



# SHarED Implementation Guide

Created by



West of England  
Academic Health  
Science Network



University Hospitals  
Bristol and Weston  
NHS Foundation Trust

Supporting High impact users in Emergency Departments

# Acknowledgements

This toolkit was originally created in 2019 for the SHarED project by the West of England Academic Health Science Network (AHSN) in collaboration with the Bristol Royal Infirmary (BRI), University Hospitals Bristol and Weston NHS Foundation Trust.

Revisions were made in November 2021 following completion of the project, based on the experience and practice of the High Impact User Team implemented in the Emergency Department at the BRI and further built upon using learning from the SHarED project. It is intended for use in any ED looking to set up a High Impact User Service.

We would like to thank the team at the BRI for their work in the development of this project.

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# Foreword

By Dr Rebecca Thorpe, University Hospitals Bristol and Weston

## NHS Foundation Trust

I first got involved with this project because our Emergency Department Matrons had recognised there was a cohort of patients coming into our Emergency Department (ED) time and time again, with un-met health needs. Historically, it had always been easier to “patch up” these patients, and send them on their way, rather than addressing the cause of their frequent attendance.

Patients known as “High Impact Users” (HIUs) attend our ED up to eighty times per year. Mental health problems, drug/alcohol use and homelessness account for almost all of the presentations. The group has an annual mortality rate of 15%, with an average age of death in the thirties. Some service users cost £30,000 per person per year in ED attendance and hospital admission tariffs alone.

Service users report that increased ED use is associated with mental health/physical health/housing/personal/substance misuse crisis; they come to the ED because they feel they have nowhere else to turn. When we ask service users about their experience of healthcare in general, they describe health care professionals treating them without compassion and being judgmental. ED staff report that this cohort consumes large amounts of time and resources, and can be distressing for staff and other patients.

Our aim is to provide parity of esteem for all patients in the ED, and this has required an enormous cultural shift. Our aspiration is that a homeless patient attending after being found unconscious from recreational drug use, is treated with the same compassion as a patient having a heart attack.

In 2014, our Matrons set up the BRI HIU service and I was asked to get involved as medical lead. We wanted an innovative system-wide approach which would improve service user experience, support staff, and reduce ED attendances and hospital admissions. We put together the HIU MDT to make bespoke plans for all of our patients. We have now expanded our team to include mental health nurses, a psychologist, a paediatric ED nurse, ambulance and police services, domestic violence advisors, as well as the core team of an ED Consultant, ED matron and HIU Co-ordinators. We now manage the top 250 patients a year.



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# Introduction

This guide has been developed to support the implementation of a High Impact User team within the Emergency Department. It takes learning and resources from the HIU team at the Bristol Royal Infirmary (BRI) team, University Hospitals Bristol and Weston Foundation Team and from the SHarED project, which finished in September 2021.

SHarED is the name of the spread project for implementing the BRI High Impact User model in to other Emergency Departments, led by the West of England Academic Health Science Network (AHSN).

The majority of resources available in this toolkit are made for immediate use; however they may require some adaptation to suit the local implementing site and have been designed accordingly.

All resources are available online at [www.weahsn.net/shared](http://www.weahsn.net/shared)

It may be helpful to look at the Quality Improvement section of the West of England AHSN website: [www.weahsn.net/qi](http://www.weahsn.net/qi)

# PART 1

## Introduction to SHarED

- 1.1 Background
- 1.2 What is a High Impact User?
- 1.3 The impact of the BRI HIU team
- 1.4 The aim of the SHarED project
- 1.5 The impact of the SHarED project



## 1.1 Background

Patients who repeatedly attend healthcare facilities represent between 1-2% of Emergency Department attendances annually. Literature suggests these patients also frequently access other health and social care facilities, generate greater admission rates and have a greater burden of chronic disease.

Furthermore, frequent attendance at Emergency Departments is known to be associated with increased stress and dissatisfaction amongst patients. The mortality rate is double that of the “average” population. This cohort has a higher burden of alcohol and substance misuse, and psychiatric illness.

The Royal College of Emergency Medicine (2017) has published guidance for managing this group of patients including a multi-disciplinary approach with

a senior decision maker reviewing attendances and developing management plans, accessible by all health care staff within the hospital.

In April 2015, the BRI High Impact Users (HIU) Team was formed to tackle this exceptionally vulnerable cohort of patients. The work was initially completed in addition to existing workloads. In 2018 the HIU Co-ordinator role was officially funded to support ongoing work.

In 2019, SHarED was selected as a local Evidence into Practice project at the West of England AHSN. The BRI HIU model was spread and adapted across all Emergency Departments in the West of England, with all teams submitting business cases for ongoing funding at the end of the project.

## 1.2 What is a High Impact User?

**High Impact Users can be defined in a number of different ways:**

1. On the basis of frequency of attendances - The Royal College of Emergency Medicine (RCEM) define a frequent attender as anyone who has five or more attendances to the ED per year.
2. On the basis of impact on the department - anyone who has a significant impact on departmental resources for any reason, including medical and nursing needs, social needs or behavioural problems.
3. A person with a complex medical condition, mental health problem, chronic illness, or a social situation which results in repeat hospital attendances and/or admissions.
4. In the BRI, the term “super user” is defined as a user who has attended the ED 20 times per year or more.



## 1.3 The impact of the BRI HIU team

During the first year of operation at the BRI, the team reviewed the outcomes for the “top 100” frequent attenders and discovered that the mortality rate was 15%; the average age of death was in the forties. Deaths were due to a combination of reasons:

- **Sudden unexplained death**
- **Presumed suicide**
- **Drug toxicity**
- **Medical causes e.g. throat cancer**
- **Hypothermia**
- **Alcohol withdrawal seizures**
- **Recreational drug use**
- **Alcohol intoxication**

This very high mortality rate in a young population is significant. The one-year survival rate in this group is 85%. This is similar to survival rates to some malignancies such as laryngeal cancer, and significantly worse than survival rates for breast and prostate cancer.

Over the first year, a total of 26 patients were discussed and managed at the MDT meetings. Of these patients, 24 had a significant reduction

in ED attendances after intervention, such that they were no longer classified as a frequent attender. Two patients were more complex cases and remained on the HIU MDT caseload for ongoing management at the end of the year. A further 20 patients with predominantly chronic medical problems, were managed by a subgroup of the HIU Team - the ED consultant and specialist teams to produce individual personal support plans (PSPs). All of these patients have significantly reduced their attendances, with no adverse outcomes noted.

A further 50 patients were managed by a combination of ED Consultant, drug and alcohol specialist nurses, and Liaison Psychiatry. These patients are usually those who do not get allocated a space at the MDT due to resource limitation; they have been identified as having chronic drug/alcohol/mental health problems, that could be better supported, in such a way as to optimise their care and avoid ED attendances.

In total over the year first, over 50 PSPs were written. These are reviewed annually for every patient, or sooner if indicated.

## 1.4 The aim of the SHarED project

The aim of the SHarED project was to reduce Emergency Department attendances by High Impact Users managed under the High Impact User Team by 20% and to improve the experience of High Impact Users and Emergency Department staff in one year.

## 1.5 The impact of the SHarED project

During the SHarED project, **146** patients were reviewed by the 5 HIU teams. The final evaluation will be completed by Autumn 2022, however interim results demonstrate improvements in the number of attendances and hospital admissions and on staff experience when managing HIUs.

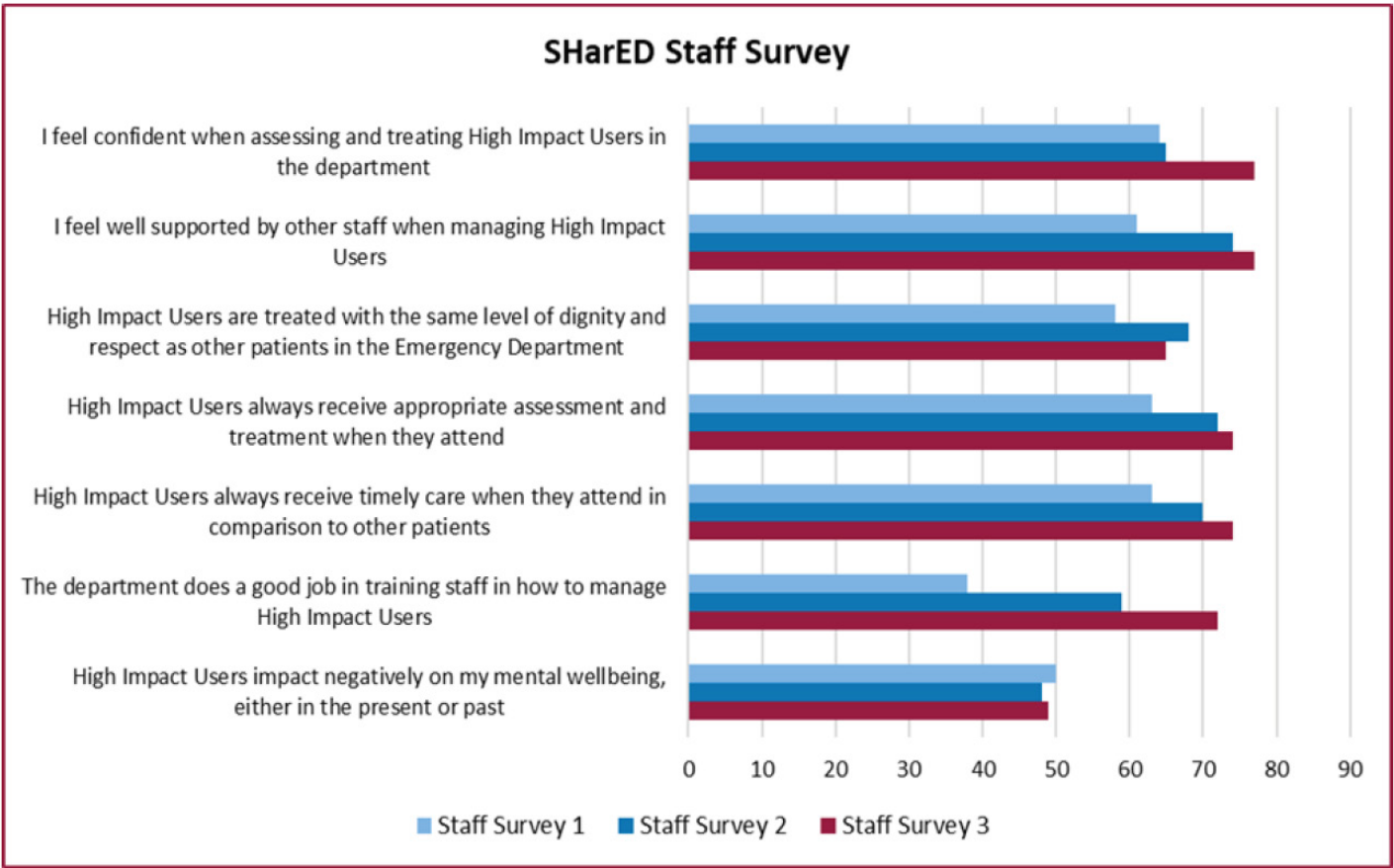
A **43% reduction in the number of attendances was seen following the first month of engagement** for 89% of the patients engaged. For the same 89% of patients, there was also a 61% reduction in the number of hospital admissions.

