an A&E list of high attenders to identify service users to engage.
- 🟨 HIU teams provide innovative and personalise approaches to connecting service users to support and interests in the community
- 🟨 Service users are aware of alternative services to U&E care that are available and more appropriate to their needs
- 🟨 Service users know how to self-manage their triggers especially out-of-hours
- 🟨 Caseworkers build service user confidence to use VCS services independently
- 🟨 Service users are aware of the time-bound support provided by the HIU team even if the word 'discharge' is never mentioned.
- 🟨 De-escalate, discharge and relapse are managed as a process, rather than distinct entities, recognising their independencies
- 🟩 There is emotional support available to HIU staff that need it.
- 🟧 HIU networks are established to share good practice and solicit advice
- 🟩 HIU team receives regular training as relevant to their role, e.g strategic support for HIU service leads to interact with commissioners
- 🟧 A quasi-experimental mixed methods approach to a national evaluation is developed

Intermediate Outcomes

- 🟨 Service users who would most benefit are identified
- 🟨 Service users are reconnected to their community and report improvement in their overall wellbeing
- 🟨 Service users are more confident in being able to self - manage their needs
- 🟨 Service user reliance on HIU service is reduced
- 🟨 Relapse and crisis is prevented
- 🟩 The caseload of service users is appropriate to the caseworker
- 🟩 A resource is created based on HIU services knowledge of the types of service users and the approaches to support them
- 🟩 HIU service offer improves its offer over time based on shared experiences of other HIU teams
- 🟧 Stakeholders are clear as to the scope and value of the HIU service and use it appropriately

Impacts

- 🟨 HIU service users have an improved quality of life through more meaningful community connections.
- 🟨 Service users are less likely to attend U&E services inappropriately
- 🟩 HIU teams are recognised and valued for their role by local stakeholders
- 🟩 A sustainable HIU service is established and integrated within local systems
- 🟧 Cost-effectiveness of the service is robustly evidenced

🟨 **Principles** 🟧 **Key success factors** 🟩 **Additional features (as identified by the evaluation)**

Appendix A – Stakeholder interviews topic guide

Evaluation of the HIU Programme

Service stakeholder interviews: topic guide (commissioners and providers)

Purpose of interview (to be introduced at the beginning of the interview)

To include:

Introduction to the Strategy Unit

The Strategy Unit is part of the Midlands and Lancashire Commissioning Support Unit (MLCSU). We provide a broad range of consultancy services including evaluation, evidence reviews, service improvement and data analytics, employing a range of methods and approaches.

We have been commissioned by NHSE/I to evaluate the implementation, delivery and outcomes of the HIU Programme through qualitative case studies.

Introduction to the project:

This project aims to recognise and learn from the variation in approach to setting up HIU services across different health systems, to better understand how organisations worked together to deliver the aims of the HIU Service. Through five case studies we will explore the context within which the HIU services operate, the variation in approach taken by them and the outcome of those differences from the perspective of professionals and patients.

The project research is being conducted over the spring/summer of 2021 and we expect to report to NHSE/I in September 2021.

Format:

45-60 minute telephone/MS Teams interview.

Key: In the interests of time, some sections/questions might be omitted depending on the role of the interviewee: **Provider** or **commissioner**

Supporting information

Participants will be sent an information sheet prior to the interview explaining: the purpose of the interviews (outlined above); data security; and how their contributions will be used in confidence.

Processes for data security will be explained and all participants will be asked for consent to record the interview.

Where existing evaluation materials have been shared for a case study site, the interviewer will be familiar with these and draw on them in the interview as appropriate, focusing on what has changed in the time since the last evaluation.

Topic guide

These questions are only a guide, intended to provide some structure to the interview. Questions will be adapted according to the interviewee.

Section 1: Introductions

1) Can you please briefly introduce yourself and your current role within the HIU service?

Section 2: The local context of the HIU service

2) What, if any, support for frequent users of health services was already in place prior to the development of your HIU service?

   Prompts:

   - *a) How was this support coordinated and by whom?*
   - *b) What were the aims of this support?*
   - *c) How successful was it in realising those aims?*

3) Where did the impetus for a HIU service originate?
   Prompts:
   - *a) NHSE/I*
   - *b) Local commissioners*
   - *c) Local providers*
   - *d) Clinicians*
   - *e) Service Users*

4) (Where case study site initiated HIU service prior to 19/20 Planning Guidance) Why did you decide that a HIU service was the right approach to support frequent users in your system?
   Prompts:
   - *a) Evidence of success from elsewhere?*
   - *b) Made best use of existing support?*
   - *c) Advice and guidance from NHSE/I*
   - *d) Other?*

Section 3: Experience of designing the service

5) How did your system go about engaging with stakeholders in designing your service?

   Prompts:

   - *a) Who/what services were engaged in the design?*
   - *b) How were service users involved?*
   - *c) What, if any, were the challenges in engaging with stakeholders in the design phase?*

6) What information/resources/tools did you draw upon in designing your service and how useful were these resources?

Prompts:

  a) *National/International evidence base*
  b) *National guidance e.g. NHS RightCare Resource pack*
  c) *Shared learning from other areas e.g. through visits to other sites*
  d) *Local data e.g, activity data from Business Intelligence teams with the local Acute Trust or CSU*

7) Did you pilot your service prior to launch?
Interviewer note: draw on existing evaluation materials where available
Prompts:
  a) *If yes, what was the scale of the pilot?*
  b) *How long did the pilot run for?*
  c) *How was it funded?*
  d) *How did you evaluate the pilot?*
  e) *What changes did you make when implementing the wider roll-out of the HIU service?*

8) What has worked for you in designing and improving your HIU service?
Prompts:
  a) *Were challenges political/cultural e.g. required developing new relationships or overcoming particular partner issues?*
  b) *Were the challenges structural e.g. data sharing, use of estates, hosting*
  c) *Were the challenges resource-driven e.g. cost of establishing and running the service, having the right staff to deliver it?*

9) To what extent did your system feel able to follow the advice from NHSE/I to 'be brave, just start, and adapt as you go along' in designing and improving your service?
Prompts:
  a) *Did this require a significant change in approach to previous service design and implementation?*
  b) *What, if any, barriers were there to operating in this way?*

Section 4: Delivering your HIU service

10) Can you please describe your HIU service?

Prompts:

  a) *Who is involved and what is their role?*
  b) *What are the aims of the service?*
  c) *Can you describe the patient/service user pathway for your service?*
  d) *What are its governance and reporting mechanisms?*
  e) *How does it communicate with its target client group?*

11) How are patients who might benefit from the HIU service, identified?

Prompts:

- *a) How are patients referred to the service?*
- *b) Do all referrals get seen?*
- *c) How many people have been seen by the service?*
- *d) Has the number of people who are supported by the service changed over time?*
- *e) How did you identify these patients and what were the challenges in this?*
- *f) How were/are they prioritised for support?*
- *g) What have been the challenges with engaging with patients?*
- *h) What has worked well in supporting engagement?*

12) How were staff recruited to the service?

Prompts:

- *a) How did you recruit to the HIU lead role?*
- *b) Where/which sectors, if any, did you target for recruiting to this role?*
- *c) Did the recruitment process yield sufficient appropriate candidates?*
- *d) Are there any lessons you would share from the recruitment process?*

13) What kind of training and development was required for staff recruited to the service?

14) How has the principle of a personalised approach to support been realised in your HIU service, with particular reference to:

- *Crisis intervention*
- *Preventative measures, identifying causal factors in high intensity use; self-management of conditions etc*
- *Discharge support*

15) What, in your view, have been the main enablers of success in delivering your HIU Service?

Prompts:

- *a) Leadership*
- *b) Service user engagement*
- *c) Partnerships*
- *d) Resourcing – e.g. staffing, time*
- *e) Data*
- *f) Front-line workers*
- *g) Communications*
- *h) Clinical engagement*

16) What, if any, changes to the original approach have been made as it has developed?

Prompts:

- *a) Why were changes required?*
- *b) How did you manage and agree these changes with stakeholders?*

Section 5: Outcomes delivered by the service

17) What benefits of the service have been realised to date in the following areas?:

- ***Patient experience**, e.g. experience of the service compared to previous healthcare use; changes in risk factors relating to wider determinants of health e.g. better able to engage with employment, education, training*

- ***Staff experience** e.g. ability to support service users; better use of time/resources*

- ***Health and care system** e.g closer collaboration across providers; data sharing; freeing up capacity in unscheduled care.*

  ***Cost-effectiveness;** reduced need; less use of unscheduled (A&E, 999 calls, non-elective admissions) care by service users*

18) Are these benefits sustainable in your view?

19) Where evaluation of your service has taken place and what action has been taken in response to the findings?

    Prompt:

    a) *Who has been involved in the evaluation?*

Section 6: Other comments

20) What advice or recommendation would you make to another system who are considering establishing a HIU service?

21) How, if at all, would you like to further develop your HIU service?

22) What support will you require, if any, to implement these developments?

23) What are the contextual factors you think will impact on your future HIU service approach?

    Prompts:

    a) *Role of Primary Care Networks*

    b) *Ownership of the HIU Service within Integrated Care Systems*

    c) *Resilience of the local voluntary and social care sectors*

24) Is there anything else you would like to add in terms of delivering a HIU service that we haven't already discussed?
25) Is there anyone else you suggest we should speak to and could you put us in touch with them?

Thank you for your time

Close interview by explaining next steps.

Appendix B – Service user interviews topic guide

Evaluation of the HIU Programme

Service user interviews: topic guide

Purpose of interview (to be introduced at the beginning of the interview)

To include:

Introduction to the Strategy Unit

The Strategy Unit is part of the NHS.

We have been asked by NHSE/I to review the High Intensity Use Programme in your area. This is a support service for people who attend hospital or other health services regularly or are particularly vulnerable to requiring support from healthcare professionals.

Introduction to the project:

As someone who has accessed HIU services (or supports someone who accesses HIU services) we would like you to hear about your experience. This will help us to understand how the service has worked for you, so we can assess if this is better than your previous experiences of healthcare.

The project research is being conducted over the spring/summer of 2021 and we expect to report to NHSE/I in September 2021.

Format:

45-60 minute telephone/MS Teams interview.

Supporting information

Participants will be sent an information sheet prior to the interview explaining: the purpose of the interviews (outlined above); data security; and how their contributions will be used in confidence.

To ensure that participants understand references to the High Intensity Use Service in this interview the role and purpose of the service will be rehearsed at the beginning with them if required.

Processes for data security will be explained and all participants will be asked for consent to record the interview.

Topic guide

These questions are only a guide, intended to provide some structure to the interview. Questions will be adapted according to the interviewee. The questions refer to the HIU service, but this may need to be adapted for each site.

Section 1: Introductions

26) Can you tell me a little bit about yourself?

Section 2: Experience of health service prior to HIU service engagement

27) How were your health and care needs supported before you started using the [HIU service]?

    Prompt:

    a) Which services were you most likely to use e.g. your GP, hospital, ambulance, social care, voluntary services, formal or informal care, other?

28) For those services that you did use, how would you describe your experience of them?

    Prompts:

    a) Did you feel supported to manage your own health and wellbeing?
    b) Did you feel listened to?
    c) How well did you feel these services communicated with each other; did you have to repeat your health concerns multiple times to them?

Section 3: Experience of using the HIU service

29) When did you first start using the HIU service in your area?

    Prompts:

    a) Who approached you and how?
    b) Was your involvement in the service clearly explained to you e.g. what the service did, how long the involvement would last, why involvement was being recommended?
    c) What were your expectations of being involved with the service at the beginning?

30) Can you describe what changed for you as a result of being contacted by the service?

    Prompts:

    a) How did the service respond to your health concerns?
    b) Did how you access services change as a result of you being contacted by the service?
    c) Did you feel that the service you were provided with met your needs and how?
    d) Outside of supporting your health needs directly, what other aspects of your wellbeing did the service support e.g. befriending, employment, learning?

31) Are you still using the service?
If yes:

- When do you expect to stop?
- Will you be moving to using more specific health and care support?
- How does that make you feel?

If no:

- What was your experience of leaving/being discharged from the service?

Prompts:

a) *How was your transition managed by the service? What happened?*
b) *Were your transition arrangements clearly communicated to you and by whom?*
c) *Were you able to contact someone from the service following your initial period of support?*

32) What difference has working with the High Intensity Use Service made to you?

Prompts:

a) *To the kind of healthcare you access and how often?*
b) *To the range of support you access to support your wellbeing outside of healthcare?*
c) *To your overall wellbeing?*
d) *To your view of healthcare services?*

Section 4: Improving the service

33) You earlier described your expectations of the service. Were your expectations met?

Prompts:

a) *Is there anything that, in your view, could have been improved to make your experience of the service better?*
b) *Is there anything you thought was particularly good about working with the service?*
c) *Would you be happy to work with the service again if required?*
d) *Do you feel better able to manage your own health and care needs having engaged with the service and how?*

34) Is there anything else you would like to add regarding your experience of the HIU service that we haven't covered?

Thank you for your time

Close interview by explaining next steps

Appendix C – Case studies

East Kent

A: Overview

*Table 1: Overview of **East Kent** HIU Programme*

Launch date	November 2019
Host organisation	British Red Cross
Location(s)	Queen Elizabeth The Queen Mother Hospital; the William Harvey Hospital (both part of East Kent Hospitals University NHS Foundation Trust)
Team	2 (HIU Service Lead and Community Connector)
Estimated number of service users to date	75 (at May 2021)
Number of people interviewed for case study:	
Stakeholders	3
Service Users	1 (plus case study provided by British Red Cross)

Regional context:

Frequent use of urgent and emergency (U&E) health services was identified as an issue in East Kent (EK). There was already a service in place to support frequent users of mental health services and the local commissioner felt that there was a need for additional support that focused on those attending A&E in hospital, although recognising that these service users would often also have mental health needs. The mental health commissioner at Kent and Medway CCG spoke with Rhian Monteith, the High Intensity Use Lead (HIUL) for NHS England. The HIUL talked though local and national provider options. The commissioner approached the British Red Cross (BRC) who had been commissioned to manage HIU services elsewhere in England; they currently manage sixteen services across the country.

The reported attraction of the BRC model was in its non-medical approach, focusing on the social and environmental context that could lead to an individual attending A&E frequently. The BRC also provide significant infrastructure for a local HIU service via their organisation. For example, they have access to a network of community organisations that can support the HIU service, as well as training and support infrastructure for HIU teams. The NHS commission in EK pays for the HIU team (two FTE workers) and BRC provide the IT, administrative and physical space resource for them as part of the contract. The team consists of a HIU Lead and a Community Connector. In the BRC service model the Lead is responsible for more complex service users, and the Community Connector takes on less complex cases, although this approach is flexible dependent on the case load and experience of the team.