For the remaining 11% of patients, there was an increase in their attendances of more than 100%. It was recognised that these patients are highly-complex and their attendance will be multi-factorial.

A **staff survey** demonstrated positive improvements that spanned a range of challenges that they encountered with HIU's. On a rating scale of 0-100%, where 100% indicates

strong agreement, ED staff were asked to score themselves and their department on 7 statements on the management of HIUs. For most statements, a higher percentage indicates an improvement. For the final statement, 'I feel confident when assessing and treating High Impact Users in the department', a lower percentage indicates an improvement. This final question was recognised as being the most difficult to influence and did not see an improvement.

Improvements varied across the participating hospitals and the multiple professionals that work in the Emergency Department. The graph below demonstrates the average findings at the beginning and at the end of the SHarED project. Three surveys were complete throughout the course of the project; at the beginning, midway and end.



Throughout the project, SHarED contributed to 361 staff members completing training delivered by the HIU teams on the management of High Impact Users.

The response rate for the first, second and third survey were 25%, 36% and 12% respectively. The final survey was lower than expected due to the Omicron wave of COVID-19.

Staff were most concerned about providing inadequate care and missing a diagnosis, as well as violence and aggressions from some HIUs.

**Feedback from staff**

“The ED do an amazing job to educate staff about high impact users and developing PSP for the patients to ensure a consistent approach to their care.”

“Dedicated HIU teams are making a real difference to the appropriate management of these patients!”  
 The HIU service, and particularly personal support plans, are a great way to empower staff to ensure these patients get the appropriate care while maintaining the safety of the department and availability to provide good care to others.”

# PART 2

## The service structure

### 2.1 The Core HIU Team

### 2.2 Interventions

- a) Referral, triaging and prioritisation
- b) Personal Support Plans
- c) A multi-professional approach
- d) Governance of the Personal Support Plan
- e) Sharing of the Personal Support Plan
- f) Specific interventions
- g) Review and discharge



This section outlines the structure of the HIU team as it is set up at the BRI. When implementing the SHarED model, there may be some variations in your set up to suit your local services. However, the core principles of the structure should be applied.

## 2.1 The Core HIU Team

The core HIU team consists of:

- ED Matron
- ED Consultant
- HIU Co-ordinators (in the BRI, there are two Band 7 whole time equivalents from a variety of clinical backgrounds)
- Administrative support

The extended team may include representatives from Clinical Specialities, Drugs and Alcohol Teams, Homeless Teams, Domestic Violence Workers, Liaison Psychiatry, GPs, Police, Ambulance Services and Safeguarding Teams. It may also be appropriate for the HIU teams from neighbouring trusts to attend.

## 2.2 Interventions

The below interventions are also summarised in the process maps in section 5.2.

### a) Referral, triaging and prioritisation:

Internal referrals can be made to the HIU team via email or through the electronic referral systems. The referrals are then reviewed and prioritised alongside the patients on the list of the top attenders, as described below.

It is recommended that you use a triage tool to prioritise and assess patients appropriateness for the service. In the BRI, the Bristol EDITT tool is used to assess the patient's level of risk and their attendance in the last year. It is important to note that The EDITT Tool has not undergone validity/reliability testing at this stage.

Quality improvement techniques can be used to test the Bristol EDITT in your department and compare local tools. The table below highlights the different elements that were used across the five participating emergency departments, each given different weighting depending on the needs of the local service.

The number of patients on the HIU caseload at any given time is variable and dependent on the complexity of the service users. After patients have been triaged, they are prioritised according to the frequency of the recent attendances and the level of impact on the emergency department, alongside the EDITT Score. (See page 40 for a visual representation of the referral process into the HIU service). Throughout the SHarED project, the teams aimed to triage and prioritise six patients each month.

Whilst acknowledging that patients may not have a fixed address or may have difficulty with literacy, a standardised letter is sent to all appropriate patients along with a questionnaire for them to complete. A letter is also sent to the GP alerting them to the fact that the patient is a frequent attender. A questionnaire is included with the letter to assist the GP in involving the patient in the process.

<b>Scores on Most Tools (5 out of 6 sites min)</b>	<b>Scores on Some Tools</b>
Has GP	Lives Alone
Accommodation	Recreational Drug Use
Alcohol Misuse	Intravenous Drug Use
MH Issues/ LDs/ DS/ Suicidal ideation	Aggression to others
Victim of Domestic Abuse /	Previous child protection
Chronic Medical Problem <u>inc</u> Dementia	Impact upon department
0-9 attendances in past 12 months	Multiple physical attendances
10-19 attendances in past 12 months	Escalating Attendances (9 in 3/12s)
20-29 attendances in past 12 months	Referral from security/ known incident reports or flags for violence
>30 attendances in past 12 months	Referral received from staff
	MUPS
	Age greater than or equal to 75
	Presentation is pain
	Admission conversion rate over 12/12s
	2 or more attendances in last week
	0-5 attendances in 12 months
	5-10 attendances in 12 months
	10-20 attendances in 12 months
	>20 attendances in 12 months

## b) Personal Support Plans

Personal Support Plans (PSPs) are written for all selected individuals using a multi-disciplinary approach. They are guides for clinical staff to describe the patients normal presentation, how best to respond and de-escalate certain behaviours and support recovery, for example:

- Patients who present frequently reporting self-harm are consistently encouraged to contact community services designed to support them, rather than being referred to on call Liaison Psychiatry Services during each ED attendance.
- Signposting of patients with chronic drug and alcohol problems to Community Services.
- Patients who present with physical symptoms who have been subject to multiple, thorough investigations with negative results are encouraged to manage their symptoms with simple measures. Clinicians are empowered to avoid repeated, potentially harmful over-investigation and hospital admission – which all have potential risk of iatrogenic injury.
- Consideration for social prescribing where appropriate via primary care.

## c) Multi-professional approach

It is recommended that a multi-disciplinary meeting is held monthly for patients to be discussed. In the BRI model, a maximum of 10 patients are discussed in each meeting. This group is designed to facilitate discussions around the selected patients using the ED clinical notes and supporting information from specialist nurses, primary care and other representatives. All management plans should involve the patient's Consultant, ED Consultant, G.P. Specialist Nurse and any other relevant agencies and specialists. They should be shared with the G.P. and patient (when appropriate), and then uploaded onto the electronic patient record system.

Relevant specialties are involved to risk assess and provide safe management plans for patients with chronic medical problems, for example:

- Open access to "hot clinics" to prevent patients reaching crisis point and needing to phone 999
- Remote monitoring e.g. of cardiac defibrillators with phone support by cardiology services
- Community Matrons conduct home visits and monitor chronic disease
- Palliative care hospice outreach involvement

## d) Governance of the Personal Support Plan

It is recommended that the governance process below is followed:



**1** Personal Support Plan is written

**2** Reviewed by a minimum of two other members of the team: HIU co-ordinator **or** ED Matron **AND** Lead HIU ED Consultant (all PSPs to be signed by the ED consultant with the exception of patients whose PSP is predominantly social).

**3** Copy sent to any other contributors (for example: care co-ordinators/medical specialist/specialist nurses/homeless support team) for their approval

**4** PSP completed to document who it has been written and verified by, and the review date.

## e) Sharing of Personal Support Plans

Once the PSP has been written and agreed by the team, it needs to be published on the Electronic Record System and shared to offer patients a consistent approach for when they access any local service. It is recommended that you share patients that are on your list with neighbouring trusts who also run a HIU service, in order to improve the care patients receive across the area. Note, appropriate data sharing agreements will need to be in place for this.

If PSPs can be automatically uploaded on to the data sharing systems such as Connecting Care, they can be accessed by other Emergency Departments in the city, Primary Care, Out of Hours Primary Care, walk in centres, urgent care centres, the ambulance service and local police service (via Control Room triage). This facilitates a consistent approach from all services.

The PSP should also be shared with the patient, to provide them with the opportunity to review and comment as is their right. This can be done in writing, and also opportunistically by the HIU co-ordinators when the patient attends the ED.

## f) Specific interventions

When developing the PSP, you may wish to consider referrals to specific services such as:

- Medically Unexplained Physical Symptoms (MUPS) clinic, run by the Liaison Psychiatry team
- Mental Health Services
- Cardiac Psychology team through liaison with the GUCH team

## g) Review and discharge

Each patient should be reviewed monthly until their presentations reduce to an acceptable level, agreed according to the current level of demand, or after all possible interventions have been attempted. They can then be removed from the MDT list, but should continue to be monitored to pick up any subsequent increase in attendance rates. Plans should be reviewed annually and archived if no longer active.

# PART 3

## The Project structure

3.1 The scoping stage

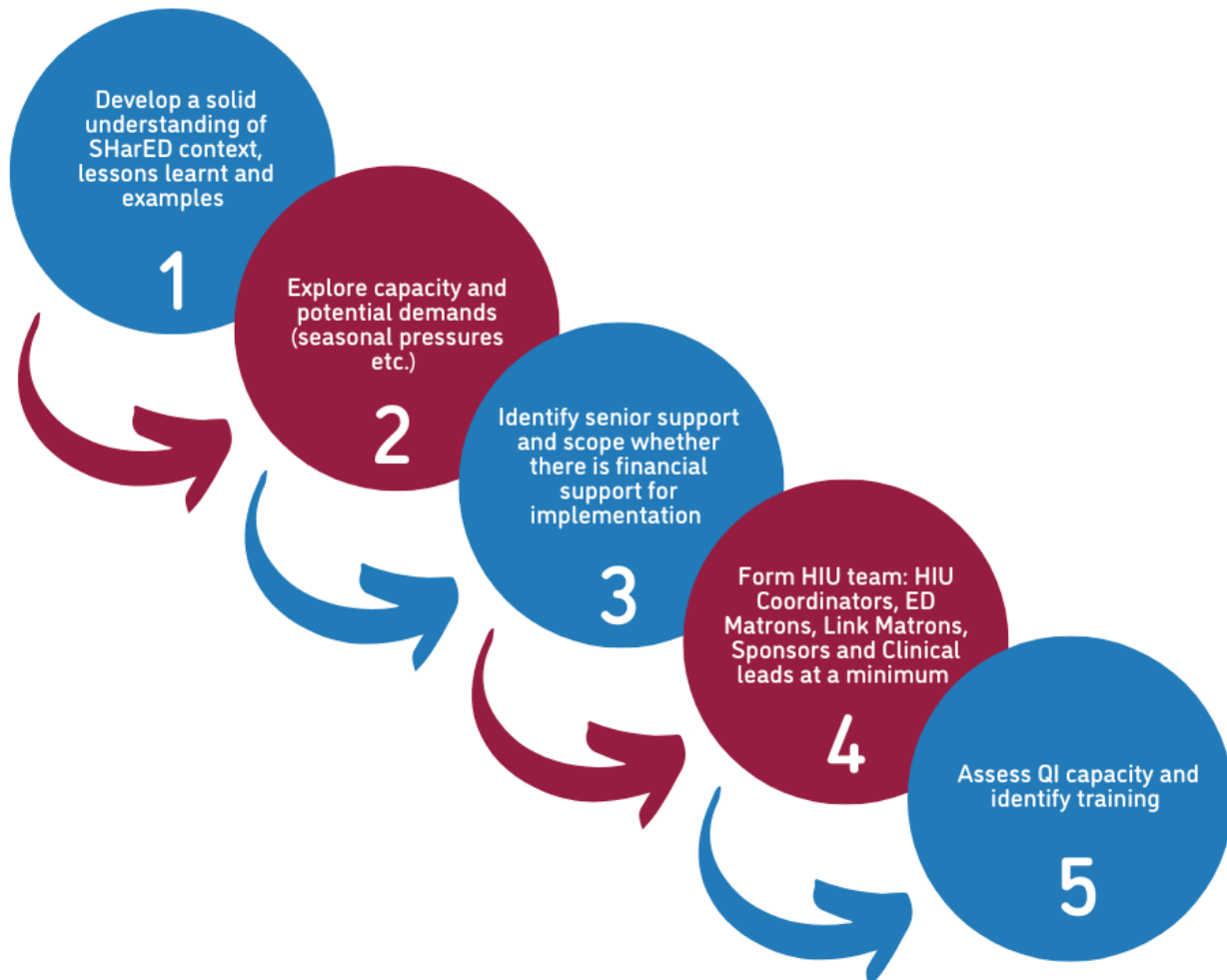
3.2 The planning stage

3.3 Implementation of your HIU team

3.4 Worked example of cost benefits



## 3.1 The scoping stage



## 3.2 The planning stage

See “Part 4: Quality Improvement Resources” section, page 27, for further details.

A key factor to gaining engagement with the project is to invite input from all staff involved in the pathway from the very beginning. Having agreed the aim, brainstorming with the group about what is required and listening to all views is important for good engagement. Using tools, such as process mapping or developing a driver diagram, may be useful as part of the planning stage.

A driver diagram is a visual way of breaking down the stages of the project, the driver diagram can act as a personal project plan. A blank template can be found online so that you can create your own diagram with your team.

These following steps outline vital components of the planning process: stakeholder engagement and data collection and measurement strategy.

### **Step 1: Stakeholder engagement**

Set up a multi-disciplinary team (MDT) to include all roles involved in the process. Each person should have defined roles and, in particular, ensure that effective communication is fed back to each discipline. An example Terms of Reference for the MDT can be found on our website.

It is recommended to nominate an Executive sponsor, as they can be important in unlocking difficult obstacles if they arise. Plan to keep them briefed regularly.

Regular meetings to review progress and discuss issues are important to ensure the practicalities of the project are being addressed, staff are being supported and messages are being appropriately disseminated. Frequency of these meetings can be decided by the project lead and alternative ways of communicating such as posters, email and presentations at relevant meetings can also be effective. At this point you must recruit to your HIU Coordinators and Clinical Lead roles. Please see section 5.1 for more information.

Suggested inclusions in the MDT are:

- Clinical Specialities
- Drugs and Alcohol Teams
- Homeless Team
- Domestic Violence Workers
- Liaison Psychiatry
- GPs
- North Bristol Trust HIU Team
- Police
- Ambulance Service
- Safeguarding Team

### **Step 2: Data collection and measurement strategy**

Development of a robust measurement strategy is important for co-ordination of the project. This ensures progress is tracked and maintained and any difficulties addressed and can be documented using a measures checklist if helpful.

The strategy should include:

- i) The type of measures that you will be collecting and their definitions
- ii) Your data collection method
- iii) How you will present your data

#### **i) Type of measures and definitions:**

The measures that were used for SHarED have been fully defined in the measurement strategy (page 20), categorised as outcome, process and balancing measures.

It is important that you collect baseline measures for outcome and process measures before starting your project. Baseline measures are essential so that you can demonstrate any change in outcome and demonstrate improvement in the processes to achieve the improved outcome. In the instance of the SHarED project, the baseline measures consisted of the number of ED attendances and hospital admissions for all selected patients for one year prior to the PSP being started. Although it is useful to be able to compare data between trusts, it is important to remember that the data you are collecting is for improvement in your organisation, rather than for comparison or benchmarking, as each organisation is different.

Alongside the quantitative data collection, it is recommended that you gather qualitative feedback from the staff and patients.

A staff survey will help to establish the cultures around HIUs amongst all staff in your ED, including both clinicians and administrative staff of all bandings. This should be completed prior to implementation and at two subsequent time points to understand progress and to help identify further areas to improve.

Throughout the SHarED project, it proved difficult to get responses to the patient questionnaire with only one response which was poorly completed. The ICECAP-A Questionnaire was also used to assess the impact of the HIU Service on Quality of Life of patients under the team. Similarly, there were minimal responses to this questionnaire despite trying multiple avenues of dissemination.

A data analyst within your organisation may be able to help you to gather and understand your data and it is suggested that they form part of your project team, if possible.

The measures that were used for SHarED have been fully defined in the measurement strategy (page 20), categorised as outcome, process and balancing measures. Some teams also collected additional data, including time to diagnosis and time spent in the ED.

### ii) Data collection method:

Consideration needs to be given to how data will be collated.

- How are the measures going to be collected (paper, electronic, telephone, postal)
- Who is going to collect them? Allocating responsibility adds reliability and ownership of measures, thereby increasing chance of achieving success. Measures may be collected by different people depending on availability of staff in your organisation. For example:
  - o HIU Co-ordinators
  - o The Clinical Lead
  - o Admin staff
  - o QI audit departments
  - o Input might be needed from IT for electronic systems or admin support to post out the questionnaire and input the returned information

Data collection needs to be reliable and continuous. Do not rely on one person to do this; it must not be person dependent.

### iii) Displaying your data

Decide how you are going to display and feedback your data and to whom. Allocate responsibility for this.

Present baseline measures, such as the development of PSPs and the number of staff trained, to stakeholders to win 'hearts and minds' and help engage stakeholders in valuing your project as a necessary change. Due to the nature of working with HIUs the changes with their behaviour can take some time, and so it may be a few months before you can start to demonstrate improvements in their attendances. Presenting a patient story from your organisation is also very helpful for getting staff on board.

An infographic has been developed to support this, as shown on page 23.

## SHarED Measurement Strategy

Type of Measure	Measure	Operational definition	Source	Frequency / Timescale	Duration	Collector	Reporting location
<b>Outcome</b>	% reduction in ED attendances in patients managed under HIU Team	Number of ED attendances per month	Patient Records	Monthly / once 10 patients have a PSP started	12 months data backdated pre PSP and up to 12 months post PSP	HIU Co-ordinator	SHarED Trust Data Dashboard
	% reduction in hospital admissions in patients managed under HIU Team	Number of hospitals admissions per month	Patient Records	Monthly / once 10 patients have a PSP started	12 months data backdated pre PSP and up to 12 months post PSP	HIU Co-ordinator	SHarED Trust Data Dashboard
	Patient quality of life	ICECAP-A score for patients managed under HIU Team (as able)	ICECAP-A Score	For each patient pre PSP and 6 months post PSP	SHarED project funding duration (20 weeks) and up to 6 months after funding	HIU Co-ordinator	SHarED Trust Data Dashboard
<b>Process</b>	Emergency Department culture around HIUs	Qualitative information via culture survey	Survey Monkey	At beginning of project, at the end of the 20 week project funding and at the end of the project (12 months)	SHarED project duration (12 months)	Clinical Lead	West of England AHSN will gather results
	% of ED staff trained on managing HIUs	Number of staff trained	Project records	Monthly / once 10 patients have been PSP started	SHarED project funding duration (20 weeks)	HIU Co-ordinator	SHarED Trust Data Dashboard
	Number of PSPs started	Number of PSPs started	Project records	Monthly / once 10 patients have been PSP started	SHarED project funding duration (20 weeks)	HIU Co-ordinator	SHarED Trust Data Dashboard
<b>Balancing</b>	Number of PSPs completed	Number of PSPs completed	Project records	Monthly / once 10 patients have been PSP started	SHarED project funding duration (20 weeks)	HIU Co-ordinator	SHarED Trust Data Dashboard
	Cost	No requirement for this to be calculated for the SHarED Project, but to be considered as a balancing measure.					

\*PSP = Personal Support Plan

## 3.3 Implementation of your HIU team

### 1. Test in a small group first:

PDSA stands for Plan-Do-Study-Act. This means doing small tests of change and understanding what works before changing your system. Details of how to do this are in "Part 4: Quality Improvement Resources" on page 29.

Ideally start testing how one or two changes to the service work before making further changes. For example, this may mean implementing and gradually improving the referral mechanisms to the HIU Service and reviewing how effective each improvement has been. Ensure all relevant staff members that are fully informed before the start of the case and have been asked for feedback so they feel involved in the change. The important part of doing small PDSAs is to learn from what happened:

- What went well and should be repeated?
- What could have made things easier?

Add these to the plan for making the next change.

### 2. Ensure the changes are delivered and audited:

Adapt processes as you learn from testing the changes and listen to staff feedback. In doing so, the team will feel ownership of the change which in turn will help sustain the change in the long term. You may want to review how effective your referral mechanisms are through auditing referral routes, or audit how frequently staff are checking for PSPs. The data can then be fed back to the ED team to show how well implementation of the service is going.

## Data Collection Dashboard

The dashboard below has been developed to support data collection. Once populated, the dashboard will demonstrate your progress with development of plans and staff training. This dashboard can be found on our website.

Once the number of ED attendances have been recorded, a run chart will be produced to show how effective the PSP has been.