At the outset, the CCG staged a stakeholder event to communicate the HIU service prospect. This included presentations from the BRC, the HIU Lead, the lead commissioner and the HIU Champion regarding their plans for the service and how it would interact with other health and non-health services.

HIU Programme Delivery:

Service overview

BRC are commissioned to work with approximately 90 service users in EK per year, with the aim of reducing the number of A&E attendances and non-elective admissions of this group by 40 per cent, whilst improving access to appropriate alternative services and improving patient outcomes. The Key Performance Indicators for the BRC service are included in section F below.

The service was first commissioned in November 2019 with the two members of the HIU team in post by early 2020. Relatively early in the service's life COVID-19 restrictions meant that the service had to adapt its offer. This is described in more detail below.

Although the service was established to support frequent attenders to A&E departments in EK, there was a delay in agreeing data sharing between the East Kent Hospitals University NHS Foundation Trust (EKH FT) and BRC meaning that for the first six months the HIU team were not able to access lists of frequent attenders. In the interim, the HIU team:

- Received referrals from discharge lounges in hospitals, mental health liaison teams and GPs;
- Shadowed healthcare teams who has access to frequent attenders such as mental health teams in hospital and the assisted discharge team;
- Attended multi-disciplinary (MDT) team meetings at EKH FT attended by clinicians, social workers, police and the ambulance service to discuss frequent A&E attenders;
- Engaged other healthcare and community services professionals who worked with frequent attenders such as community support workers, GP practice staff and the local voluntary and community (VCS) sector.

Once the Information Governance (IG) issues were resolved (see section D) the HIU Lead was able to access the frequent A&E attender list from EKH FT without issue.

Service leadership

BRC have a Product Lead for their HIU services across the UK. They are responsible for the recruitment, training, development and performance of the HIU team, hosting the service within the organisation.

The HIU Lead for EK was recruited in November 2019 and has a background in sexual health and social prescribing. The Community Connector has a background in the police.

Having an established model for a HIU service, BRC were able to provide the HIU Lead with clear guidance in setting up the service, as well as the necessary administrative tools such as consent forms for service users. The HIU Lead and Community Connector were also provided with training from the outset, both in relation to BRC processes as well as more specific training related to the service such as how to support people living with trauma.

The HIU Lead is provided with autonomy to deliver bespoke support to their service users as they see fit, but also are accountable for delivering against the performance targets set by the contract between BRC and the CCG. The HIU Lead is responsible for submitting a quarterly report through the BRC leadership describing their activity over the period, including service user case studies.

The national HIU Lead also supported the HIU team as part of their training; providing mentoring support and attending the first few service user visits to build the team's experience in interacting with this service user group.

B: Service User Pathway

Identifying service users

Service users are identified predominately through a 'high attenders' list provided by EKH FT, although some have also come from GPs and mental health teams in the early life of the service.

This list contains 250 names and is sent every three months. This list includes people who have attended A&E more than five times in the preceding three months. The service aims to take on between twenty-five and thirty people from this list.

The lists usually contain some basic personal information such as name and age and limited detail pertaining to why the individual had attended hospital and how frequently. If an individual is identified as a possible service user for the service the HIU team will access their more detailed records at the hospital which provides additional information as to their clinical history and flags any potential safeguarding concerns.

Personalise:

In the first instance, identified service users are contacted over the phone by the HIU team. Describing the support in the right way is seen as important; the team do not describe themselves with service users as a HIU team and explain to them that they are being contacted because they have been in hospital often recently and they would like to help them. The majority of people consent to a follow-up call.

Subsequent contact can happen in a variety of locations to suit the needs of the service user. The higher frequency A&E attenders the team tend to meet at their homes as it provides a more stable environment and lessens the likelihood of a missed appointment. Prior to the COVID restrictions, the HIU team would go together on an initial assessment to ensure safety.

Once service users have accepted the offer of support, the team work on building a trusted relationship so that they can encourage the individual to identify unmet social needs. Ways in which the HIU team foster positive behaviour change to reduce reliance on A&E are included in table 2 below:

Table 2: Type of support provided by the EK HIU service to service users

Type of support	**Description**
Direct support	Meeting 1-1 to establish a connection and to provide support in a variety of venues (local parks, walks, cafes, charity shops).
	Phone calls and text messages for ongoing support and wellbeing checks
	Assisting with food (foodbank, shopping, online shopping orders) and picking up prescriptions
	Accompanying service users to appointments such as medical, housing, multi-disciplinary meetings etc
Broadening the support network of the service user	Liaising with family members, social care workers, healthcare professionals and others to promote and ensure service users' wellbeing
	Accompanying services users to introductory attendances at community groups (Age UK, coffee mornings, church groups, mental health groups)
	Delivering activity packs and resources – this ensures that full use is made of existing services and sources of support within the community.
	Help with finding local activities, groups and services reducing service user's feelings of isolation and loneliness.
	Signposting for long term support to well established private or community/charity sector organisations and enabling service users to manage their circumstances in their daily lives.

The HIU team are able to access limited funding to support a service user to access a community service, through the payment of registration fees, for example. In one instance, the HIU team were able to support a service user to get some furniture as they were frequently attending A&E with leg issues and through engagement with them, the team found out they currently had nothing to sit on in their accommodation.

A strength of the service is seen as the single point of contact who has the time and capability to really understand what is happening in a service user's life. For example, the HIU team can follow-up on what happened after a service user attended a health appointment and support them with the next steps.

Some of the skills required of a HIU worker were summed up in the interviews:

> *"I think the [HIU worker], their main things are needing to be able to listen well and understand how to approach that situation, being able to read a person, being able to negotiate… Negotiation is such a big thing. We're working with people who have been through the health service and through every single organisation through the past 10 years and they're still struggling, and then you try to tell them you'll be able to help them."*

Support varies significantly from service user to service user. Some people prefer face to face contact, others prefer to speak with the HIU team over the phone. The frequency of contacts also varies greatly. Setting boundaries is important with service users. Some call their HIU contact multiple times throughout the day and night. In these cases, the HIU worker might establish a time window for the service user, within which they would guarantee they would be available to speak to them.

Impact of COVID-19:

The COVID-19 restrictions have limited the level of support the HIU team has been able to provide. During the period where lockdown rules prohibited many services from running the HIU team focused on:

- Increased support via telephone
- Delivering activity packs to service users to reduce boredom and loneliness
- Support with food shopping and collecting prescriptions
- Distributing appropriate literature to service users' homes.

De-escalate:

The service provides a lot of guidance around what a service user can do if their situation is escalating. For example:

> *"We do a lot of education around who the best person to contact is if you're feeling different ways or if you've got different things. For example., we tell them when to contact the GPs, when you should be contacting us, when you should be contacting [other] services. With a lot of our service users, we give them a journal type thing, a*

> *book, and that's because a lot of our service users, their anxiety raises throughout the day and by after dinner time, when we stop work, they're at their crisis point and there's no one to contact and that's why they go into A&E. So.., we do a lot of work with them throughout the day in order to bring those levels down and if there is anything during the night or during the time when we're not working or can't talk to them, we ask them to write it in their journals."*

The HIU worker also keeps a journal and they compare these with the service users at regular intervals. They have found this a useful tool for de-escalating their service user's needs.

The approach of the service is to try and engage with a service user before they reach a crisis point. This is why they keep in regular contact in order to try and manage potential issues before they escalate.

Discharge:

The service provided by the HIU team doesn't have a specified discharge point. Numbers are managed through reducing the contact time with existing service users as they require less support and also taking on a mix of high intensity and lower intensity cases to match the capacity within the team.

Manage Relapse:

The HIU team have relapse prevention plans. Through their access to A&E attendance data, they can identify if a service user's A&E attendance is increasing and they can act swiftly by contacting the individual concerned and work with them to understand the reasons for this increase and explore alternatives to A&E attendance as appropriate.

C: Outcomes

Patient experience:

The value of the HIU service is seen in its flexibility and time commitment it is able to provide to service users:

> *"There's no other service that I've come into contact with that can meet the service user completely where they are. What other service can go to their house? Or, if they don't like their roommates, can meet them in a café instead and do all of those sorts of things with them; going out and meeting them in a variety of places. Working with them.., for however long we think we're helping them."*

More detail on the patient experience is provided through the service user stories in section E.

Cost-effectiveness:

Data provided by the BRC provides evidence of the impact of the HIU service. 53 service users have had their pre and post HIU intervention activity calculated in terms of emergency department attendances, non-elective admissions and ambulance conveyances over a 3 month period following initial intervention. Financial savings are based on tariff calculations for these services from NHS RightCare. Table 3 below shows the findings.

Table 3: Impact on acute hospital activity and financial savings following HIU intervention as at Feb 21

Service type	Activity after intervention	Financial saving
Emergency department attendance	46% reduction	£43,855
Non-elective admissions	48% reduction	£331,667
Ambulance conveyances	48% reduction	£45,489
Total		**£421,010**

D: Learning

Enablers of success:

Contracting an organisation to manage the HIU service who have a good understanding of what services exist in the local community that they can link service users has been reported as important to the success of the service.

Establishing good working relationships with both EKH FT and the ambulance service is also a key to success. In EK, the relationship with staff in the acute trust has been strong from the start - excepting for the initial IG challenges – although establishing a working relationship with the ambulance service has been more challenging as they already have a frequent caller team of their own. This is not able, however, to look holistically at why a service user is calling 999. The BRC have taken time to improve the collaboration of these two HIU services and demonstrate the benefit of its approach of wider social support.

Linking in with the local mental health teams has also supported the HIU team. Many of the people who appear on the frequent A&E attender list are also experiencing poor mental health and are known to the mental health teams. Fostering a good relationship with them is important so that both services can understand the challenges facing service users and support appropriate referrals. The HIU team spent time shadowing the mental health team to understand what they do and who they should speak to if they had a mental health concern regarding one of their service users.

Being part of BRC who manage multiple HIU services across the country is useful to individual HIU teams as they are able to access support and learning from others involved in this service across the organisation. They are able to provide advice to each other on how to handle individual cases where a colleague may have had a similar experience:

> *"I think generally the biggest thing whenever we {HIU teams} talk to each other or connect with each other, it's normally around case studies and around 'I have this service user and do not have a clue what to do with them'... It's really handy to be able to talk to other HIU workers and say 'have you ever had any experience of this? What did you do?' Because our job is very outside of the box it's very handy to get those little random suggestions that can just trigger what you think you are going to help them with."*

There is a WhatsApp group for the HIU teams to support each other and National HIU Lead zoom sessions every 6 weeks. There is also a peer support group that meets every 2-4 weeks.

Barriers to success:

Information governance (IG) was a significant challenge to overcome at the outset and it took six months for a data sharing agreement between BRC and EKH FT to be agreed, allowing the HIU team to be able to access lists of frequent attenders to the local A&E department. This was despite the HIU Lead for EK having an honorary NHS contract and BRC having implemented their model and successfully negotiated data sharing agreements in other areas. This was resolved through support for the data sharing agreement being provided from NHSX and it being signed off by the EKH FT board.

The transition to an ICS in Kent and Medway is also providing some uncertainty at the moment as to the future of the service as ongoing commissioning arrangements are not possible until the future of the CCGs in the system are confirmed.

Although building collaborative relationships with other health and non-health services in EK has been an enabler for the service, the service is dependent on what is available in the area in terms of community services, volunteering opportunities and other activities that service users may be signposted to. In EK, these opportunities may not be as voluminous as in other areas which places some restrictions on what the service can offer.

Next Steps:

Long term funding for the service has not yet been secured. The challenge for the service is evidencing return on investment in terms of financial savings that is recognised by the CCG and EKH FT. This is most likely to be realised through time saved by the stakeholder A&E departments not seeing patients who regularly attend. The service is working to determine the financial benefit of this with the EKH FT.

The service would like to expand to include more hospitals in the area, subject to the future commissioning structure of the Kent and Medway ICS.

The service has recently started working with Section 136 Suites. These are facilities for people who are detained by police under Section 136 of the Mental Health Act. This is intended to reduce the amount of police and ambulance time required to support these service users by providing them with the HIU tools and guidance offered to frequent A&E attenders.

There is an ambition for the service to provide more bespoke support. For example, HIU workers specifically for those with drug and alcohol addiction, or mental health issues, older people and young people. For example, in the third quarter of 2021/21 the service focused on those aged between 18 and 25 years of age.

E: Service User Stories

Service User 1: Pseudonym - Gail

I was contacted by the British Red Cross and the support worker and I started going out to places to have a cup of tea or-, lunch at the pub once. The time they spent with me, it was really useful in understanding my needs.

We would meet up once a week or so. I would also phone them just for a chat The support worker said they could help my mental health and they were going to take me to different places to socialise and get me out the house. The support worker cheers me up, we have a laugh. They make me feel like someone's bothered about things, they are very understanding.

Before I saw the support worker I wasn't going out at all, I've got nowhere to go really. But now I can get on buses etc. We went out for meals together and that gave me the confidence to go and socialise on my own. I used to feel very paranoid when I went out on my own and since I've had the support that seems to have eased. They have a calming influence on me.

I'd like to carry on seeing my support worker as much as I do. I consider them a good friend.

Service User 2: Pseudonym - Hazel (provided by the BRC)

We first got in contact with Miss S in January 2020. At that time, she was one of the highest attenders in East Kent and in the 12 months before our engagement had attended the William Harvey Hospital A&E department 84 times. She had been admitted to hospital 29 times and had been taken in by ambulance 72 times. She was well known to the staff and had been recently attending the A&E department twice per day. We were told that she was impossible to work with and that she was physically and verbally aggressive. The hospital staff told us that she was quite childlike and responded well to games and simple tasks.

Hazel was extremely complex and there was no one reason why she was using the emergency services so frequently. She was difficult to get hold off and missed her first two appointments that we had lined up. Upon finally meeting with her face to face, she told us that she had lots of health problems and was on lots of medication. She said she often felt frustrated which caused her to lash out at paramedics and hospital staff. When she didn't get the help she wanted, she would take overdoses and then take herself up to the hospital to be seen.

We initially met Hazel in her home where she lived on her own. She explained that she had fallen out with her neighbours and the building manager and this was fuelling her frustrations. She had limited mobility but refused help from various health services.

We continued to meet her at least once per week to get to know and build up trust. The process was slow but we could see that she was beginning to accept our help. Our visits included meeting at the coffee morning at her local Church, charity shop shopping and attending various groups at Age UK.

She was regularly spoken about at the hospital MDTs in addition to the frequent attender meetings and the mental health meetings. They quickly started to notice her attendances dropping and we were pleased to see that we had had an impact on her wellbeing.

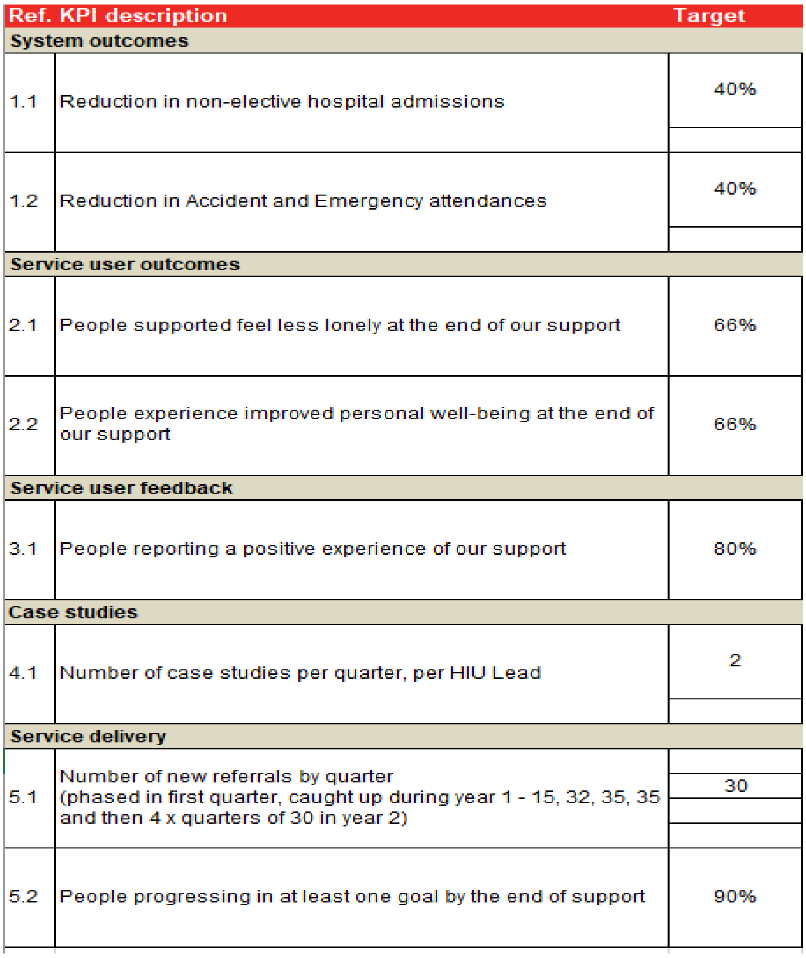
We had regular phone calls with her in which we would talk about her emotions and how she can manage them. I spoke to her about her daily routine and together we established a plan to keep her body and mind busy each day. We put together a resource which showed in picture form when it is appropriate to call 111, 999 and the GP. The resource gave clear instructions on who to call including the Samaritans, Live Well East Kent and ourselves.

We contacted social services to get her an appointment for different housing and took her to bank appointments so that she could set up a safe way of banking and talk to staff about how to manage her money. We were in regular contact with her GP and the local pharmacy about the huge amount of medication that she was taking daily and that a lot of it was out of date or not appropriate. We arranged more support for her in her home and by the end of the first (COVID-19) lockdown she had a support worker visiting once per day to assist in washing, dressing and housework. This support worker also took her out of the house twice a week.

By the summer, her admissions had dropped significantly, and she had only attended hospital twice in the previous 3 months. She had lost a lot of weight through exercising and eating better, and she was sleeping well due to a change in medication and sleeping pattern. She was very vocal about how she felt like a different person and no longer felt depressed or suicidal. Our team, through the HIU service, was able to give Hazel the time and patience that other services were not able to offer. We had the time and the knowledge to link up appropriate services, liaise with professionals on her behalf and to educate her in what behaviour was appropriate and what was not. Our work with her allowed her to deal with her frustrations in a positive way.

A lot of Hazel's problems haven't gone away but she now has appropriate support in place to help her deal with them and is no longer relying on emergency care to fix them.

F: British Red Cross HIU Service Key Performance Indicators



Ref.	KPI description	Target
System outcomes		
1.1	Reduction in non-elective hospital admissions	40%
1.2	Reduction in Accident and Emergency attendances	40%
Service user outcomes		
2.1	People supported feel less lonely at the end of our support	66%
2.2	People experience improved personal well-being at the end of our support	66%
Service user feedback		
3.1	People reporting a positive experience of our support	80%
Case studies		
4.1	Number of case studies per quarter, per HIU Lead	2
Service delivery		
5.1	Number of new referrals by quarter (phased in first quarter, caught up during year 1 - 15, 32, 35, 35 and then 4 x quarters of 30 in year 2)	30
5.2	People progressing in at least one goal by the end of support	90%

Kernow

A: Overview

*Table 1: Overview of **Kernow** HIU Programme*

Launch date	November 2018
Host organisation	Volunteer Cornwall
Location(s)	Royal Cornwall Hospitals NHS Trust; Cornwall Partnership NHS FT; St Austell Primary Care Network; Pentreath; Cornwall Mind
Team	HIU Lead plus five caseworkers
Estimated number of service users to date	C. 95
Number of people interviewed for case study:	
Stakeholders	4
Service Users	2

Regional context:

The South Western Ambulance Service (SWAST) was experiencing a high volume of 999 calls from a small cohort of service users in Cornwall. Kernow CCG, working with SWAST, quantified the rate of utilisation of these frequent callers. An initial scoping exercise found that most frequent attenders at emergency departments and calls to 999 came from people who did not have an acute condition that required them to be in hospital. Rather, they had other issues that required more holistic support, but did not have the means of accessing this. This confirmed to stakeholders that working with these individuals to support them with these underlying issues may reduce their reliance on urgent and emergency (U&E) services.

The idea to develop a High Intensity Use (HIU) service in response to this issue came from a national health and care conference in 2018 where the Blackpool HIU model was presented. Senior leaders of the Cornwall health and care system were present and presented the idea to local stakeholders. This was then picked up by the lead commissioner at Kernow CCG for U&E care. Volunteer Cornwall were identified as an appropriate host for the service as they had experience of working with disadvantaged people. The commissioner contacted the NHSE HIU RightCare programme team and the national HIU Lead (HIUC), Rhian Monteith provided training, mentoring and coaching support to help the service in Kernow to hit the ground running. This support included attending service user visits, telephone coaching, face-to-face classroom training and ad hoc weekly support to the newly recruited HIU Lead for the first three months.

At the outset, the CCG staged a stakeholder event to communicate the HIU service prospect. This included social prescribers, community health workers and the local acute trust (Royal Cornwall Hospitals NHS Trust), amongst others. This was important to bring together and engage services who would be needed to support the HIU service and its service users. The scope of the service was clearly stated to cater for frequent callers of ambulances and high attenders to the acute trust's emergency department. This has subsequently included an additional arrangement with the community mental health trust (Cornwall Partnership NHS Foundation Trust) that is funded until March 2022 (see below).

HIU Programme Delivery:

Service overview

The Kernow HIU service is funded by Kernow CCG with additional money secured through the local acute trust, the Better Care Fund and NHSE. Funding for the service is currently in place until January 2022. The HIU Lead was recruited to the service in November 2018 and they received their first service users in January 2019. After an initial period of c. 12 months with the HIU Lead managing the service themselves, two support staff were added to the team at the beginning of 2020 who manage their own service user lists, allocated to them by the HIU Lead. A further team member was recruited in September 2020, hosted by a partner mental health charity, Pentreath. In 2021, three new members were recruited hosted by Pentreath and another local mental health charity, Cornwall Mind.

The service aims to:

> *"Listen to the needs of the service users with a friendly approach, supporting them into finding solutions to their issues, aiming to reconnect them back to a better life, to their families, to their communities and often helping them to access the appropriate services in a less chaotic style."*

Hosting the team within Volunteer Cornwall has some clear benefits for the service. It provides the HIU team with direct links to other community organisations that would not be so readily accessible if the team was based in the NHS. This creates easy referral pathways for service users into other community services who can offer social support such as community activities, access to education and volunteering opportunities.

Service leadership

The Kernow HIU service is managed by a HIU Lead who has a background in education and the voluntary and community sector. Some of the qualities required of a HIU Lead have been described by those involved in the service:

> *"You've got to have a really high emotional IQ.., you've just got to have the drive and the sparkle, and this passion for people."*

The HIU Lead is hosted by the charity Volunteer Cornwall but they are also permitted an NHS email account which is necessary to receive the relevant information regarding potential service user lists. This has been possible by providing the HIU Lead with an honorary NHS contract through the local acute trust.

The HIU Lead reports to the service commissioner at Kernow CCG and also the senior leadership of Volunteer Cornwall. The 'key success factor' of giving the service lead the freedom to act and innovate has been reported as highly important in Kernow, and well-practiced.

B: Service User Pathway

Identifying service users

Service users are identified primarily via the hospital data tool 'Radar' list of frequent attenders to the acute trust's emergency department. This includes the top 50 frequent attenders. SWAST also contributes to this list but there have been issues reported around the quality of this data. This list is discussed at a multi-disciplinary team (MDT) meeting including the HIU Lead and other health and care workers with a stated interest in supporting this service user group. The service also accepts some referrals from the neighbouring Derriford Hospital in Devon on an ad hoc basis. These referrals result from regular attenders at Derriford's emergency department being asked if they would like to be contacted by the HIU service by hospital clinicians. This differs to those engaged from the 'radar' list, who are not made aware they might be contacted in the first instance.

Where the line is drawn in terms of how many people are contacted from these lists depends on the capacity within the HIU team and is at the discretion of the HIU Lead. As a general rule, each member of the HIU team can take on about 10-15 service users at any one time, but this can vary dependent on the needs of those service users. COVID-19 has influenced these numbers and also the method of engagement (see below).

An initial screen of these lists is done by the HIU Lead to ensure that the potential service user does not represent a risk to staff and that their high use of U&E services is not obviously warranted due to present complex medical needs. They are then allocated to a case worker who will contact the individual over the phone in the first instance.

The level of information provided to the service regarding those on these lists has improved over time, and this has been important in identifying any potential risks posed to the HIU team by the service users. However, the information is still variable in detail and often members of the HIU team are going in 'blind' to their first contact with a potential service user.

Although the initial brief for the service was to engage 50 service users in the first year, due to the nature of the geography (significant coverage with a dispersed population) and demography (significant numbers of older service users without internet connections), around 30 service users were engaged in year 1 but the service only had one member of staff during this time. This has subsequently increased in line with the target following the recruitment of additional team members.

In January 2021, the service opened up referral routes from the local community mental health trust who now refer directly to the service. This is specifically to support patient discharge and try and prevent early readmission. This has been funded by Winter Pressures money.

Personalise:

At the initial contact with a potential service user the allocated case worker from the HIU team introduces themselves and the service and asks the service user if they would like their support. This is not described in terms of 'you use ambulances or A&E a lot' but rather 'you've been identified as someone who might benefit from some support in the community and I'm calling to offer that support.' The boundaries of the service are also explained; for example, appropriate times to contact the case worker. If the service user consents a visit is agreed with a case worker who completes a form with the service user describing what they like, why they think they have been a high frequency attender, and what they don't enjoy or things that frustrate them. This form is based on the template provided as part of the NHS RightCare toolkit for a HIU service. This visit is supported by notes provided by the referring organisation that may include vital information to ensure the safety of the case worker e.g. a history of violent conduct. Although, as already described, the quality of this information is variable. These initial conversations assess the suitability of the service user for the service.

The HIU team is not based around a medical model and the team stress that this is important in the way they talk with their service users:

> *"So I don't come from a medical viewpoint or I'm not there to try and tell people off or try and get them to do things, it's really relaxed. That works really well so that people actually will, most of the time, agree to meet me. It's just getting that foot in the door with people really so you can start to get to know them a little bit better and actually*

> *see what's going on. Get them to trust you because..,, lots of people just don't trust services or have been let down by services or they're not working for them."*

Subsequent support is then agreed with the service user based on these conversations. Examples of support include:

- Attending healthcare appointments with a service user
- Support to attend community activities e.g. art classes, fitness classes
- Facilitating engagement with non-health support services e.g. debt advice, addiction
- Getting access to IT equipment to support access to other services
- Securing accommodation

The service also supports service users to re-engage with services where they may have been refused help previously due to challenging behaviour.

The team provide small personalised incentives for reaching goals or milestones, such as not calling for an ambulance that week, in some instances. For example, one service user was rewarded with an ice cream on the beach for meeting their milestone.

Impact of COVID-19:

The COVID-19 pandemic has caused a lot of support to shift to phone-based rather than face to face. Although this has been challenging to engage service users with community activities to support their wellbeing, and provides limitations for those who prefer to meet face to face, it has meant the service can take on some service users who were not previously deemed suitable for face to face support. Working from home has also helped the HIU team with having confidential conversations with service users, where previously this was more difficult working from an office environment.

The HIU team have widened their support network in response to COVID. They have worked with the wider Volunteer Cornwall team to provide assistance to those who were not previously in need of support, but had been adversely impacted by the need to stay at home. This includes a network of volunteers and phone support to those identified as at increased risk of attending hospital due to the isolation caused by the national lockdowns.

Overall, the HIU team have focused on helping their primary service users – those identified through the MDT – to avoid crisis points that may lead to them attending the emergency department during COVID, rather than tackling the root causes of their attendance. It has been more difficult to provide the holistic care that is central to the service in the absence of many of the community support services on which service users' rely. There is confidence that a return to improving the overall wellbeing of service users will be possible as 'normal' services resume.

De-escalate:

Many service users seen by the service have complex needs and can demonstrate suicidal tendencies. The service is clear with service users that it does not provide medical support and sees its value in this; providing space to listen to service users and remind them of the medical pathways open to them as appropriate.