Personal Support Plans		Number of ED Attendances (EDA) and Hospital Admissions (HA)																																																	
Patient ID	Age	Date Started	Date Finalised	Months Pre and Post Starting Plan																																															
				-12	-11	-10	-9	-8	-7	-6	-5	-4	-3	-2	-1	Plan Started 1	2	3	4	5	6	7	8	9	10	11	12																								
				EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA	EDA	HA																								
1		10/08/2020	09/09/2020	5	2	4	1	5	0	3	1	3	1	5	0	6	2	5	1	4	0	4	0	5	1	6	0	4	0	3	0	4	0	3	0	4	0	4	0	2	0	2	0	3	0	2	0	2	0		
2		10/08/2020	09/09/2020	4	0	7	0	6	0	6	0	4	1	3	1	1	4	0	6	0	5	0	4	0	4	0	6	0	7	0	7	0	3	0	5	1	3	0	4	0	3	0	2	0	3	0	2	0	2	0	
3		10/08/2020	10/09/2020	4	0	3	4	0	0	0	0	2	2	2	3	4	4	2	3	2	2	3	2	3	0	3	2	2	2	1	1	0	0	3	2	5	2	3	1	1	0	0	0	0	0	0	0	0	0		
4		10/08/2020	12/10/2020	6	5	3	3	5	6	7	4	6	3	3	1	6	6	5	4	3	3	2	2	1	0	6	5	4	4	3	2	4	3	2	4	3	2	3	2	3	2	1	0	0	0	0	0	0	0		
5		10/08/2020	13/10/2020	7	7	6	7	5	7	5	7	4	6	6	4	6	6	4	5	5	8	6	4	4	3	2	4	3	2	4	3	2	4	3	2	3	2	3	2	1	0	0	0	0	0	0	0	0	0		
6		09/09/2020	17/11/2020	3	4	3	2	2	3	2	1	3	4	2	3	4	2	3	4	2	2	1	1	0	2	1	1	0	2	1	1	0	1	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0		
7		09/09/2020	16/12/2020	3	3	2	8	7	3	2	2	1	3	2	2	2	1	3	2	2	2	1	1	5	4	1	2	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
8		16/10/2020	18/12/2020	3	2	3	3	2	3	1	2	3	1	2	3	1	2	3	1	1	1	1	0	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
9		16/10/2020	02/01/2021																																																
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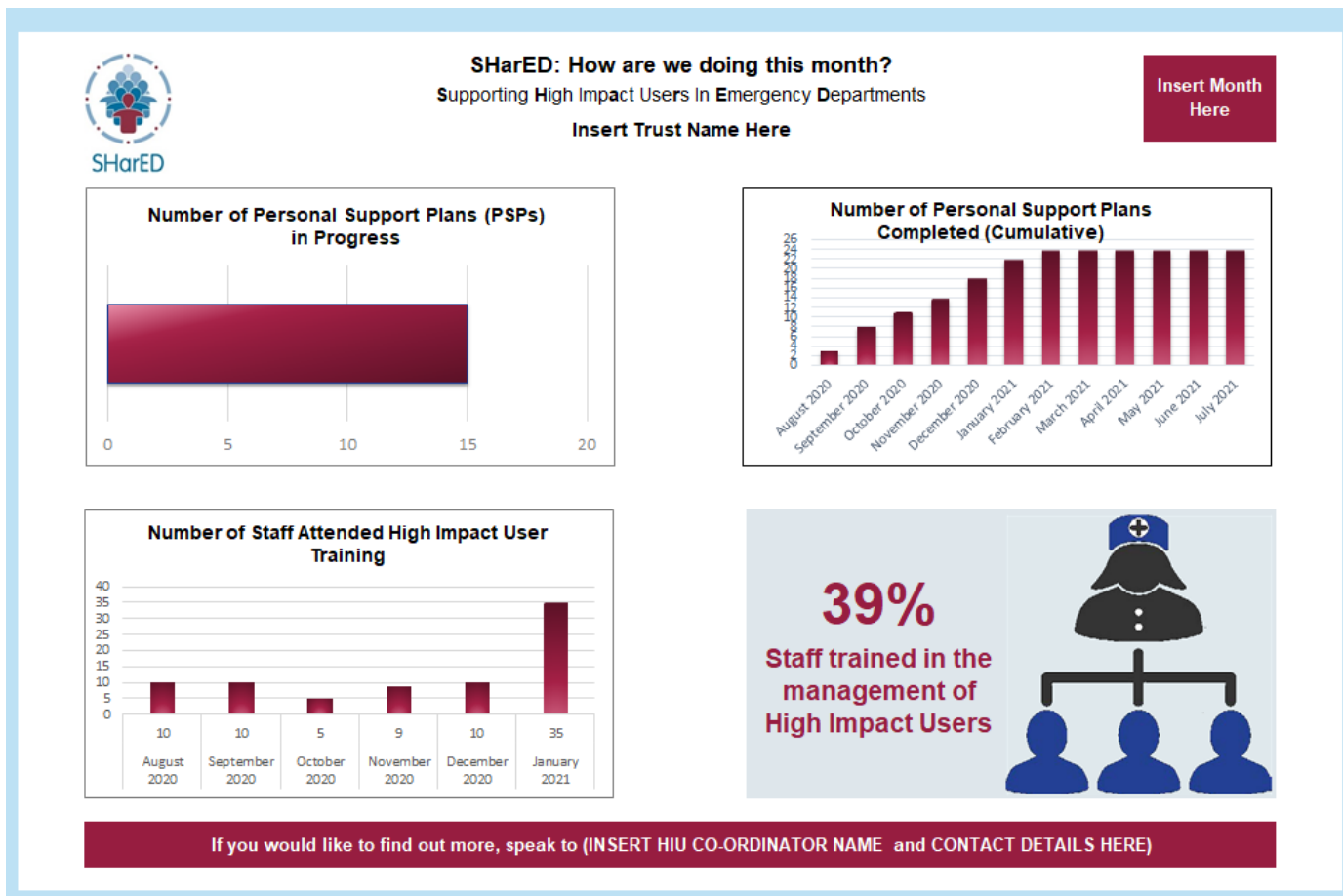
SHarED Staff Training Record														
West of England AHSN														
Staff Training Record														
	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	Total Number of Staff Trained	
Number of Staff Trained	10	10	5	9	10	35	6	0	0	30	2	1	118	
Total number of staff in ED	300													
Total staff trained	118													
Percentage of staff trained	39%													

Quality of Life Score: ICECAP-A										
West of England AHSN										
Pre-Personal Support Plan					Post-Personal Support Plan					
Patient ID	Date completed	Follow up date	Question					Overall Score	Completion Method	Comments (Optional)
			1	2	3	4	5			
1	20/08/2020	20/02/2021	1	2	2	3	1	12231	Face-to-face	
2										
3										
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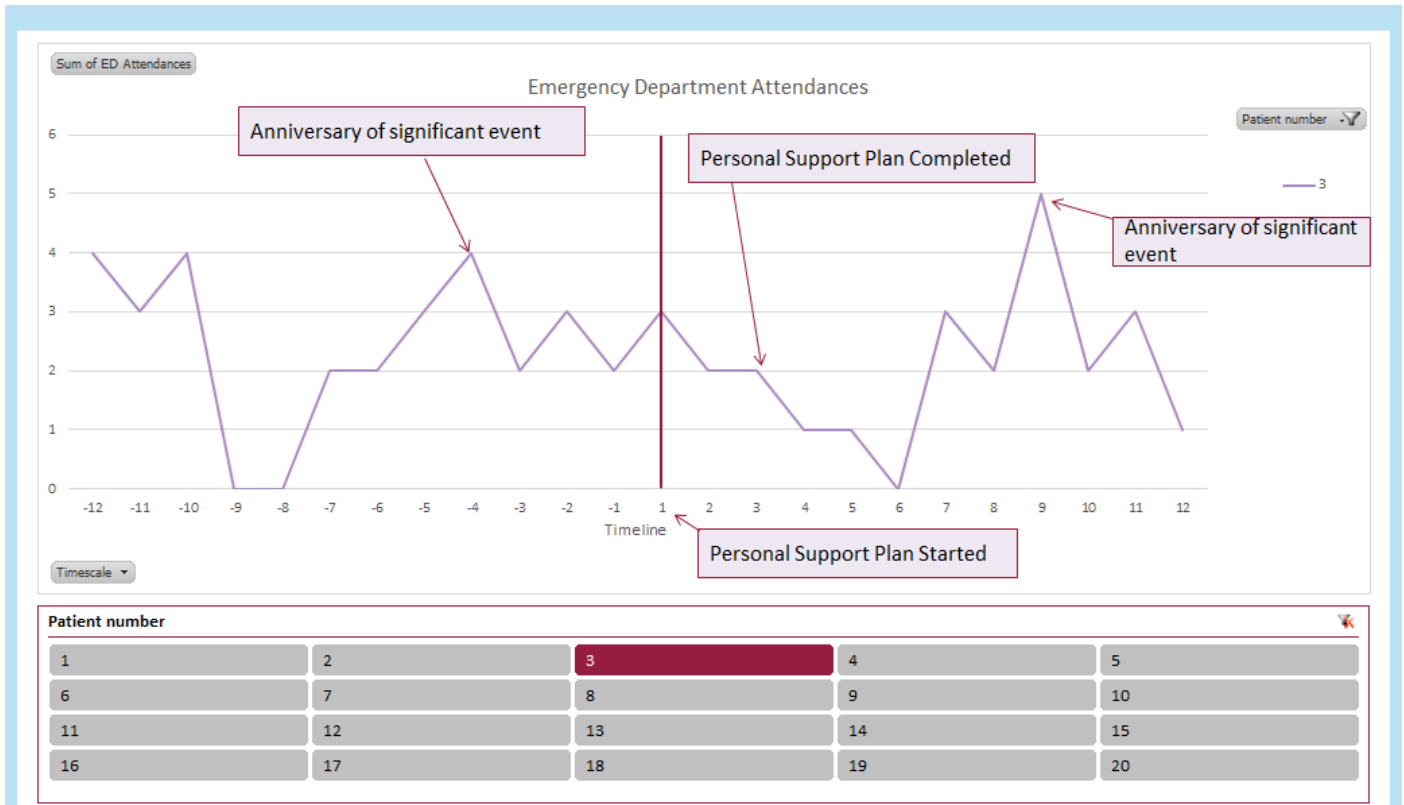


## Review and feedback

Feeding back in a simple way to the team and other stakeholders is important to maintain momentum and support. Displaying progress with the plans and the staff training is a simple and effective way of visibly seeing overall development of your HIU. Infographics are a helpful way of disseminating key information to stakeholders and staff members.



Once you can start to see improvements in attendances, you may wish to share the run-charts with ED staff to show effectiveness of the service. The run-chart can be annotated to show when the PSP was implemented. An example is shown below.



Further information is available in the Quality Improvement section on page 33.