The team has provided service users with specific tools to help them cope with a crisis. This has included:

- Music to help them relax
- Reminders of medical and other support services they can contact in the instance of a crisis
- Reassurance over the phone where service users are suffering anxiety
- Targets for reducing the number of times the service user calls their case worker each day

A feature of the Kernow HIU team is that they respond flexibly to the sometimes chaotic lives of their service users. They expect the unexpected, and find it is important to be able to adapt to a service user's changing needs and circumstances:

> *"One thing about HIU is it's quite flexible.., if someone needs to change something at the last minute or if something happens, you can just roll with people.., which is the good thing about HIU. That happens all time, every day people will have things going on or what you thought you were going to do that day just doesn't happen because something else has happened. Every day is different I think with HIU, you just don't know, don't know what you're going to be faced with today."*

The service also places importance on persevering with service users even when the situation becomes difficult. This helps service users who have experienced health (and non-health) services withdrawing support due to difficult behaviours and the HIU service, by its nature, places a higher threshold on refusing their support. They recognise this is a unique position:

> *"I think, because HIU gives you that time, you can work with people as long as you need to, I have that luxury I suppose of being able to do that. In fairness [to] lots of services if there are time constraints and things or you're limited it would be quite difficult [to do that] I think, wouldn't it?"*

Discharge:

Discharge from the service tends to happen organically, with service users using the service less as they feel more confident to support themselves. The COVID pandemic has made it more difficult to discharge people as service users have been less able to engage in the sorts of activities that would have led to an increase in their self-reliance. The HIU team operates in a way where they don't formally discharge where possible, and will still take calls from service users they haven't spoken to for some time. The volume of these calls, however, will reduce over time as a service user's needs reduce due to the work of the service. This frees up capacity for new service users.

The important thing from the service's point of view is that service users do not become overly reliant on them. One mitigation for this is to involve other community services in their support, so they have multiple avenues they can access dependent on what they need.

With the service users the HIU service supports on discharge from the mental health trust, they are clear at the outset that their support will only be provided for a specified period of time; this is normally 6-8 weeks.

Manage Relapse:

The service operates an 'open-door' policy for service users so that if they are in danger of relapse, even if they have not been in contact with the service for some time, they can still call their case worker.

C: Outcomes

Patient experience:

Service users have often lost contact with family and friends and are socially isolated and this contributes in some cases to their high usage of U&E services. The HIU service provides important social interaction that can reduce this help-seeking behaviour. The patient stories in section E below provide examples of how patients have benefitted from the service.

Staff experience:

The HIU team (with the consent of the service user) share behavioural details with health staff who work in U&E services to help them to manage the individual should they attend. For example, one service user found communicating with male members of staff difficult, so the HIU service shared this information with SWAST and they now know that the service user will respond more easily to female members of staff.

Health care services:

The presence of the HIU service has improved the relationship between the local acute trust and the voluntary sector and they are now working in a much more integrated way.

Cost-effectiveness:

Data provided by the acute trust provides evidence of the impact of the HIU service. 89 service users have had their pre and post HIU intervention activity calculated in terms of emergency department attendances, inpatient admissions, and outpatient appointments over a 12 month period following initial intervention. Table 2 below shows the findings.

Table 2: Reported savings attributed to the HIU service in Kernow

Service type	**Activity after intervention**	**Financial saving**
Emergency department attendance	-130 attendances	£14,241
Inpatient admission	-59 admissions	£122,404
Outpatient appointment	-34 appointments	£2,529
Total	**-223**	**£139,174**

D: Learning

Enablers of success:

Support from the HIU Lead, Rhian Monteith, was reported as important in the implementation of the service in Kernow, to provide expert knowledge and experience in this field.

One of the reported strengths of the service is its agility. The team are able to respond flexibly and quickly to the needs of their service users and are not restricted by any sense of a 'fixed' intervention for issues they are presented with.

Each case worker submits a monthly report to the service lead outlining who they have been working with, the needs of that person, how they have supported them and what future support might look like. Case workers have some autonomy in the information they provide with the core requirement being that they reflect the personalisation of the service they are providing.

Quality data and accurate lists of potential service users are vital to success. Volunteer Cornwall has worked previously with the NHS and has Data Security Level 2 accreditation which was important in mitigating data protection concerns raised by NHS partners. The HIU Lead has an honorary contract with the acute trust and attends MDT meetings with hospital and other health staff to discuss frequent attenders and is also able to access relevant data through the trust. Although it is important to have adequate information regarding a potential service user to make a risk assessment, the HIU team have expressed that their medical history is not required as it does not tell them what they really want to know about the person; the aspects of their life beyond their health that underly the reasons for their behaviour.

Relationships with other public services, such as the police, who may know service users, is important for the service. This is also the case for drug and alcohol services and housing, where joint visits may be beneficial in engaging the service user. Over time, the service has built up strong relationships with its health partners and this has helped them in their support of service users as they are able to access health workers directly to discuss an individual service user (with consent).

Links to community services and businesses that can provide support to service users is vital. The HIU team feel the depth and quality of Cornwall's voluntary and community services has really helped them to support their service users, and these organisations work really well together. This includes addiction charities, debt support, volunteering opportunities, amongst others. For example, the Kernow HIU service has links to Tesco who provide clothes and other items that are unsold to offer to service users. Being able to source funds from local funding streams is also important to pay for activities that support a service user's wellbeing. Volunteer Cornwall also manages social prescribing services in Cornwall which has helped in getting service users support for their wellbeing beyond the immediate crisis management tools offered by the HIU team.

Having the support of leaders within the emergency department of the local acute trust, and the CCG, is integral to the service's success and Volunteer Cornwall and the HIU team has been allowed significant autonomy to develop the service.

Barriers to success:

The service would benefit from having an enablement budget to support service users to pursue activities that reduce their reliance on health services. This has, on occasion, been possible through social prescribers and some enablement funds are provided for service users that come through the community mental health trust but this is not consistent for all service users.

Overall funding of the programme is also a challenge. To date this has been short term and the long-term future of the programme is not confirmed. This creates uncertainty for staff and service users involved in the HIU service. There are currently plans for the CCG to commission the service on a three-year cycle but this is not yet confirmed and the transition to an Integrated Care System (ICS) is causing a delay in this decision.

The service is also funded separately for service users who are referred through the mental health trust and those that are identified by the acute hospital. Stakeholders have suggested these budgets be pooled but this has not yet happened.

Collecting data relating to how frequency of 999 calls has changed following HIU engagement with the service user has been challenging. This is making it difficult for the service to demonstrate impact.

Next Steps:

The service has plans to support primary care, so that they can engage service users before they present with high use of emergency services. The service also has ambitions to engage with children and young people, as well as their families, who are at risk of becoming establishing long patterns of high intensity use, may also act as a preventative measure to improve mental health and wellbeing.

E: Service User Stories

Service User 1: Pseudonym – Anna

I was in a difficult relationship with an abusive partner who was threatening me and being verbally abusive to me, so I was regularly presenting to A&E with being in a lot of pain. The mental illness of me being so unwell with the abuse I was having was making me unwell physically. So I was, at one point, going into A&E every other day just because I found it as a place of safety.

I think for me it was hard because I didn't realise how unwell I was mentally, then although they [A&E staff] ask the safeguarding question, 'are things safe at home?', I didn't fully appreciate and understand how unwell I was, so I couldn't actually admit to it. So, although they ask that question, I think there are times where patients aren't potentially safe at home but they're so mentally unwell they can't actually admit to it. That's the stage I got into.

[The HIU worker] phoned me to say that, 'I work for the High Intensity User team and I want to see if there's anything I could do to help you?'... It was a relief in one way because it was an outside contact. It was someone outside the friends and family social group but like a medical professional. Someone that I could contact that knew that I was going into A&E a lot and that point of contact... So I've met up with them and we had a chat and we were just talking about my complex medical history...So there are the physical conditions there that sometimes will make me present to A&E regularly. And the HIU worker was just trying to work out is there anything they can do as a team to help. And it was mainly trying to do things to get me out and about more, to help my mental health, seeing how much of the A&E visits were due to my mental health and how much was due to my physical conditions. And then they put me in touch with a social prescriber as well to help get me doing more activities, [such as Nordic walking] ... [The HIU worker made] sure that I had somewhere safe to be [and] even told me if I feel like I'm going downhill to keep in touch.

I've been working with the HIU worker quite a while on and off because I had a relapse when COVID first happened... I got in touch with [the HIU worker] again to say things aren't brilliant, and they tried to say to me, 'just find distractions in other ways.' And recommended things like Headspace and the meditation apps. So, I can just put my headphones and just listen to things *on my phone or listen to the radio. Even just do things on my phone or watch a couple of films and try and do things that I like still but at home.*

I've also been trying to get care plan sorted out for me, something I've been fighting for, for a long time. So then I can phone up 111 or [my] GP and they'll have a detailed plan that says what symptoms need what treatment if it's out of hours. Because with my complex health history..., 111 have got a set pathway they have to follow, and set questions but with me sometimes, I need help quicker than that. So, if I have that care plan sorted out, at least I've got it documented to say, if I'm out of hours with these symptoms, this must happen. I've been asking for that for a long time and it wasn't until I spoke to [the HIU worker] that they started to get things sorted for that.

[The HIU service has helped me because] I know I've got someone else that I can call on and get more advice on what I need, because people with chronic illness' that regularly present aren't necessarily as well recognised or treated the same because they are regularly attending A&E. But with the support that you get from [the HIU worker] and the team, it's making sure you've got everything in place and finding other ways to help. Because sometimes you have got an illness, you go into A&E and they just say there's not much they can do. And then you end up going in again a couple of days later because nothing's changed. That's sometimes what chronic illness is about, you need that 2 or 3 days of extra care because you can't manage at home. But with [the HIU service it's about] trying the best ways to manage at home.

I'm almost there [not needing the service] now but.., I know that [the HIU worker is] only a phone call away if I'm relapsing again. And even if I don't phone them for 2 or 3 weeks, they'll phone me to check in to see how I'm doing, just to make sure I'm okay.

I feel like a different person. Although I went through that really horrible experience, it's made me a better person because I'm doing things that I wouldn't have normally done before. Like, I wouldn't have tried Nordic walking and I may not have had the confidence to go out and try activities in the community, to meet new people. It was doing these activities that made me meet new people but people that were similar to me. People that were either on low income or had medical conditions that affected certain aspects of their lives as well. So it gave me someone to go and meet to relate to because we were going through similar things.

[The] HIU service saved and changed my life. I wouldn't be here or the person I am now without them.

Service User 2: Bernadette

I see the [HIU worker] twice a day and that's every day through the week plus one day for outreach which is where it's like either going out or doing shopping or something for 2 hours. Around the time that I got approached [by the HIU team].., I was going through mental health [problems] and

I kept self-harming and stuff. So, I know that I needed help to get more involved in the community and I was struggling with the waiting list to do with [my support].

It's been great company.., to be honest, chatting and all.., great for helping and all and writing the letters and stuff [for my support] and actually understanding.

[When I was first contacted by the HIU worker they said they could] help in the way that if I need support of getting out and about, going through to appointments, really it's support around what I need. So, they'll be basically person-centred…. So, like for me, it was more around help on getting through to [appointments] and all but then helping to build up my confidence. I think we'd done some stuff on money management skills as well. Basically, we looked at a chart wheel, which was separated into different parts, like social parts of life, work parts of life and lifestyle. 'How good are your skills in money management?', 'how good are your skills in time management?', [it asked me] 'how good are your skills in communication?', 'how are your skills with self-esteem and self-worth?', and so on. Learning about that, we could then break it down and be like 'these skills you're quite good at, so we don't need to really need to focus on these, but these skills are the ones that we need to focus on.'

The service works, which is amazing, and it still works. I don't want to lose this service because it works that much. It's helped with my anxiety. It helped with my depression. It's got me to a stable point, so I'm not going into hospital. Technically, some people could say, it's then using up resources, where they could be used somewhere else. At least this way, I am one person, out of maybe hundreds or thousands, that's not using those resources, at least then they can be used somewhere else. The service has been amazing, no doubt about it. I wouldn't question it whatsoever.

I would literally put it [going to hospital less] down to the support, what the service can do and how it can help a person in reaching their goals and getting targets done. For me, it's been emotional and physical support. It's helped push me in the right direction… Actually, just having that support there to be able to chat, to be able to say what's on my mind, to be able to have clarity from that and to really be able to speak freely, to be honest. To know that you're in safe hands and that nothing's going to happen.

Having the service there, having someone I can chat to and knowing that [it] is there. If I needed to speak to [my HIU worker], I can give them a message on their phone and they'd call me. Knowing it's just like that, having that support, where it's like 'I'm here for you. If you want to speak, we can chat.' It's been keeping me level and keeping me sustained on my feet, where I can keep going day by day, getting past my negative thoughts, knowing that I can carry on, and not going to hospital because of mental health. So it's really helped. If the service ended because it couldn't be funded, I would cry. It's a service connected with the NHS, but it's mainly I'm heard, *and it's not just about myself. I have heard it's made differences to [many] people. It needs to stay because of the way it's worked.*

Southport and Formby

A: Overview

*Table 1: Overview of **Southport and Formby** HIU Programme*

Launch date	September 2020
Host organisation	Sefton Council for Voluntary Service
Location(s)	Southport and Ormskirk Hospital
Team	HIU Lead, 3 case workers
Estimated number of service users to date	47 service users from September 2020– July 2021
Number of people interviewed:	
Stakeholders	4
Service Users	2

Regional context:

Southport and Formby Clinical Commissioning Group (SFCCG) and South Sefton Clinical Commissioning Group (SSCCG) have a jointly registered population of 250,000. There are high levels of long-term conditions, co-morbidities and a growing ageing population with more residents aged over 65 than the national average. There are some areas of extreme deprivation with lower-than-average earnings, poor housing, and high unemployment. Life expectancy in some areas is markedly below the national average.

Southport and Ormskirk Hospital (SOH) and Aintree Foundation Trust (AFT) have experienced unprecedented pressures in system flow; demand has increased over time with limited capacity. To enable an improvement in system flow, a need was identified to ensure that patients are treated in the right place and at the right time. NHS RightCare identified unscheduled care as a key area for improvement with c. £7.2m of opportunities across SFCCG and SSCCG. Based on 18/19 activity, South Sefton had 117 high intensity service users who generated 713 attendances and 973 admissions, equating to £1.571m non-elective activity. Similarly, Southport and Formby identified 66 high intensity service users who attended Accident and Emergency (A&E) 4 or more times with 65 generating 499 admissions at a cost of £862k.

The High Intensity Use (HIU) scheme undertaken in Blackpool was known to stakeholders in the CCGs and demonstrated that a holistic multi-professional approach to planning patient care can reap benefits to the system and the patient. The Blackpool model has subsequently been replicated across the Primary Care Network (PCN) areas of Southport and Formby. In the near future, once information sharing agreements are in place with AFT, the plan is to work with them to cover the PCN areas of South Sefton.

HIU Programme Delivery:

The host organisation for the HIU service is Sefton Council for Voluntary Service (CVS), an independent registered charity aiming to develop voluntary, community and faith sectors that support independent and resilient communities. CVS recruited the HIU Lead and case workers, with the posts funded by SFCCG. The HIU service was initially funded as a 12-month pilot. When information sharing agreements were secured with SOH, lists of high frequency users of the A&E service were shared by the hospital Business Intelligence (BI) team with the HIU team. Lists were first shared in August 2020 and the service commenced a month later in September 2020. The BI team continue to send lists of high frequency users on a quarterly basis. The Hospital Alcohol Liaison Team (HALT), who are based at SOH and support patients with alcohol dependency issues, have additionally engaged the HIU team to work with specific patients of theirs who are also high frequency service users of A&E.

The HIU team adopt a flexible and agile way of working and currently operate from home. There are currently three case workers who work full time with service users, one lead who provides oversight of the service and one administrator. The HIU Lead has previous experience with setting up projects with Sefton CVS and the case workers have previous experience in health and community services.

The objective of the HIU service is for case workers to identify the root causes of presentation or admission at urgent and emergency (U&E) services. They build trust with service users and coach them to utilise coping strategies to help them manage independently. Service users are supported with developing support networks with family, friends, and relevant services in the community. Further detail of this support is provided in section B.

B: Service User Pathway

Identifying service users:

The A&E BI team sends a list of 50 eligible patients to the HIU Lead on a quarterly basis, detailing names, number of attendances or admissions and related costs. To ensure information governance (IG) standards are met, all documents are password protected. The criteria for eligibility to the HIU service include being over 18; having four or more A&E attendances with more than one admission within a 12-month period; and experiencing crisis or at risk of becoming a high intensity user.

The list is reviewed by the HIU Lead to check for appropriateness and distributed amongst the three case workers. In-depth discussions of cases take place on a weekly basis between the HIU Lead and case workers. HIU case workers attend regular Frequent Attender Multi-Disciplinary Team (MDT) meetings at SOH to have discussions around high frequency service users of services and the interventions implemented by the HIU team.

When the HALT team refer into the HIU service, they provide a detailed service user history to the case workers and inform service users about their referral into the HIU service. Service users who come through A&E are rarely informed in advance that they will be contacted by the HIU service.

The service has received 132 referrals from the BI team at SOH since its launch and 47 service users have been supported from September 2020 to the end of May 2021. The caseload of 50, which the HIU service initially receive on a quarterly basis, is often reduced. This is due to service users struggling with engagement, some service users already being involved in other local services or some falling outside the Sefton catchment area. Nonetheless, most service users have good engagement with the HIU service and generally accept the support offered.

Personalise:

Once eligibility and suitability of service users on the list has been agreed by the HIU team, each person is contacted via telephone by a case worker. Once the service user agrees to access support, the case workers will typically adopt an informal approach when undertaking an initial in-depth review. To encourage engagement, they might visit a service user at home, arrange for a walk or meet them for a coffee. All first visits to the service users are done in pairs for safeguarding purposes. At this point, they will also ask for consent to liaise with other services on their behalf.

During the initial meeting, they will try to uncover the underlying reasons for regular use of U&E services including (but not limited to) social issues, alcohol dependency, mental health, criminal justice and medical complexities. The case workers will act as an advocate for each service user and facilitate and adapt the support offer around the needs of the patient. Solution focussed techniques are utilised to encourage service users to think positively. The aim is to move away from a ‘tick box exercise’ and adopt a humanistic, collaborative and person-centred approach whereby the support centres on the needs of the individual. This develops trust, allows them to open up about their personal lives and connect with HIU case workers on a deeper level. One case worker described their interactions with service users:

> *“You'll get people who'll send you pictures of what they've cooked for their tea or pictures of them out and about on a walk or something!”*

Engaging with some service users has been reported as challenging; many are complex whilst some do not consider it an issue to frequently present at A&E. With such patients, a more consistent and personalised approach is adopted. The case workers try to build an initial relationship; reassuring service users that they can address a range of needs. The focus is on *"fitting services around the person rather than the other way around"*. If a particular intervention is not working, the team do not hesitate in changing their approach. Solutions to service user issues are discussed collaboratively with a shared decision-making process:

> *"You're opening it up and going, 'Okay, let me and you explore what we can do, together. What can we do, together, that will help you to reduce the times when you feel you need support?"*

Some service users have issues around trust and prefer to work with a designated person to begin with before getting referred into mainstream services:

> *"It's about building up that initial relationship with somebody, the trust, and you are whatever they need you to be, whether that's somebody to listen to, whether it's reassuring them, whether it's somebody that they know that they can ask, 'I've got this issue. I'm struggling, can you help?"*

Impact of COVID-19:

During the first lockdown the case workers were redeployed to other areas which delayed the launch of the service. Many community services were not operating during the pandemic which limited the support that was on offer.

The HIU team were asked to set up a COVID-19 signposting service which supported 1,100 Sefton residents between March-August 2020, which included welfare calls on a weekly basis, either via phone or video call which was challenging for some service users. Other support included going to change hearing aid batteries, supporting residents with prescription collections, and getting adequate shopping delivered.

Since the service started in September, it worked through local lockdown restrictions as well as another national lockdown from January 2021, which put an additional halt to face to face visits.

De-escalate:

Case workers provide holistic support or signpost to local services that address health, social and mental health issues people might face. They coordinate the care of frequent attenders who might be complex, require several care needs and may not have the knowledge of the variety of local specialist services that are available. To promote engagement with local healthcare services and address health concerns, some service users are reminded about their medical appointments or accompanied to an appointment. They might require HIU case workers to contact the GP on their behalf or connect them to mental health services. They may be connected to a range of services running in their community or offer support for aspects that fall outside the traditional remit of healthcare including (but not limited to):

- Help with shopping, managing debts, moving house;
- Referring to specialist local services (for example alcohol services, rehabilitation, befriending services and cancer support groups);
- Embedding them in community activities (art classes, faith groups and walking groups);
- Applying for Macmillan cancer grants;
- Providing them with musical instruments to play;
- Supporting them with employment or volunteering opportunities at local services such as crisis cafes or wellbeing cafes;
- Signposting to services to support development of computer literacy.

The support always aims to be tailored to the needs of the individual. The HIU case workers were described as responsive and timely in their service by both service users and stakeholders. Although the role may at times require working flexibly outside of social hours (after 5pm, weekends and bank holidays) the case workers also set boundaries as to when service users should contact them and provide backup phone numbers for services the service user may need.

Discharge:

Although the original service plan was to provide support to service users for 12-14 weeks, the HIU team take an 'open door' approach. The diverse complexities of service users have meant a flexible approach is required and the duration of the service's support depends on the needs of the individual. During the first few weeks of entering the service, there is increased contact between HIU case workers and service users to build relationships and connect them to the services they need. Thereafter, the case workers gradually step back, until their service users are independent, more established in the community and no longer need the service. The service takes a solution-focussed approach and sets goals for the service users to support them with developing relationships with the appropriate services. It aims to build self-esteem and confidence in service users to manage their own issues independently without the support of the HIU caseworkers. The way in which case workers manage a reduction in their level of support to service users has been described:

> *"[We tell them] you've got those relationships; you no longer need to be ringing me. You're now doing it for yourself as self-esteem has been built up within that person to manage their own issues, and that will depend on the person really".*

A sensitive approach is adopted to ensure service users do not feel alone. Challenges were reported with fully integrating some complex service users into the community and closing cases in a timely manner to enable case workers to take on new cases.

Manage Relapse:

Once referred to other providers, the HIU workers may need to maintain connection with the service user to act as a familiar point of contact. Case workers will receive information on A&E attendances for people who have relapsed and escalated their use of U&E service. Subsequently, case workers can get in touch with service users and re-open cases if needed or service users can call the case workers.

C: Outcomes

Patient experience:

The service has improved service user knowledge about different services available locally which they otherwise would be unaware of. Initially, HIU case workers act as an advocate, navigate services on behalf of the service users and embed them within the community. As a result of the HIU support, some service users have regained confidence, found employment and have been supported to live independently. Following support from the HIU service, many service users are reportedly more hesitant to present at U&E services. The patient experience is described in their own words in section E.

Staff experience:

The HIU team can bridge the gap between service users and healthcare professionals; they coordinate the care of service users and signpost to a range of services. They serve as a voice and advocate of the service users by communicating with a range of services. They can offer holistic support and have a deep understanding of the complexities that expand beyond the remit of physical health to include mental health, housing, anti-social behaviour and alcohol dependencies. They were described as proactive in their approach by colleagues, providing care in an empathetic and efficient manner:

> *"I always call them [the HIU team] 'a safe pair of hands', because you know that they care about the patients, so it gives you faith if you know that you're passing them on to someone that you know will do their best"*.

Health care services:

Following the implementation of the HIU service there has been a reported increase in system working. The system is keen to transfer learning from the HIU service and apply its design principles - particularly its person-centred approach - to other services (mental health services, social prescribing and Public Health). HIU workers have the potential to alleviate additional responsibilities from other professionals who have limited time and capacity. They can offer the time required to understand multiple concerns without being rushed. With HIU case workers acting as a representative for service users, they are able to coordinate the care of service users in an easier and more efficient manner.

> *"Healthcare services are not getting the 6 billion phone calls either from that service user who can't articulate themselves. They've got someone else to do that for them, which takes the weight off health care services as much as it takes off the service user as well".*

Cost-effectiveness:

A report written by the CCG has conducted a deep dive into 42 patients supported by the HIU service from September 2020-May 2021. It reviews A&E attendance and admission before and after interventions and it compares outcomes to patients who refused to engage with the programme.

To assess impact of the service the average cost of patients' A&E attendances and admissions before intervention and during/after has been calculated and forecast over 12 months to estimate annual avoided costs. The control group are assessed in the same way. Key findings are detailed below:

- The service has demonstrated a national return on investment with estimated avoided costs for the CVS cohort estimated for a 12-month period at £493,000.
- Comparing the two cohorts, the accepted cohort have seen a higher overall average cost avoidance by £166k/11%. And a £493k reduction in cost, versus the same service users, compared to the previous 12 months.

Table 2: Estimated financial savings due to HIU intervention

	Accepted (42 patients)	Refused (52 Patients)	Difference	%
A&E Attendances	-£52,653	-£34,860	£17,793	-8%
Admissions	-£440,540	-£292,013	£148,527	-12%
Total	**-£493,193**	**-£326,873**	**£166,320**	**-11%**

D: Learning

Enablers of success:

Good working relationships between the HIU service and CCG lead meant a bypass number to get directly in touch with GPs has been implemented and liaisons with the HALT team are supported. The HIU service have good relationship and communication with the A&E team at SOH and frequently attend their MDT meetings.

The service is hosted by CVS which has enabled engagement with voluntary and community (VCS) sector who can provide support for a wider range of social needs beyond immediate health issues.

The HIU case workers are reported to have specific interpersonal skills including being good listeners, caring, sympathetic, having the ability to take a person-centred approach and working collaboratively with service users to support their needs. They have been described as adaptable, motivated and have the desire to support patients in a timely way to avoid long waiting times for referrals. Service users need services which are close to home, therefore the HIU team's knowledge of services in the community has also been useful.

All case workers are given an induction through CVS and provided with mandatory training and a range of additional training including dealing with challenging behaviours, patient centred support, signposting and managing suicide. Case workers were given the opportunity to shadow community connectors, Macmillan navigators (who act as a single point of access and support patients throughout their cancer journey) and health and wellbeing trainers to develop their confidence in home visits.

Both quantitative and qualitative data has been collected since the launch of the service in September 2020. A questionnaire completed by service users before and after the service intervention has enabled the service to find out what is working well or why some service users might still be using A&E.

Barriers to success:

With the service initially being funded as a 12-month pilot, contracts were temporary, and posts were unstable, creating uncertainty with job security. The service had two small extensions (3-month extension then a 6-month extension). The HIU team put together a full business case for continuing the service. The service was granted recurrent funding in July 2021.

Supporting 50 service users at any one time (although numbers usually deplete) was perceived to be unfeasible as travel time needs to be accounted for if home visits are needed. This was particularly the case for complex patients and some older people who struggle with virtual communication.

Service users who came through the A&E list have limited notice of the HIU service which was felt to be unsettling for them; with some service users querying the exchange of their personal information. Likewise, reasons for attendance or admission at the hospital are not shared with case workers which would be useful during initial conversations.

There have been some difficulties integrating people in the community, particularly for service users with alcohol dependencies and mental health issues. This has created challenges with taking on new service users.

As CVS are not an NHS organisation, there were delays with getting IG agreements with SOH after recruiting the HIU team. It was, therefore, considered as a point of learning, important to obtain lists of service users and overcome IG issues before recruitment of case workers to ensure they can have an immediate start.

Next Steps:

The HIU service in Southport and Formby has the following plans for the near future:

- The service will continue to take on more cases and engage with more community services as they start up again following the COVID-19 restrictions;
- Roll out the service in South Sefton once sharing agreements are in place with AFT;
- With the opening of a crisis café, the service will be collecting data on which service users are going, how often and what support they are asking for;
- There are plans to increase engagement with GPs to support them with engaging with patients before they become high intensity use ensues. There are plans to extend the frequent attender multidisciplinary meetings to also include GP’s whereby they can share general practice data on frequent attenders;
- Increase promotion and education of the service within primary care to improve communication between case workers and GPs;
- Conduct an in-depth analysis on the reasons why some service users are still utilising emergency service users after receiving support from the HIU service.

E: Service User Stories

Service User 1: Pseudonym - Stella

I'm 57, I'm divorced, I live on my own. I've always been isolated. COVID has not been any different for me. I'm not working at the moment, because I haven't been too well, so I needed the support service that's been offered. I've got quite a few different health problems. I have depression and anxiety, borderline personality disorder, and I started to drink, but I'm not classed as an alcoholic. I do it because it's my only coping mechanism. I'm not smoking and I'm not drinking now, but I couldn't do all this without the support of this service. It's helped me tremendously.

When I have an episode of depression, panic and I didn't know who to talk to, what to do, or couldn't get through to the crisis team, the only place I felt safe with was if I had an ambulance person or seeing people in A&E made me feel secure. But they turn you away because they don't understand your condition.