Ensure that you are regularly reviewing your data and effectiveness of each component part of the HIU Service, as well as ensuring all staff members are informed of the progress of the work. Any difficult issues can be recorded and plans to un-blocking discussed before progressing the work further.

### 3. Celebrate success

Don't forget to celebrate success as you go and thanking staff has a great impact on engagement and sustainability. Cakes go a long way!

Sharing results in a newsletter and showcase in coffee rooms to make sure success is shared. Don't forget to showcase to your executive sponsor as well!

### 3.4 Worked example of cost benefits

The HIU team at the BRI developed a means of establishing the cost benefits for the HIU Service, as shown below.

#### **Outcome:**

ED attendances are reduced:

- From an average of 48 per person annually to 9 per person annually.
- Annual ED attendances reduced from 241 per year (for five patients) to 45.
- 82% decrease in ED attendances.

Hospital admissions are reduced:

- From an average of 65 per person annually to 12 per person annually.
- Annual hospital admissions reduced from 65 per year to 12.
- 82% decrease in hospital admissions.

**Taking into account only ED attendance and medical admission tariffs showed their total annual cost in 2015- 2016 to be £93,813 (for all five patients). When tracked prospectively through High Impact Users intervention process, and their attendance and admission patterns for the following year, these costs were reduced to £16,419 annually; a saving of £77,394 in these five patients alone.**

#### **Workload:**

A conservative estimate of the completed workload in the year 2015-2016 is below:

#### **Preparation:**

- Four hours ED matron.
- One hour each for other members.
- One hour meeting monthly.

#### **Care plan formulation:**

- One hour notes review per patient each for ED Consultant plus other specialties (Liaison Psychiatry, Drug/ Alcohol Services, medical Consultant).
- Discussion and documentation of care plan onto Medway: twenty minutes per patient.
- Communication with GP:

ED Consultant: varies from ten to thirty minutes per patient.

### **Estimation of total workload in first year**

- MDT meeting: 12 hours per each core member (12 one hour meetings annually) = 60 hours in total
- PSP preparation: 50 hours per each member (one hour each for 50 patients) = 150 hours in total
- PSP formulation: 16.7 hours per each member (20 minutes each for 50 patients) = 50 hours in total
- Communication with GPs: minimum 13 hours (minimum 10 minutes each for 50 patients needing care plans, and additional 30 patients discussed at HIU MDT) done by ED Consultant = 13 hours total

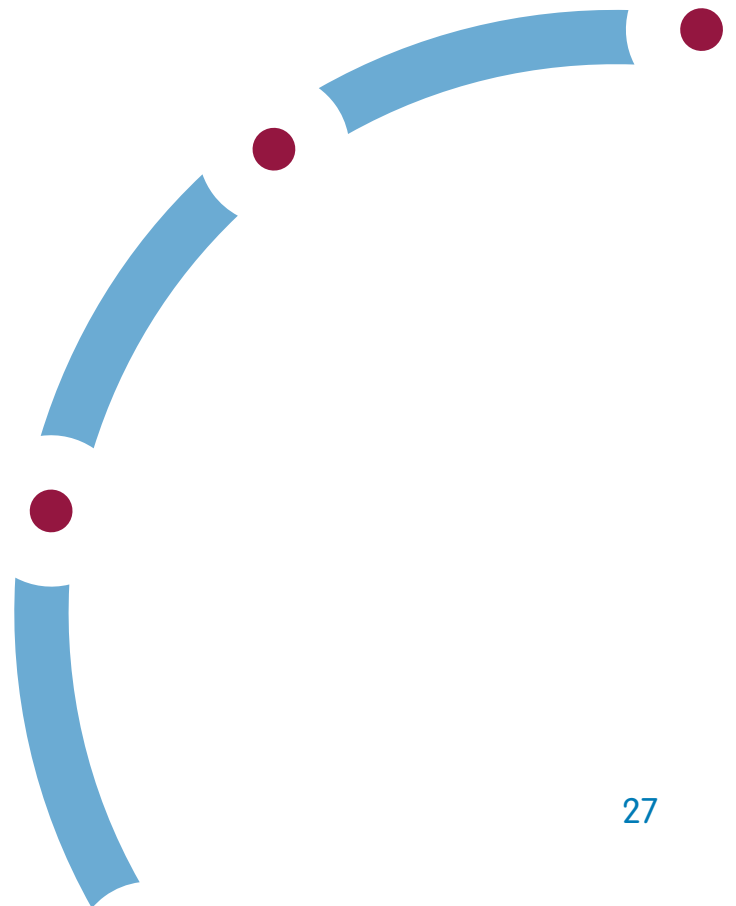
### **Total work load = 273 hours annually**

Due to resource limitation. Some patients could remain on the "top ten" list for several months as their management plan was very complex and required a multi-agency approach. This prevented other, extremely high impact users from benefiting from the process.

# PART 4

## Quality Improvement Resources

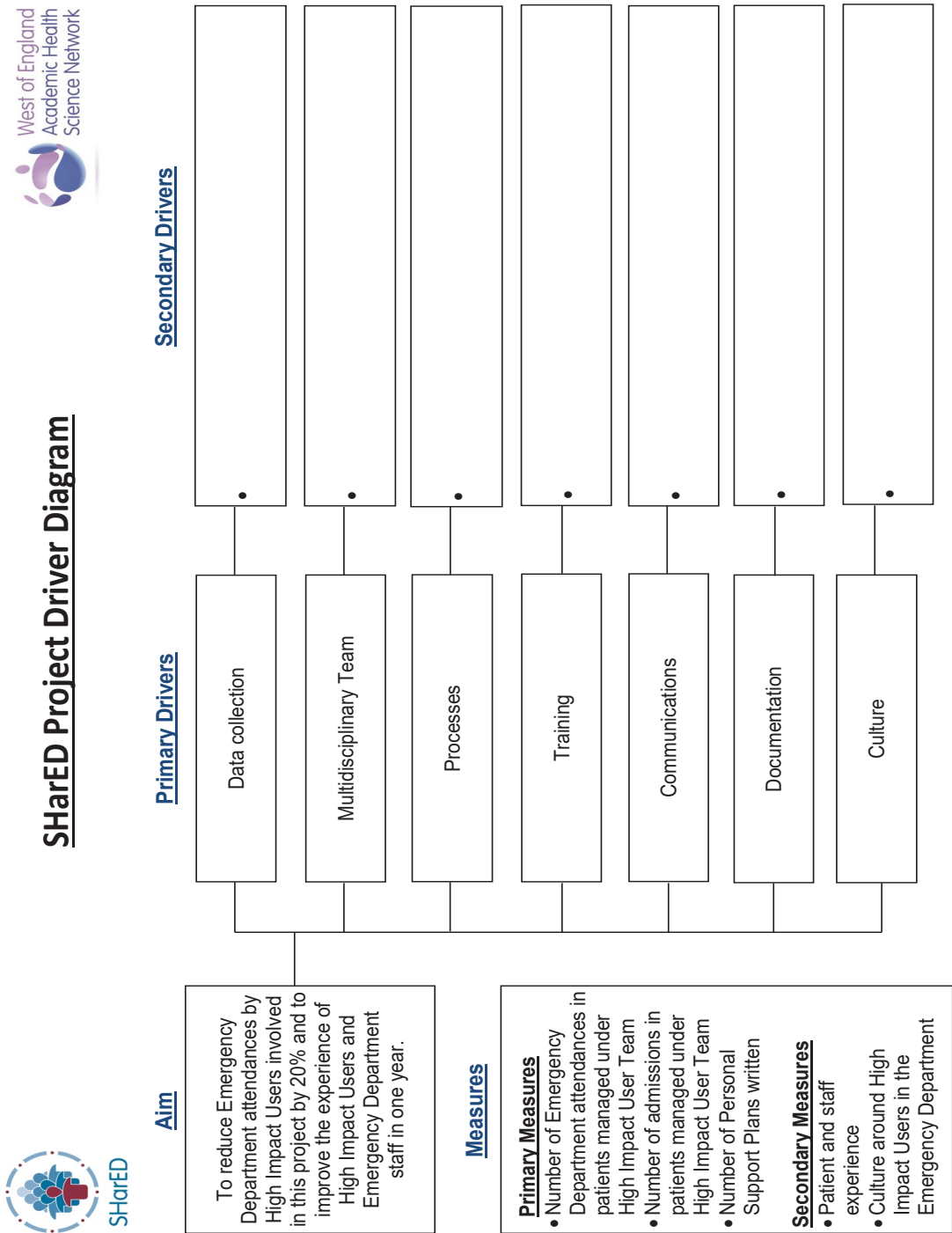
- 4.1 The SHarED Driver Diagram Template
- 4.2 The Model for Improvement
  - SHarED Quality Improvement Learning Log
- 4.3 Demonstrating your improvement
  - Run charts
- 4.4 Celebrating and sharing your success
- 4.5 Sustainability
  - NHS sustainability tool



# 4.1 The SHarED Driver Diagram template

This template can be completed to assist you with planning your actions that are required to successfully implement the HIU Service and achieve the project aim.

The Primary Drivers in this template are examples and can be edited to your local project.



INSERT TRUST NAME SHarED Project Driver Diagram

## 4.2 The Model for Improvement

In order to implement a change in a sustainable way in your organisation, and to be able to measure the impact of this intervention, we recommend a structured Quality Improvement framework for implementation.

Quality Improvement science is the application of a systematic approach using specific methods and techniques in order to deliver measurable improvements in quality, care and safety.

The processes we describe can be adapted to meet the needs of staff, service users and organisational context. Our approach uses the methodology developed by the Institute of Health called the IHI Model of Improvement.

You can find out more about the Model for Improvement through the [MINDSet quality improvement toolkit](#). Although aimed at people involved in providing and commissioning services for people with mental health projects, it is an excellent resource for practical quality improvement guidance.

Other useful resources include an introduction [video to PDSA cycles](#) and the [Institute for Healthcare Improvement Website](#).

### The IHI Model for Improvement

There are three questions to ask when developing implementation projects shown to the right. These are then followed by rapid cycle improvement using PDSA.

**Plan, Do, Study, Act** is an effective method that helps teams plan the actions for their model, test it on a small scale, and review before deciding how to continue.

Using PDSA cycles are a fantastic way of taking ideas, trying them in practice, learning what works and what doesn't, to help you achieve success.

You can then broaden the scale of the test, or adjust your ideas through more than one PDSA cycle - it may take a few before the idea starts to work reliably.

For a fun way to introduce a team to quality improvement, check out this blog post at [www.weahsn.net/2016/01/anyone-for-tennis/](http://www.weahsn.net/2016/01/anyone-for-tennis/)



If you have any immediate clinical concerns regarding a patient's safety or wellbeing please escalate via normal channels.