I didn't even know services like this were out there. When both my parents died, it was a very bad patch. You can't signpost yourself because you're not well enough to know what's available, you're not in the right frame of mind to go looking. So, you need somebody to come in and tell you what they see and what you need. And for me I thought my life was over. But that's stopped now and it's making me more positive to want to move on and become a support worker myself. I've been through it all. I know I've got things to offer people.

My first contact with the HIU case worker was a relief, because I got on with her. I just thought, 'go along with it, I've got more to gain than lose', I didn't know what to expect. But it was much better than I'd expected. It's hard to remember when I started using it. It was last year sometime. And I hope the service does not stop soon. She sorted things out that I couldn't really do myself, people would listen to her, but they wouldn't listen to me. She understands me fully and how I feel. She puts me in touch with other services, we have a good conversation. I couldn't fault it at all. I hope it doesn't go. I know I can't have her forever.

I'm not on any tablets or anything. I had a lot of anxiety over Christmas, I had no heating, and I've got fibromyalgia and osteoarthritis, and I was in so much pain and the sink was leaking. It was too much for me to cope with. So, it was a relief when I had somebody to talk to, because I'm on my own and I was finding it hard to cope. She knows I've got fibromyalgia, so she tried to sort that out. She knew that I needed to go right to the mental health for my DBT, she sorted that out for me too. I've got somebody from the befriending service who phones me up. I've got somebody else that phones me from Vita Living. So, they're doing teamwork, working together with me. I'm also with the alcohol services as well, they phone every 2 weeks just to check in on *me, and that's helpful. So, they're all helping me in different ways. They're communicating together.*

I went to A&E twice since I've been with the service. I went through a very bad patch. It was all to do with this flat, I couldn't stand the pressure. The flat aggravated my illness. When I can speak to my case worker; she calms me down. This is probably my second week of being strong. If I don't understand the bill or whatever's come in, I know that I've got my case worker to ask, instead of me sitting and dwelling on it. That would make me sick again.

I think it's the reliability as well, she always says to me, 'Any problems, you know I'm here,' which is reassuring too. I contact her during working hours. Outside of those times, is a problem. They have the crisis team but the phone lines are always busy and when you're desperate, you start feeling worse, and then you go to A&E because nobody's picked the phone up. In A&E, there's no care at all there, they don't understand it, and I can't expect them to, they're not trained in it, are they?

My support worker never leaves it too long. Say, if I wanted to go for a cup of coffee because I'm anxious, and the other day I said, 'Well, there's a little café that I'd love to go into it, but I don't feel as if I'm confident enough,' so she took me into the café. Little things like that. And then you have the chat, and it just feels as if you've got a friend. She's a role model. A perfect role model, she's marvellous.

<u>Service User 2</u>: Pseudonym - Carolyn

I'm 47 this year. Health-wise, I've got an alcohol problem and debt problem. I have been struggling for the past year. I've got quite a lot of health concerns at the minute; I've got lots going on. I'm on all sorts of different medications, appointments with hospitals. I live on my own. I do have friends and neighbours, or people phoning up to speak to, so that's good. I wasn't doing anything before the service because we had lockdown. I've been at hospital with chest infections, I've just been up and down, not being so good. It's a shame.

I have recently started using the service. My support worker is lovely, she's fantastic. She is helping me out, with day-to-day basic things to get me out a bit more, be myself. We go for a walk and coffee, and she also helped me with moving home-issues and things like that. She is helping me out with my phone because I'm not very phone or computer literate, she's going to hopefully put me on some courses which I'll benefit from. In September, I'm doing a computer course and the second one is how to work my phone properly. The other one is creative design at college. I can't wait! Since I used the service, I've been to hospital twice with a bad chest infection. I've been diagnosed with COPD, and it flares up.

I wouldn't know unless it had come through the Hospital Alcohol Liaison Team. I only found that out because I was that poorly I got taken to hospital a while ago and then she came around. I *could've done with it a long time ago, but I'm getting there now and it's fantastic. When I was first approached, the service was clearly explained to me. I've got more confidence, I'm a bit more myself, I can do things myself instead of relying on other people.*

I've got 2 different team workers; they help me to be more independent and learn how to deal with things. I am put in touch with them either once or twice a week. If I've got any problems or issues, I've got a contact number that I can always phone up, and I can always text or they'll phone me back. Sometimes we just get a coffee, and we have a walk around and we chat about things and it's just good to get out and talk about anything in general. And it picks me up quite a lot.

I have a bit more confidence in myself, I've got something to aim for. Because beforehand, I didn't have any confidence. It's about learning again. It's like learning to ride a bike. Some people don't know the support is there or some just don't want to get involved, but I'm the sort of person that wants to change my lifestyle. I think there should be more advertising of the service. It's changed my life around. It really has. I can't thank them enough for it. I've got all the confidence, a bit more self-esteem. Absolutely fabulous.

Stockport

A: Overview

*Table 1: Overview of **Stockport** HIU Programme*

Launch date	October 2020
Host organisation	British Red Cross
Location(s)	Stepping Hill Hospital
Team	HIU Lead Community Connector
Estimated number of service users to date	47
Number of people interviewed:	
Stakeholders	5
Service Users	2

Regional context:

Prior to establishing Stockport's HIU service, there was no other similar service in place for frequent users of A&E in the town. There was an outreach team and a community alcohol team, however they were limited in the type of support they could provide. The impetus for setting up the HIU service in Stockport came from staff working in commissioning, mental health and urgent care attending the 2019 NHS RightCare conference at which the service was presented. It was felt locally that frequent users of urgent and emergency (U&E) services required a holistic approach to supporting them, as opposed to a model consisting of only medical interventions. Around the time of setting up the HIU service, a procurement procedure was in place for a daytime Safe Haven and a 24/7 mental health crisis telephone line, as these had been identified as areas of significant need. Stockport had one of the worst performing A&Es in the country, however the urgent care team at the main hospital, Stepping Hill, did not have the capacity to support a new project. As a result, the HIU service was commissioned from a mental health perspective to address people's underlying mental health issues. Rhian Monteith, the NHSEI HIU Lead, signposted the mental health commissioner at Stockport CCG to potential local providers.

HIU Programme Delivery:

The Stockport HIU service is funded by Stockport CCG, via mental health funding. Additional funding was sourced through a bid for Service Development Fund money from NHSEI, ringfenced for providing crisis alternatives to A&E. Funding is currently in place until April

2022; there have recently been discussions in place to retain funding for a further two years, as well as providing funding for an additional member of staff. The HIU Lead was recruited in May 2020, working 0.6FTE, however the first referral list from Stepping Hill Hospital (SHH) was not received until October 2020. Before commencing in their role, the HIU Lead was required to complete mandatory BRC training, and received one-to-one coaching support from the HIU Lead.

The Stockport HIU service also has a full-time Community Connector. Initially when allocating service users to a member of the HIU team, service users anticipated to require the greatest levels of support (having attended A&E more than 50 times) were passed to the HIU Lead, with the Community Connector working with those who attended A&E fewer than 20 times. However, this was later changed; at present, both the HIU Lead and Community Connector visit all new referrals together. A decision is then made as to who is best suited to work with a particular service user and should therefore manage the relationship going forward.

The service then aims to provide a:

> *"De-medicalised, de-criminalised and human approach to better meet the needs of people who attend A&E regularly."*

The target of the Stockport HIU was to work with 50 service users over a 12-month period, achieving a 40% reduction in A&E attendances, hospital admissions and ambulance conveyances.

Initially after being hired, the Stockport HIU Lead networked with other agencies in the area to find services that they could refer service users to, including drug and alcohol support, intensive mental health support, housing associations, debt management agencies, and community groups. The Stockport HIU Lead credits their previous experience working in this sector as key to knowing what support services are available to the service's users.

Although the Stockport HIU service is hosted by the BRC, they are provided with NHS mail accounts to ensure that they can communicate personally identifiable data with healthcare partners, securely.

B: Service User Pathway

Identifying service users

Referrals to the HIU service are currently received from SHH A&E. Every three months, the business intelligence teams send the HIU Lead a list of people who have attended A&E more than five times in the past three months. The Lead then identifies the patients who are suitable for the programme, excluding under-18s, those who live outside of Stockport, those attending A&E for end-of-life issues, and people having an acute mental health episode. The Lead then ensures that the correct information sharing and consent is in place. To maximise the impact of the service, the HIU Lead selects patients who they feel are most likely to engage with the programme and benefit the most.

So far, c. 50 service users have engaged with the HIU service. Just under half of these were live at the time of undertaking this case study, with the remainder having fewer, infrequent catchups with their HIU worker. Generally, patients are reported as receptive and happy to take part in the programme, with many grateful to have a chance to receive extra support.

B: Service User Pathway

Identifying service users

Referrals to the HIU service are currently only received from SHH A&E. Every three months, the Stockport HIU Lead receives a list of people who have attended A&E more than five times in the past three months. The Lead then identifies the patients who are suitable for the programme, excluding under-18s, those who live outside of Stockport, those attending A&E for end-of-life issues, and people having an acute mental health episode. The Lead then ensures that the correct information sharing and consent is in place. Due to capacity limits on the service, the Lead selects patients who they feel are most likely to engage with the programme and benefit the most. As the list is retrospective, this has created some issues with the information being out-of-date. A further issue is that the referral list only includes the person’s age and not their date of birth, which is often required when working with partner and referral agencies.

So far, c. 50 service users have engaged with the HIU service. Just under half of these were live at the time of undertaking this case study, with the remainder having fewer, infrequent catchups with their HIU worker. Generally, patients are reported as receptive and happy to take part in the programme, however more recently some patients have declined to take part as the referral was out of date, and the service user felt it was no longer needed.

Personalise:

When first contacting people referred to the service, the HIU Lead or Community Connector will initially telephone the patient. If they consent, a convenient time is arranged for both the HIU Lead and the Community Connector to visit the service user at home. The non-clinical, relaxed approach, where service users are given time to chat, is cited as a key reason as to why service users engage with the programme. The approach is very different to other medical appointments with set time limits and narrow scope. It can take multiple home visits before a service user agrees to join the service, which takes a lot of time and resources that other services are unable to provide. During the home visits, staff try to understand the difficulties the service user is having and begin to determine, if there are obvious services, what services the person may benefit from. Such services may include drug or alcohol dependency support, debt management agencies, the housing association, voluntary and community (VCS) services and mental health support organisations.

The HIU service builds a relationship with the service user based primarily on trust. Staff set clear boundaries with service users as to when they can be contacted and for what reasons. The staff interviewed stressed that if they had set an appointment time and thought they might be late; they would always ring the service user to let them know. Another key role for the HIU service staff is communicating with healthcare, social care, and community teams. This ensures that everyone involved in the person's care is aware of any other issues they are having and what is being done to manage them.

The service user and HIU worker typically meet weekly; these meetings can take place at an agreed location, including the service user's home, a local café, a mental health drop-in, or in a local park. During these staff-service user meetings, the HIU worker will get to know the patient – not just their challenges, but also their interests. Rather than focusing on something that they would like to be doing now, they will discuss what they have enjoyed in the past or an aim they have for the future. The HIU worker will then find and suggest a community group, such as gardening, art or chess, that may interest the person, and if they agree, both will attend the group until the service user is confident enough to attend alone. Aside from making community connections, the HIU worker also acts as an advocate for the service user. Some service users have been 'written off' by services as being aggressive or hard to work with. The HIU worker can step in and contact the service user's GP, specialist or housing association to request an appointment or change to their medication, with the consent of the client. HIU workers also organise for transport to enable service users to attend appointments.

Impact of COVID 19:

During the COVID-19 pandemic, restrictions meant that although staff-service user meetings could continue as an essential service, they had to be outdoors. It was challenging to find outdoor spaces that had the required privacy to discuss the service user's personal circumstances.

Through the pandemic, BRC also organised for people to be given, and learn how to use, low-cost smart phones or laptops to enable them to keep in touch with family and friends.

De-escalate:

Service users can contact their HIU worker on their mobile, via call, text or email, whenever they wish. However, it is explained when joining the programme that they will only receive a response during the usual work hours of their HIU worker. For some service users, they can be given targets to contact their HIU worker less, instead using an alternative support service, such as a mental health drop-in or attending a community support group.

When a service user goes into crisis, the team enact their safeguarding policies and contact relevant agencies such as the police or social services. The HIU service is not a crisis management team, so they will typically step back when the service user is in crisis and resume contact when the service user is ready.

Discharge:

The average duration of support for service users with the Stockport HIU service is between two and six months. Initially, the team established that 12 weeks of support should be the standard, however this was found not to be realistic. After this time, if all the necessary support is in place for the service user, such as hospital transport, housing, benefits or community groups, the HIU worker can begin to reduce their contact with the service user. In the Stockport service, they do not use the term discharge as this can have negative connotations for the service user. Rather, service users are told that whilst they may not have regular contact with their HIU worker anymore, they can contact them at any time.

Managing relapse:

The HIU service continues to receive data about the service users after they are not seeing them as regularly, so that if they are not receiving the support they need, this can be re-established. One example of this is for mental health support; the waiting list for NHS or low-cost counselling can be over a year. This can be a sticking point for some service users who don’t require support from the HIU service but would benefit from mental health interventions. In some cases, HIU staff are able to signpost the service user to alternative mental health support provided by the voluntary sector.

C: Outcomes

Patient experience:

Many of the service users have often lost contact with friends and family; this was further exacerbated during the COVID-19 pandemic when other forms of social support were stopped. Social isolation can contribute to high usage of health services for many service users, as they have very few other people that they can contact about their worries. As such, the HIU service reconnects people with community groups which improves wellbeing and strength- based recovery. Out of the 47 people the Stockport HIU service has worked with, several have been able to return to voluntary or paid work after being supported by the programme. The experience of service users is further explored in the case studies below (section E).

Staff experience:

The HIU team find it very rewarding seeing the changes in the people they work with. Due to the nature of the work supporting service users with often complex support needs, they also have access to a psychosocial team who they can ring for support.

Health care services:

The HIU service and the support provided to service users resulted in significant reductions in ED presentations, non-elective attendances and ambulance conveyances, based on activity in the three months pre and post HIU intervention. The figures below are for the third quarter of 2020/21, reported by the BRC.