### **SHarED Quality Improvement Learning Log**

The purpose of the learning log below is to record implementation activity, learning and reflections from implementation of your HIU project, through PDSA cycles, to:

- Capture lessons learnt
- Inform the approach of future improvement initiatives and
- Contribute to the evaluation



# SHarED Quality Improvement Learning Log



**PDSA Cycle Number:**

**Date:**

**Author:**

**Aim:** What are you trying to accomplish? What issue would you like to improve

**Plan:** What will your test be? How could the issue be resolved? What could be introduced to make an improvement? Who is a useful contact to support you with this improvement? What data will you collect to know if the change has made a difference?

**Prediction:** What do you think will happen as a result of your test?

**Do:** What happened when you carried out your test? What did the data show?

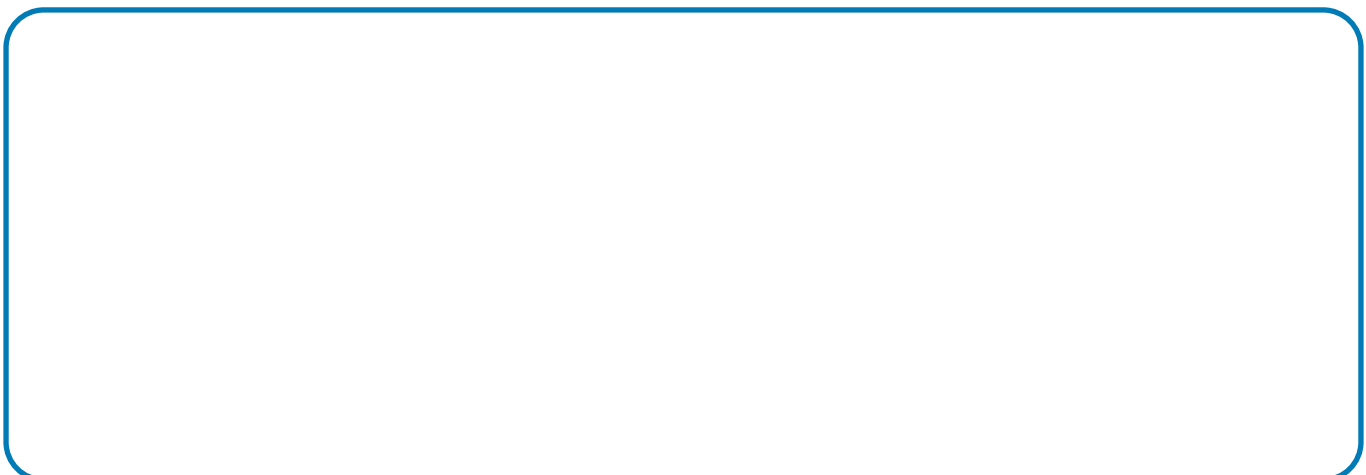
**Study:** How did the results of your test compare with predictions? Has the change been an improvement? What have you learnt from making this change? Do you have any tips for other improvers?



**Act:** Next steps: Is there still room for improvement? What will you do next?



**Learning and reflections:** What worked well? What would you do different next time? Any other points to record?



## 4.3 Demonstrating your improvement

### - Run charts

Run charts are line graphs where a measure is plotted over time, often with a median (the middle value of those plotted so that half are above and half are below) also shown. Display of the data in a run chart, demonstrating the change in compliance over time, is a very visual way of demonstrating improvement. They allow us to:

- Display data to make process performance visible
- Determine if a change resulted in improvement
- Assess whether improved performance has been sustained

Changes made to a process are also often marked on the graph so that they can be connected with the impact on the process.

Ideally a minimum of 20 patients a month should be sampled or all of the patients if you have less than that. Sampling smaller numbers has also been shown to be an effective and reliable way of obtaining data where data for all is not easily available, and it allows for continuous repeated data collection.

Data should be reviewed each month so you understand what is happening and any issues can then be addressed promptly, as in the example above when there was a decrease in the availability of fluid warming devices.

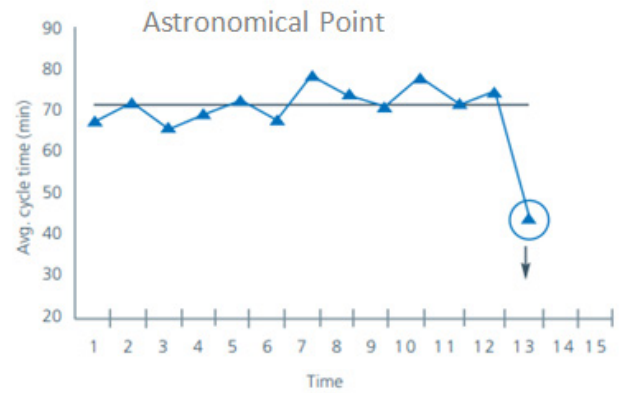
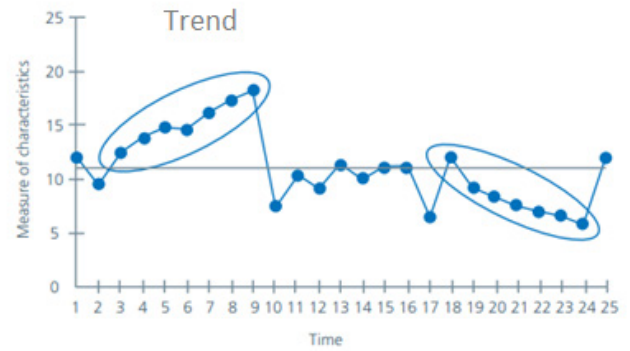
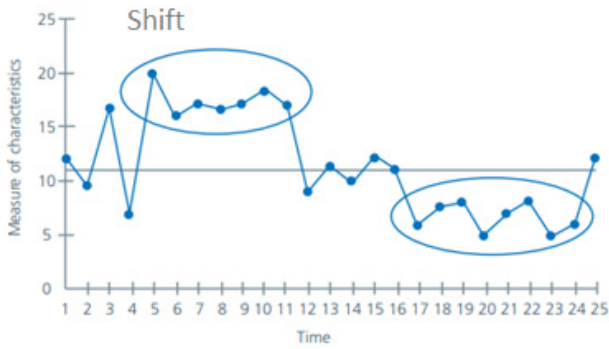
Displaying data in run chart format is not only useful as a visible demonstration of the impact of your changes but can also be used to demonstrate whether any improvement is significant and that processes have become more reliable, if the variation between data decreases.

#### Run Chart Rules

Run charts are a powerful tool for detecting special cause (non-random) variation. If there are at least 10-12 data points on the graph, run charts can also be used to distinguish between random and non-random variation using four simple rules.

1. A shift: six or more consecutive data points either all above or below the median. Points on the median do not count towards or break a shift. This suggests there has been a genuine change.
2. A trend: five or more consecutive data points that are either all increasing or decreasing in value. If two points are the same value ignore one when counting. This is a good sign and might demonstrate that the PSP is working and that change is happening although not yet established.
3. Too many or too few runs: a run is a consecutive series of data points above or below the median. As for shifts, do not count points on the median: a shift is a sort of run. If there are too many or too few runs (i.e. the median is crossed too many or too few times) that's a sign of non-random variation.
4. An astronomical data point: a data point that is clearly different from all others. This relies on judgement.

It is important to understand the reason for special cause variation and not to react unnecessarily to one-off changes in the behaviour of a process. Analyse the chart by studying how values fall around the median. Below are some examples of run-charts and their corresponding rules.



## 4.4 Celebrating and sharing success

This is important to maintain engagement with the teams. There are various ways of communicating with the teams, such as newsletters and notices. Remember to feedback to divisional leads and your executive sponsor.

## 4.5 Sustainability

Sustainability means 'holding the gains and evolving as required, definitely not going back' and needs to be thought about from the beginning of the project.

A project has increased chance of being sustained if:

- Team engagement is encouraged from the beginning
- The team have ownership of the change and have had input into it
- The team understand the need for change and have visible feedback on progress
- Senior leadership and organisational engagement are visible
- New processes are added to existing processes that are reliable
- Processes do not rely on one person and reliable processes are in place for change-over of staff if necessary
- Making the new processes as easy as possible ('making it easy to do the right thing') – embedding processes into your electronic system can support this.

### The NHS Sustainability Tool

The [NHS Sustainability Tool](#) utilises many of these factors and is useful to do with the team at the beginning, middle and end of the project and can guide you as to which areas to concentrate on.

This guide will serve to support the drive to improve outcomes for HIUs and reduce their attendance to the Emergency Department. Implementation and development of the first PSPs is likely to take approximately three months, and therefore improvements will not be seen immediately. However, once in place reduction in attendances should be apparent within a few months.

Writing a business case will be a key milestone for the project team to work towards securing ongoing funding. Both qualitative and quantitative data will be required to support this and sufficient time lapse since the start of the project will be required to ensure data is available.

# PART 5

## Implementation Resources

This section contains templates and resources that you may find helpful in the implementation of your HIU service. All resources are available on the West of England AHSN website and can be adapted for local use. Go to: [weahsn.net/shared](https://weahsn.net/shared)

### 5.1 Key roles

- Senior Executive Sponsor
- HIU co-ordinator: the champion role
- HIU co-ordinator: the clinical role
- Clinical Lead
- ED Matron
- Other stakeholders
- Resources
- A day in the life of a HIU Co-ordinator

### 5.2 Pathway mapping

- Data gathering
- System Alerts
- HIU Referral Pathway
- HIU Attendance Pathway
- Complex HIU Timeline of Events and Milestones

### 5.3 Training

- What, where, how?

### 5.4 Communications

- Communications plan
- Example email to ED Staff for launch
- Poster: Think SHarED

### 5.5 Checklists

- Patient questionnaire
- Staff survey

### 5.6 Further resources

# 5.1 Key roles

The appointment of key roles for the programme is a key milestone to achieve. Role descriptions can be found online.

### **The following roles are essential in the implementation of the HIU Service:**

- Senior Executive Sponsor
- HIU Co-ordinator – The Champion Role
- HIU Co-ordinator – The Clinical Role
- Clinical Lead
- ED Matron
- Other stakeholders
- Link Matron from UHBristol

## A Day in the life of a HIU Co-ordinator

**Arrive at work and log in to check emails. Respond to enquiries and any issues that have arisen since last at work**

**Check clinical alerts to see which high impact users have attended the Emergency Department over the last 24/48/72 hours**

**Check the notes of those that have attended to ensure that PSPs have been accessed and utilised if appropriate. Make a note of any new information that might be relevant to PSP e.g. changes in presentation/social situation/support**

**Attend the Emergency department/observation unit if any HIU's are currently there.**

- Make sure staff have checked the alerts and are aware of the PSP
- Speak with the service user, if appropriate, to discuss any recent attendances and offer opportunity to discuss PSP

**Head back to the office and check to see if there have been any new referrals.**

- Triage any new referrals to ascertain risk level
- Allocate referrals to HIU coordinators for further investigation and work

**Work on current caseload. On any given day this can include:**

- Researching patient notes to identify need and risks.
- Writing to each HIU and their GP to invite their contribution to a PSP via questionnaire, phone call or face to face meeting
- Liaising with other professionals involved with the HIUs
- Writing PSPs and discussing these with the team.
- Reviewing PSPs annually (often before a year due to the evolving needs of service users) and updating appropriately

**Attend meetings, these can include:**

- Professionals meetings
- Safeguarding meetings
- Meetings with service users

**Attend to any ongoing projects. These include data collection and quality improvement.**



## 5.2 Pathway mapping

### Data gathering

Below is an example of the coding you may want to use to find your first HIUs to start working with. This has been coded using the parameters below; you may wish to adjust these as your service develops.

Data for the last 12 months for patients who:

- Have attended the emergency department 5 times or more in the last 12 months with their last attendance within the last 3 months
- From the sample generated, select the top 20 only.

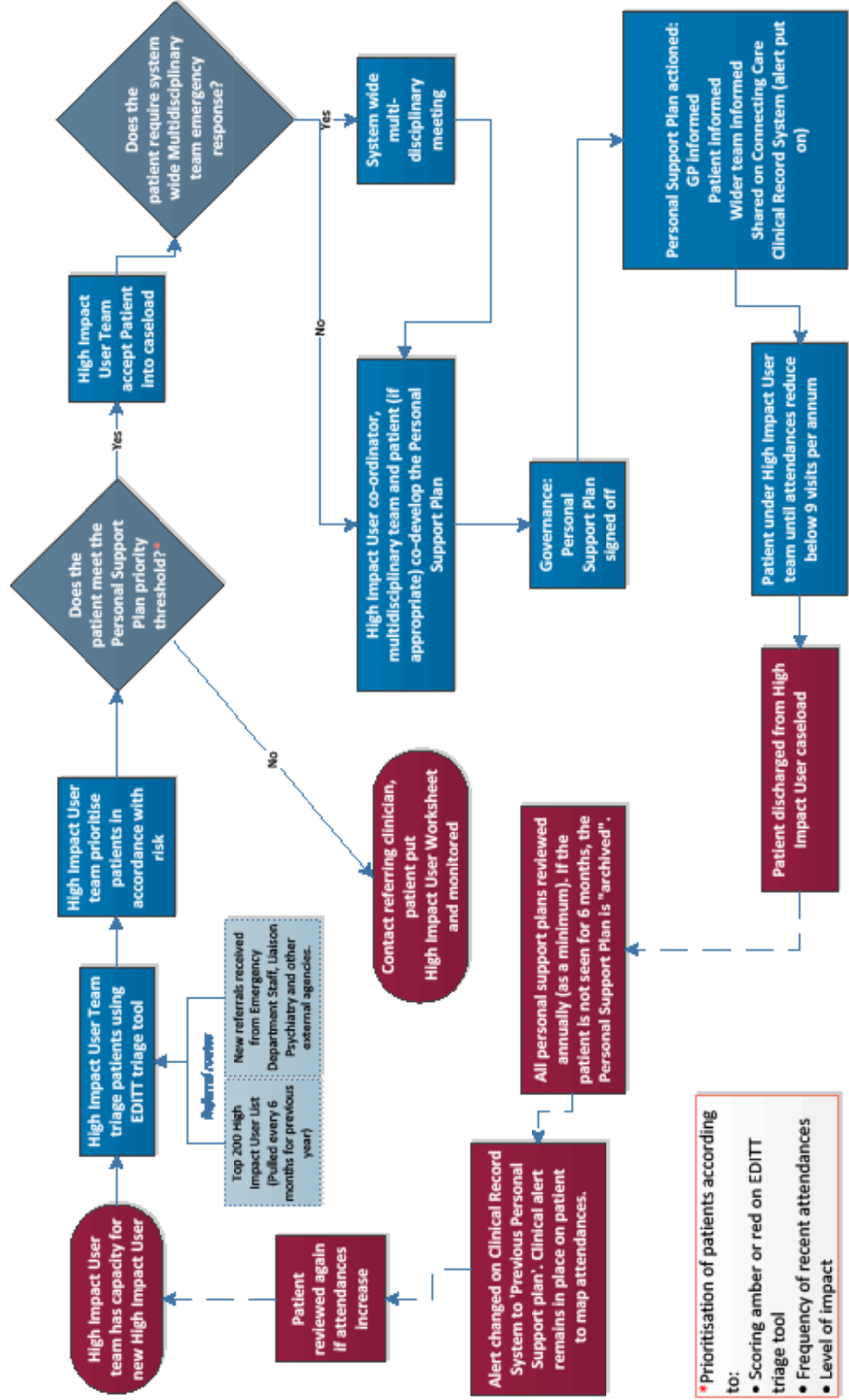
An example of the coding you may want to share with your Business Intelligence Team to find your first HIUs is available at [weahsn.net/shared](http://weahsn.net/shared)

### System alerts

It is important that alerts are set up on your systems to inform staff that patients have a PSP in place. Additionally, if the HIU co-ordinators are available when a HIU attends the ED, it is useful for them to be alerted so that they can assist the ED staff. Therefore, an alert email informing them of their attendance is useful. The instructions below explain how alerts are set up on the systems at UH Bristol. Please note that this is for Medway only and processes are likely to differ depending on the local systems.