Table 2: Impact on acute hospital activity and financial savings following HIU intervention for Q1 2021/22

Service type	Activity after intervention	Financial saving
Emergency department attendance	66% reduction	£19,278
Non-elective admissions	63% reduction	£25,968
Ambulance conveyances	100% reduction	£9,408
Total		**£54,654**

D: Learning

Enablers of success

The initial support from the national HIU Lead through one-to-one coaching was key to establishing the HIU service in Stockport, as they were able to provide advice and guidance to establishing and managing the service.

While the team in Stockport only has two members, their flexibility in being able to work with the service users' schedules is a key enabler.

The HIU Lead and Community Connector both have significant experience working in this area, which has enabled their networking and knowledge of the services available in Stockport. These relationships with other agencies enable greater multi-disciplinary working and ensure that everyone involved in a patient's care is aware of their current needs. Staff also cited good leadership from the service managers and the commissioners as an enabler of success.

Barriers to success

A significant challenge that the team in Stockport has faced – particularly through the COVID-19 pandemic – has been ensuring that their service users are seen promptly by local agencies after being referred there. Mental health services have been particularly stretched in the area, with some VCS services increasing the threshold at to which they will accept a referral in response.

Information sharing was initially a challenge for the Stockport service, with data sharing between NHS and non-NHS organisations required. This was mostly overcome by the BRC demonstrating how they had overcome information sharing challenges in other projects. However, some issues remain, including the fact that the list of referrals can be out-of-date by the time it is received by the team.

There was a gap of five months between the HIU Lead being in position and the first referral list being received. This meant that it was harder to prove the benefit and worth of the service to commissioners, as there was limited data available.

The lives of some of the service users referred to the HIU team can be chaotic. Some service users may not have a mobile phone or telephone number, and others may not be willing to engage with the service. It is therefore key that the staff select the right patients who are most likely to benefit from the support provided by the HIU team.

Next Steps:

The Stockport HIU service has several ambitions for the future. These include:

- Increasing the types of organisations that can refer to the HIU service: this would enable people who are at risk of becoming high intensity users of health services to access the support they need sooner, with staff working across the whole of the crisis pathway;
- Embed the work of the HIU service into the crisis pathway: when support is tapered off from service users, ensure that there is an enhanced case management team. This approach would aim to work more effectively with the police and other adult support services and make the work of the HIU team more visible;
- Implement an additional member of full-time staff to increase the capacity of the service.

E: Service User Stories

Service User 1: Pseudonym - Peter

I was approached by the Red Cross after frequently visiting the hospital. I have always worked, and it has only been I the past year that I've had these significant health issues. I didn't know the Red Cross supported this sort of service, but it has been invaluable.

I have had type one diabetes my whole life, and this has been hard to manage. Due to not being able to leave my flat, I haven't been able to exercise which has only made matters worse. Over the past year I have had several illnesses requiring admission to hospital. I have found my GP to just prescribe me medication and leave me to get on with things. When I have rung my GP it has taken weeks for me to get an appointment. I had been told that I would be put in touch with a social worker, but this never happened and then the people from the Red Cross came.

The Red Cross visited me at home and asked what kind of support I needed. Anything I have asked for they have been able to help me with. The staff ensure that all my information is linked up with the hospital staff. I have never had to sign-on before, but the Red Cross are supporting me to access the benefits I'm entitled to. I can't read or write, so their support is a massive help. They have also supported me with my housing situation, helping me to relocate into a downstairs flat. This has been important as due to my Type 1 Diabetes, I can't walk up and down stairs at the moment. The Red Cross have supported me with transportation, helping me to get a bus pass, as well as organising for an ambulance to come to my house to take me to my hospital appointments, as I have a lot at the moment. The service has also connected me with a psychologist who supports me with my mental health. My case worker has also advocated for me when I have needed my medication changing due to the side effects I'm having. Their support has meant that I haven't needed to go to A&E as frequently, because they stop the problems worsening and get me the help I need.

"I don't know how I would have made it through without them…she [Peter's case worker] always puts a smile on my face."

Service User 2: Pseudonym - Carol

I've lived in Stockport for 15 years. I was approached by the British Red Cross at the start of the year, after I went to A&E 12 times in three months.

I had been struggling with my mental health, feeling suicidal, and didn't know where else to go. A&E wasn't helpful, as they would put me in a room, send the crisis team in and then send me home. I also visited my GP a lot, but they didn't know what to do with me either. I felt constantly judged by staff in the health service. It's been really hard.

When the British Red Cross contacted me, they came out to see me and explained how they could support me. One thing that I do with my HIU worker is go for dog walks, which has really boosted my confidence in leaving the house for other errands and appointments. I have joined several groups for activities like art, music and gardening. The support I get from the British Red Cross has meant that I don't feel that I need support from my mental health team, and my diabetes is better controlled now too. When I have a problem, I can speak to my HIU worker and they help me get through it.

"I think they're [the HIU team] absolutely amazing and they should get more praise than what they're already getting."

Chelsea and Westminster

A: Overview

*Table 1: Overview of **Chelsea and Westminster** Next Steps Service*

Launch date	October 2020
Host organisation	British Red Cross
Location(s)	Chelsea and Westminster Hospital; in partnership with the Psychiatric Liaison team.
Team	HIU Lead, Community Connector, Team Support Worker
Estimated number of service users to date	99
Number of people interviewed:	
Stakeholders	4
Service Users	2

Regional context:

The Psychiatric Liaison team at Chelsea and Westminster Hospital (CWH) identified that there were a cohort of individuals who were referred to liaison psychiatry with mental health needs, but for whom an unmet social need was the underlying factor contributing to their presentation. These underlying social issues are often complex in nature and include themes such as substance use, homelessness, isolation, and lack of income. The service has therefore been designed to provide holistic support for anyone who attends A&E and is then referred to the Psychiatric Liaison team. Within the hospital, it is known as the 'Next Steps Service', as it provides the next steps for the service user once they've engaged with Psychiatric Liaison services at CWH.

This model differs from the standard HIU approach, as service users do not require a certain number of presentations at A&E to be referred into the service, but it uses all of the methodology in approach and principles. Prior to implementing the service, readmission data and presentations to the Psychiatric Liaison team were reviewed to understand the need. The aim of the service is to tackle the underlying causes of presentation to Psychiatric Liaison, and hence prevent service users from becoming high intensity users. This is a cohort of service users who are often unaware of the wider support services available to them, do not know how to access such services, or face additional barriers, such as digital exclusion.

Prior to the introduction of the Next Steps service, there wasn't a formal process for service users referred to Psychiatric Liaison to be socially or practically supported following their discharge. The Psychiatric Liaison team would signpost service users to other support services but they felt there was a need to provide more reliable and consistent follow up support which was delivered within their own service. The Next Steps service is designed to deliver a more practical style of support alongside or following their discharge from Psychiatric Liaison. The support is strength based and goal orientated, using a personalised support plan to identify how best to support service users to live independently in the community and feel fulfilled with their life. The support is provided through individual case work which can range in length anywhere between 1-12 weeks depending on the complexity of the social needs, and the time required to address these difficulties.

HIU Programme Delivery:

The service is hosted by the British Red Cross (BRC), who also run a separate project at Chelsea and Westminster, providing Assisted Discharge support to the acute hospital and a further HIU projects in neighbouring boroughs The Next Steps service has been funded by Liaison Psychiatry at Central and North West London NHS Foundation Trust, initially for twelve months and has now been extended by a further six. The funding secured a team of 2 x FTE, which includes the Service Lead, a Community Connector and a Team Support Worker. The Service Lead manages a higher-risk caseload and works with a greater number of service users (approximately 15), in conjunction to providing oversight, managing relationships, gathering data and evaluating the service. The Community Connector and Team Support Worker both work part-time and manage a lower-risk case load and fewer service users (approximately 6-10). The Service Lead is communicative with the team about their caseload intensity, to ensure that the workload is manageable and adequate support is provided. The service is flexible in the number of active cases, which enables them to sometimes take on shorter-term interventions or more preventative work where appropriate.

The team have diverse experience working in health and social care, included volunteering with the BRC and the NHS COVID response. The Service Lead has previously worked as an emotional and wellbeing practitioner in children and young people's mental health services. The Lead identified the key skill set for the role as: being able to form positive relationships with service users and community partners, working in a person centred and flexible manner, being able to work under pressure, respond calmly in a crisis, have a good understanding of safeguarding and risks whilst balancing competing priorities and responsibilities.

The model was described as:

> *"… trying to help people integrate with the community and help them work out where their support base is and if they don't feel like they have one, helping them find one."*

The service users leaflet further states that:

> *"We can provide you with practical support, such as booking and attending appointments, and social support to help you connect with groups, services and activities within your community."*

B: Service User Pathway

Identifying service users:

The referral process for the Next Steps service varies from the standard HIU model. As opposed to a quarterly list, the team receive regular referrals live from the Psychiatric Liaison team when they believe that a service user in their care has an underlying social need that they would benefit from support to address. It is worth noting that these unmet social needs would be those that do not meet the threshold for adult social care intervention. An example of this might be if a service user is not registered with a GP and they do not know where or how to register, or they are presenting as suicidal because they have become unemployed and don't know how to access financial support from the benefits system. Many of the service users are referred following their first or second presentation at A&E. The team can support the service users showing early signs of crisis and work to prevent them becoming a high intensity user.

The referral to the Next Steps service will be made via email, or the team will receive the referral verbally in a morning handover or throughout the day in the office. The HIU Lead attends the Psychiatric Liaison Multidisciplinary Team Meetings (MDTs) where all service users are discussed to identify individuals who are suitable for the service. This conversation provides a very good understanding of what the team can do for the service user and what the remits are amongst the team. The Next Steps team share an office with the Psychiatric Liaison team and have built strong working relationships with nurses who refer into the service. This is beneficial for service user engagement, as the service user is made aware of the service from someone that they trust. The Psychiatric Liaison team gain verbal consent from anyone they refer into the Next Steps service.

Due to the nature of this live referral process, the referral numbers can fluctuate day by day. The criteria of an 'unmet social need' is purposely broad, allowing the team to be flexible in who they support and assessing each referral on an individual basis. The number of service users per case worker depends on the intensity of the caseload and is not prescriptive, which is consistent with the model that the Psychiatric Liaison team already work to. Referrals may be considered less appropriate for the Next Steps service when there is a lesser need for such personalised support, however referrals are rarely declined as there is usually a benefit to even a one-off session to offer support or signposting.

The Next Steps team have access to SystemOne, where they can view the relevant service user information and clinical notes to check that referrals are appropriate. Before approaching the service user, the case worker will complete a risk assessment form which details any mobility and communication needs, risk to service user, risk to staff, suicide attempts and self-harm, to further ensure that the referral is appropriate for the service. The psychiatric nurses will also send over notes and discuss any risk with the Next Steps team.

Personalise:

One key performance indicator for the service is that contact with the service user from the Next Steps team is made within 24 hours of the referral. Usually this will be a phone contact where the case worker might arrange to see them in person in the coming days. This is flexible depending on the service user need. For example, service users who have only recently come out of A&E may need more time. If the service user is still at the hospital, the case worker will make first contact on the ward, which helps to build rapport from the outset.

Every intervention is different as the service is centred on individual need. The service aims to provide support for 4 to 6 weeks, with the possibility of an extension. This would usually involve one visit from their case worker per week. The average length of time is approximately 30 days, however this can range from one meeting to longer support (up to 3 months). When the service user is first approached by the Next Steps team, the case worker will make them aware that the service provides up to 6 weeks of support, whilst keeping in mind that an extension could be introduced. This is shorter and more focussed than the standard HIU model.

Support is provided in a very person-centred way. The first contact with someone is set aside as ‘listening time’; to understand what's going on, what the underlying issues might be, and what the service user would like to be done. There is an understanding that these are potentially individuals who haven't formed good relationships with other healthcare professionals. The case workers seek to understand the service user’s life experiences, their environment, their social and economic standing, their culture, their hobbies and interests, in order to better understand their behaviour and build trusting relationships. One of the case workers speaks multiple languages which has enabled the service to support more people who face language barriers to healthcare.

Following this initial conversation and/or first meeting, the case worker will then develop a personalised support plan with each service user, considering any short-term and long-term goals which the service user might have. There is a focus here on what the individual would like to achieve from the service:

> *“A big question we sometimes ask is, 'What do you think are the most important things to address first?' Honestly, when you've sat with someone for 3 hours, someone who's*

> *really, really in social deprivation, and has been in social deprivation for the last 40 years, since they arrived in this country, and they sought asylum, and they've never integrated, they don't speak the language very well, they don't know their finances."*

The service commenced at the beginning of the pandemic which presented additional challenges. There were many 'unknowns' and new-found considerations such as office occupancy, types of delivery (face-to-face or telephone) and access to technology. The influx of service users into the Psychiatric Liaison Service fluctuated throughout the pandemic, which impacted on case numbers. Despite the fluctuation, the Next Steps service consistently received incoming referrals and have operated around full capacity. The Next Steps service were able to deliver face to face support during the pandemic due to being regarded as key workers and always practicing within government guidelines. Where many vulnerable and isolated individuals had struggled to access virtual/digital support throughout the pandemic, the team could still meet service users face to face if they wished to do so. The most significant impact of Covid-19 was the challenges it created when making onward referrals to other services, many of which had limited accessibility due to the pandemic.

De-escalate:

BRC have access to many different professionals, charities, organisations and community groups, meaning that support is varied and service user centred. This includes befriending services, accommodation services and food banks. In some cases where abuse has been reported, the Next Steps Service Lead has worked closely with the police as well as adult social care. The case workers can also provide coaching to help service users interact with healthcare professionals. The team have built a good relationship with the local drug and alcohol service, who are able to provide advice to case workers. However, within the 6-week model it has been more difficult to engage with service users with substance misuse issues.

The direction of support is led by the service user. The case workers will help them set small achievable goals and focus on these, with the aim of getting them onto the right path and helping them feel empowered to make a difference in their life themselves. Connecting the service users with a support group is described as key:

> *"I think as soon as you manage to help them get to a support group, that's where loads of things will start for them without really needing to rely on someone."*

The case workers are available to contact during working hours from Monday to Friday. This was found to be the most effective time in order to align with other services such as GPs, food banks or employment agencies. The service user is made aware that Next Steps is not an emergency service and case workers will ensure that service users are aware of who it is that they can contact in case of an emergency. Everyone who has been through Psychiatric Liaison is given a crisis plan. The case worker will go through this with the service user to ensure they know who to contact if they require medical or crisis assistance, and when it is appropriate to make contact with which services. This includes understanding which phone numbers to use in a crisis, including their Single Point of Access number, Samaritans, emergency services and adult social care.

Discharge:

The case worker will evaluate the service user's progress through the duration of the engagement by looking at their goals and how they are achieving them. They aim to complete an interim review at 3 weeks and a 'goal review' when the service user is discharged, where they will discuss the progress that has been made and address that the support is ending. The length of intervention is varied, however there is a clear focus on reaching an endpoint. On discharge, the caseworker will usually already have signposted and connected the individual with other services and activities which will provide further support or structure moving forward. These services might be charitable organisations, social groups, community activities, leisure/exercise facilities, a mental health service or their GP. A number of service users will also have been connected with a support group which provides someone to talk to, preferably including a peer element whereby support is delivered amongst peers and not just from professionals. This community connection and sustainability is a key aim of the project. The service has collaborated widely and considered a variety of options for discharging clients to the most appropriate services including but not exclusively; The Listening Project, NHS Responders, Age UK, Victim Support, MenCap advocacy, and Chron's and Colitis charity.

> *"Even if their goal hasn't necessarily been achieved, they feel like they're on the pathway there."*

With service users who are considered more at risk or who are more likely to return to accessing emergency services if their needs are not met, the case might be left 'open', meaning that the service user can reach out to their case worker if they are still finding it difficult to connect with the right services.

Manage Relapse:

Although this is not a service exclusively for people with high use, a small percentage of service users have presented again at A&E after being discharged from the service. The service aims to prevent relapse by ensuring that service users have a support net if they experience crisis:

> *"Our big focus is to make sure that they know where to find information, that they have confidence and feel in a place that if they are in a bad situation, they know who are the people to contact, so that it doesn't ever get to that dire situation which they just have no idea where to turn to."*

C: Outcomes

Service user experience:

Service users are supported to address basic needs which helps them to lead a happier and healthier life. As a result of the service, service users have developed confidence and are connected with support within the community to prevent crisis. The team routinely collect qualitative feedback from service users through a feedback form and interviews.

A large benefit for service users is having someone to talk to without judgement, as described here:

> *"You can tell when you work with someone 1-on-1 and you can hear just a change in attitude. When someone starts at the beginning saying they feel suicidal and near the end, they don't feel like that at all now, you can tell that it's having a benefit."*

Staff experience:

Working as a case worker is described as both challenging and rewarding. Case workers are encouraged to work autonomously with their cases, which improves job satisfaction. There is good level of support in the team and case workers feel they can reach out to their support groups and colleagues if needed.

The team have a shared document where they add anonymous quotes from service users, such as '*I will give you 1000 out of 10 as all my goals have been achieved. Thank you for your help, you saved my life'*.

This isn't part of a formal evaluation but provides valuable encouragement for the team and evidence through the words of service users, how they feel towards the support they have received.

Health care services:

The case workers directly interact with acute services and various healthcare professionals which has encouraged collaboration and integrated working in Chelsea and Westminster. The service further reduces pressure on the Psychiatric Liaison team, as they are able to refer into the Next Steps service for support with making onward referrals, and where the remit of their role as a liaison team does not enable them to address the underlying social issues underpinning the individual's presentation. The Red Cross team enables the Psychiatric Liaison team to discharge patients to a trusted service which ensures an additional layer of support is in place.

Cost-effectiveness:

This service was commissioned directly by the Trust (and hence not interested in tariff savings and more focussed on relieving staff capacity, prevention and use of non-clinical support to allow people to recover, with holistic support. More work is needed to understand the cost effectiveness of the service. The service has been operating for less than 12 months which has made it difficult to interpret current re-admission rates.

D: Learning

Enablers of success:

Next Steps workers having previous experience of working in similar roles such as mental health services and coaching has been advantageous to the service, but interpersonal qualities were perceived as paramount. These include being empathetic, compassionate whilst understanding boundaries, being reflective and having an open approach to learning and development. The informal recruitment process ensured the panel got to know the candidates and understand their motivations. Next Steps case workers were described as being able to work under pressure, balance competing priorities, respond calmly in a crisis, manage challenging conversations and responsibilities and demonstrate a good understanding of safeguarding and risks. Case workers are also encouraged to be creative within their role, finding ways to work in a way that suits the service user needs and which will enable positive engagement and progress. They are encouraged to be flexible and creative whilst always practicing in line with BRC policies and procedures. With additional funding, the service could benefit from an extra case worker.

The team described the service lead has having good interpersonal skills, being proactive and being invested in the service. The service lead was perceived as a key enabler for the service by the Next Steps team:

> *"The service lead is the most amazing talented person. I've never been so respected and in awe of someone that does their job. She just puts her heart and soul into it and not only does what she has to do, but beyond."*

A collaborative approach was taken in the design phase of the service between the commissioner, Next Steps team and Psychiatric Liaison team. The team manager for the Psychiatric Liaison team had previously set a good foundation for the service and having a shared office has encouraged greater collaboration between them. They have an 'open door policy' allowing the Next Steps team to ask questions and communicate openly about any individuals that they are working with. The Next Steps team shadowed the Psychiatric Liaison team for two weeks to understand the service, including types of service users they are working with, processes in the acute hospital, assessments, referral routes and shifts patterns.

The Next Steps team also aim to develop good relationships with community services before referring service users to them. With the service user's consent, the Next Steps team will liaise with other professionals involved in a person's care, in order to provide joined up and holistic support.

The Next Steps team completed BRC's mandatory training including safeguarding, data protection, professional boundaries and lone working prior to the service commencing. The Psychiatric Liaison team provided training regarding IT systems and internal data bases. Additional training was also offered, such as mental health training, psychosocial support, trauma informed training, and working with refugees.

Whilst setting up the service, the Service Lead had weekly coaching with the HIU Lead, Rhian Monteith, to discuss implementation, cases and concerns related to the service. HIU network meetings, where HIU staff come together nationally provided another opportunity for shared learning. The Community Connector and Support Worker were mentored by the HIU Lead and all of the staff follow the BRC learning pathway for HIU. Staff are offered the opportunity to shadow the Next Steps Lead whilst working with service users. A key consideration for the service is reviewing the career pathway for the Next Steps team and providing appropriate training to ensure staff retention.

From the outset, the team adopted a flexible and iterative approach to planning and implementing the service. The ambition is to continue with this open approach; the team will not hesitate to make changes to the service if aspects of the service no longer work. Collecting frequent feedback from the Psychiatric Liaison team and developing trust and good relationships between the teams has enabled them to work together to continue to improve the service and innovate.

Barriers to success:

The service takes referrals from across London which is not exclusive to Chelsea and Westminster borough. This means it is more difficult to build up connections with community services within a specific geographic area and home visits to different borough can take a significant amount of time.

People dealing with alcohol addiction are typically harder to engage with the service and are more likely to miss appointments. These service users are believed to have deep seated issues that need to be uncovered and worked with for longer periods of time for the service to be impactful. Trying to connect with service users who are disengaged can be time-consuming, especially as they receive new referrals on a daily basis.

Next Steps:

To develop the service, there is a need to put more resources into data collection and evaluating the service. The service does not have any set plans for development, however it is felt that the next steps for the service to grow should be developed by the current team, in a bottom-up way. The team are discussing the value of employing an additional case worker to work specifically with the HIU cohort.

E: Service User Stories

Service User 1: Pseudonym - Farhad

I'm 45 years old and I'm living by myself. I came from Iran and I've been in England for 21 years. I have sisters here and know some people here but they don't care about me. They don't want to see me, so I'm lonely. All the time I'm just outside because I don't want to stay at home. I just go to a park, walk in the street or sit somewhere on a bench.

I was first approached by my support worker two months ago, maybe. I didn't know anything about the service. Slowly I started to understand that they're here to help, they're here to listen to you, to hear what you have to say, and find a solution. She texts me, asking about my situation, how I'm doing, what I'm doing. It's good, knowing someone cares about your situation.

My health was very bad and I didn't have any hope. I didn't think I have a future. I didn't know how to speak to the doctor, how to go, where to go, who I should ask, who I should tell my problem. Which was getting worse day by day before I was introduced to the service. Before that, I didn't contact anyone because I don't know what to say. Sometimes I don't understand English, like speaking on the phone, usually I don't understand what they say. I just guess the letters and some of the words and then I can answer but sometimes it's not the right answer. Sometimes I misspeak everything, I don't understand, I get confused.

During the pandemic, people can't come and stay with you and you feel more lonely. This pandemic makes some people sick, and I was one of them. I got really sick. I was scared from this situation, and I got more sick. It's a very hard time. Sometimes when you're weak, it's going to make you weaker.

I was nervous and I didn't know what to do so l I went to A&E asking for help, and one doctor referred me to this service. When I started to meet my support worker, they talked to me and they gave me hope. It was good for me getting their advice.

They told me sometimes you need someone to help you. Yes, she helped me. She joined me in the meeting by phone and on Teams to help me with my problems. They told me if I didn't know how to speak, they would help me to explain. I didn't know what to say to be honest, but my support worker helped me to put me in the right way.

If you have any problem, they listen and they try to help, so I'm happy with them. We have phone conversations and meet outside. They didn't come to my place, but they will meet me outside the hospital, or they phone me and send me text messages. We just had a chat this week. Most of the time we meet each other in the morning, after 10 o'clock. Sometimes on the phone we speak in the afternoon or in the evening and she'll say 'We have a meeting next week', or, 'How are you feeling today'? She is always someone who cares about you. She listens to you; she gave me advice and she has tried to help me a lot. I was listening to them, and I always try to do whatever they say to me. They helped me to try to do these things. Forget about the past and try to go back to the right thing. We have had some good conversations which is helpful. It gives you hope and makes you happy.

They show you the right people and they try their best. They sent me to the right department everywhere. They gave me the right, good information. She was helping me to find my way. For me, they try. If it doesn't happen, you can't blame the organisation because you tried your best, I think.

I'd like to continue with the service. If I have any problems, then the only person that knows right now is my support worker. If I have any problems then I will call her. That is the only person that I can trust, and I know she can help me. I'm going to the GP soon. I'm still in the same situation but at least I have hope. So, I hope that good things happen in future.

Speaking to my support worker, I felt safe. Someone who understands me, someone who listens to me, and knows to help me by heart.

Service User 2: Pseudonym - James

I'm 28 and currently living in shared accommodation. I was teaching English in China before the pandemic and then I came back. I now work in Argos.

I've had Crohn's since I was 10. I have to go to hospital everyday to receive IV fluids and I have carers coming every day to help me with my stoma bag. It's a disease as much as chronic stress because I'm dyslexic, and I'm trying to get my ADHD diagnosed, I'm trying to get an assessment for Asperger's. I have all these medications for my Crohn's, when the cause is stress from having loads of mental learning difficulties, which are not being addressed. That doesn't make any logic. When I was about 16, a doctor suggested I see a psychologist, but my mum wouldn't allow it.

In primary school, I was on the special needs table. Then when I was a teenager, I was basically mute. I didn't speak in so many situations in school and no one was picking up on that stuff. I went to a very traditional high school and because my grades were good, they wouldn't help me with my dyslexia. So, I've almost fallen through the cracks a bit. I did a bachelor's in engineering, but my health was so bad, I didn't want to continue with it. I tried to go back to school but then I'm trying to tell the teachers what ADHD is or Asperger's is and they just laughed at me. When

I'm around people I'm trying to just chat, blend in, trying to be happy and stuff and it's exhausting.

Growing up at home, my dad has anger problems and quite violent. Things would get broken and damaged, we'd get beaten and bullied. When you're a kid, you're just sitting there in a constant state of worry. I'm now speaking to a psychotherapist about this.

There's just no help, I don't know what I need to do. I've been telling people for a long time but because I'm an adult it seems like it's much harder to get any help. The waiting list for adult services in mental health is very long. I tried to get a diagnosis for ADHD about 3 years ago. I kept calling for months and then it just went cold.

The doctors don't really ask what you're like. It feels like they couldn't care in the slightest. With most doctors, it's like, 'What medicines have you not tried? Do that.' They couldn't put two and two together, 'Oh he's dyslexic, he's got ADHD, he's really struggling, he's working a lot harder than he has to, and his body's not coping.' Then you could give me medication and possibly try to refer me to some other help as well, which would help me long-term dealing with my difficulties in life.

I ended up in hospital for 3 and a half months because my intestines exploded. I was eating myself into a pit of unhealthy food. The stoma nurses came every morning. I was telling my nurse 'I'd rather die, I'm not going to go home to my parents.' Because it's so dysfunctional. The nurses were very warm and empathetic. I'd just tell them, 'I'm just absolutely struggling, most of the time I'm living at home with other people who've got autism and are undiagnosed.' They put me in touch with the psychologist in the hospital who put me in touch with the BRC.

When I was approached by the BRC it was relaxed, it was very social, almost like a friendship so it didn't feel embarrassing. My support worker was amazing. She wouldn't just come for an hour, she'd come for a couple of hours, and I was really impressed. We'd usually have the meeting in an open area over lunch or something.

She helped me find the homelessness contact in my local borough. She helped me get my stuff together, move into temporary accommodation and apply for benefits. I've got a bit more confidence now because I'm away from the family. I can have a shot at trying to be myself again. In my accommodation, I can start to give myself a bit of ownership over myself. She wrote an action plan for me and made sure I started ticking things off. She has told me to focus on myself.

She put me in touch with Crohn's and Colitis online meet up groups and I've stayed in touch with a couple of those people which has been really supportive. And because of her, I got this RADAR key, so I can go into any public toilet.

It was just for 6 weeks but she put me in touch with NHS responders relief, so now I've got another carer who calls me a couple of times a week just to check up on me. In this shared *accommodation there is one person to look after ten people. I have still accessed A&E because sometimes I came late for my IV fluids. I just don't want people going through the same experience. I shouldn't have gone through this in the first place. By providing more support, you could probably save the pain and money later down with those expensive surgeries and so on. If you just provide those resources earlier in the supply chain.*

It's been amazing that someone actually listened for once in my life, in my 30 years, someone listens.

Appendix D - References

Dalkin, S.M., Greenhalgh, J., Jones, D. *et al.* (2015). 'What's in a mechanism? Development of a key concept in realist evaluation' in *Implementation Sci* 10, (49).

NHSE (2019). *NHS Operational Planning and Contracting Guidance 2019/20*.

NHS RightCare (2015). *Commissioning for Value: Reducing the Number of High Intensity Users of Unscheduled Services.*

NHS RightCare (2017, updated 2021). *Setting up a High Intensity Use service: an NHS RightCare resource pack*

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