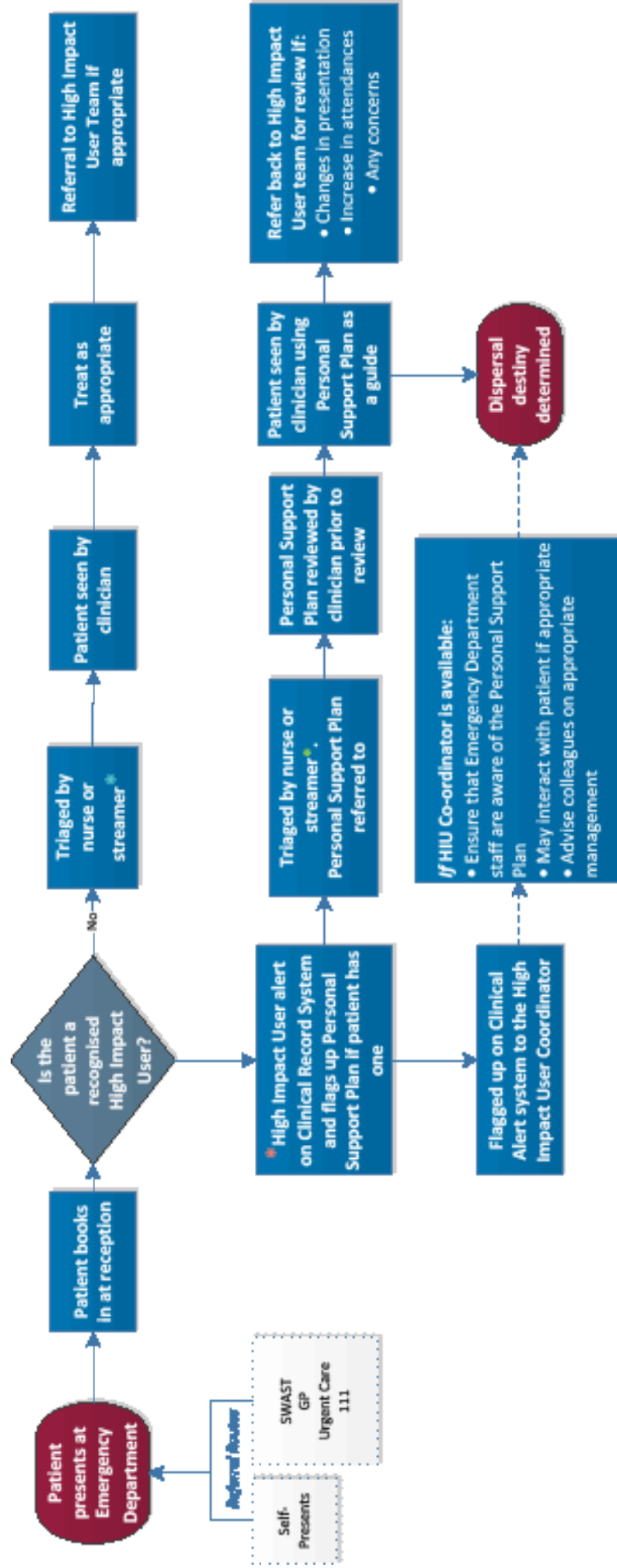


## High Impact User Referral Pathway





# High Impact User Attendance Pathway



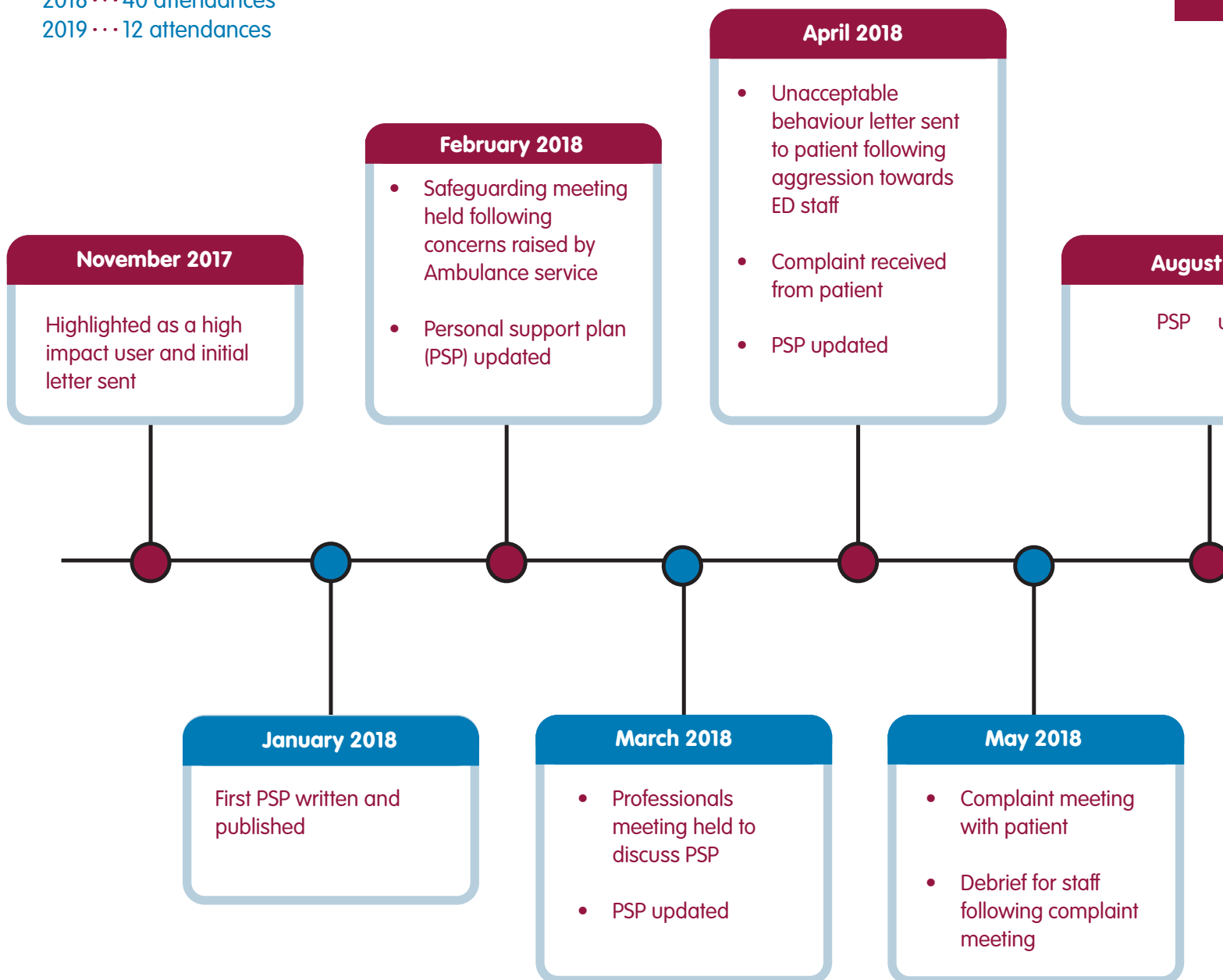
\*Streamer = patient reviewed by senior nurse, triage skipped and referred straight to relevant speciality.

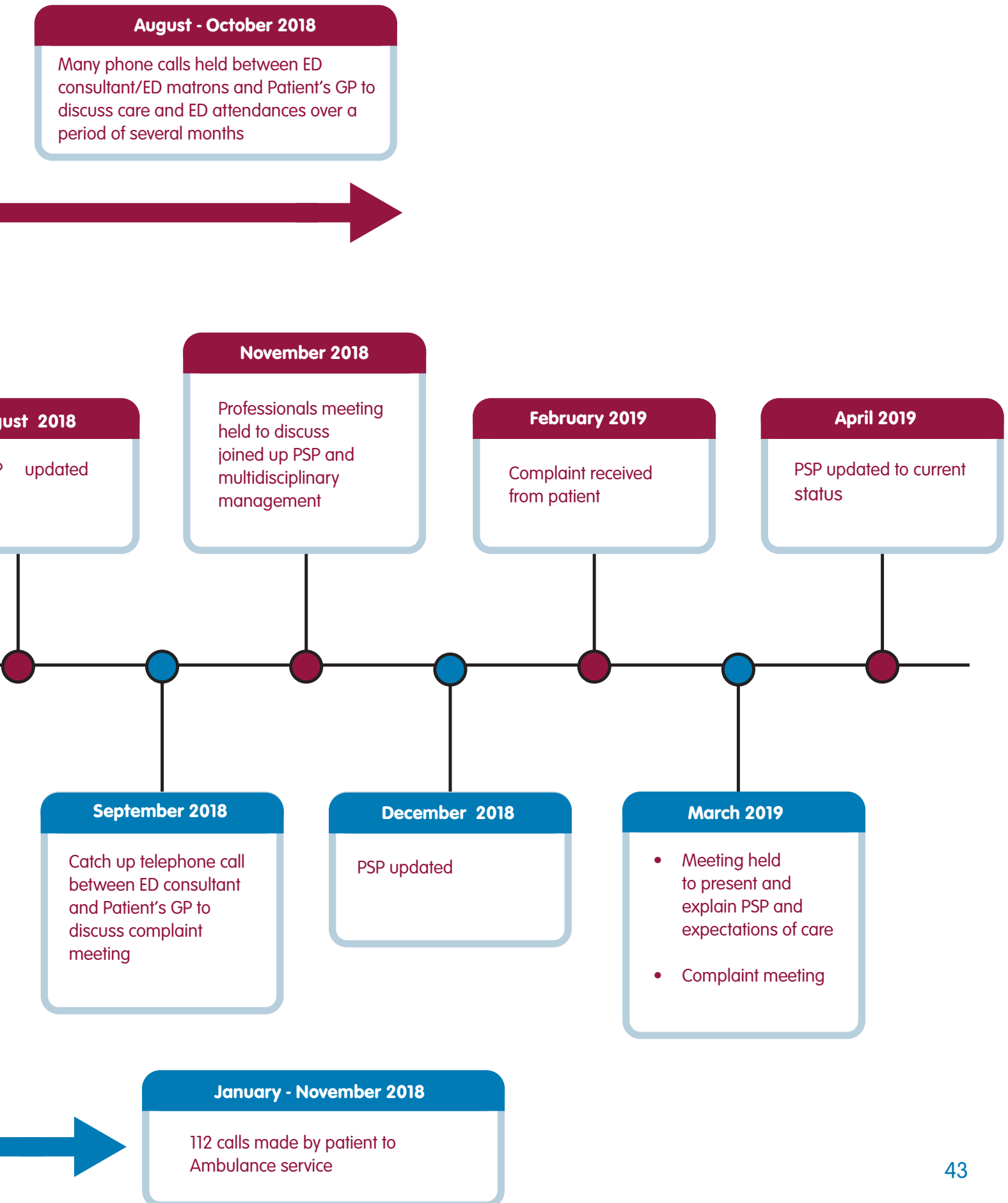
\* If patient is a recognised High Impact User but does not have a Personal Support Plan they are on the waiting list to be seen by the High Impact User Team

## Complex HIU Timeline of Events and Milestones

### History of attendances:

- 2010 ... 2 attendances
- 2012 ... 3 attendances
- 2013 ... 7 attendances
- 2014 ... 3 attendances
- 2015 ... 3 attendances
- 2016 ... 9 attendances
- 2017 ... 32 attendances
- 2018 ... 40 attendances
- 2019 ... 12 attendances





# 5.3 Training

“Bitesize training” sessions are to be delivered in the Emergency Departments to all ED staff during their shifts. The training focuses on:

- What a HIU is and the risks of being a HIU
- The role of the team
- How staff refer to the service
- How to access PSPs

These sessions have proven to be vital to the success of the team and result in staff flagging up patients early. They are also pivotal in promoting a positive culture around HIUs throughout the department. It is for this reason that it is recommended that all staff in all roles should be trained, including the administrative teams.

In the BRI, hour long sessions are also delivered to Emergency Nurse Practitioners and medical staff, including junior doctors to ensure that they are considering the PSPs from early on in their careers and as part of their teaching rota. Understanding the characteristics of the HIUs and their health needs might help support the preventative interventions required for this group, reducing harm, increasing quality care whilst attempting to reduce associated costs associated.

A template for the “bitesize” ward training session can be found online on the West of England AHSN website. This is designed to be adapted to the local set-up.

# 5.4 Communications

## Communications plan

It is important that a communications plan is developed prior to launching the HIU Service in order to boost awareness of the project within the local department, throughout the trust and also to any other members of the wider MDT (including but not limited to the local mental health trust, ambulance trust and third sector).

We recommend discussing this with your trust communications team.

The resources created for the SHarED project can be used as templates and adjusted for local purposes.

## Posters and aide memoires

To support successful implementation of this project, posters and infographics have been developed. One of these posters is shown in this toolkit, however all are available online.

**Have you seen a patient  
who frequently attends the  
Emergency Department?**

**Is the Emergency  
Department the best place  
to care for them?**

**Speak to the High Impact User Team. The patient may benefit  
from specialist review and a Personal Support Plan.**

How do you reach us?

Tel: \_\_\_\_\_

Email: \_\_\_\_\_



**SHarED**



## 5.5 Checklists for implementation

### Get Ready For Your HIU Team Set Up Checklist

HIU Team Launch Checklist	Done
1. Knowledge and understanding of the current local HIU data.	
2. Awareness of the current management of HIUs.	
3. Identify key local stakeholders for the project: <ul style="list-style-type: none"> <li>• ED Consultant</li> <li>• ED Clinical Director</li> <li>• ED Matron</li> <li>• Executive sponsor of SHarED project</li> <li>• Drug Nurses</li> <li>• Alcohol Nurses</li> <li>• Psychiatry liaison</li> </ul>	
4. Review and consider local challenges and factors for success.	
5. Identify key roles at local level: ED Consultant, ED Matron, HIU Co-ordinator.	
6. Develop project delivery plan at local level with start and finish dates for each unit (use of the example project delivery timeline).	
7. Develop a communications plan for local implementation.	
8. Agree local triaging tool and prioritisation process.	
9. Develop all documentation: <ul style="list-style-type: none"> <li>• Personal Support Plan</li> <li>• Patient Letter and questionnaire</li> <li>• GP letter and questionnaire</li> <li>• Multi-disciplinary Terms of Reference</li> </ul>	
10. Agree governance process for Personal Support Plan 'sign off'.	
11. Agree communication plan with the trust Communications Team.	
12. Clarify process for placing alerts on the Clinical Record System.	
13. Design a training plan for the Emergency Department Staff.	
14. Develop the training resources.	
15. Agree a data review process is in place: Who? How frequently?	
16. Consider the long term sustainability of the HIU team.	





## HIU Team Launch Checklist

HIU Team Launch Checklist	Done
Determine launch date with Project Team. Ensure this does not clash with other department events/Trust initiatives.	
<b>Week prior to Launch</b>	
Email staff to inform of launch (see draft email in communications section)	
Meet with Trust communications team to place a short article in Trust newsletter	
Print posters ready for launch day	
<b>Week 1 Day of Launch</b>	
Ensure HIU Service posters are up in key staff areas.	
Email all ED staff about the new initiative: what it is, what it sets out to do, what they need to do, how they contact the HIU Lead/team, how to refer patients.	
Discuss with senior nurses to ensure they are aware of the process and requests that they encourage juniors on shift to refer to the service.	
Clinical Lead to send out Culture Survey to all staff.	
Start to triage first six patients. Use the EDITT tool (PDSA 1) as well as using your own modified tool (PDSA 2) and compare the results.	
<b>Week 2</b>	
Rotate posters; replacing with a different style in each area to maintain profile.	
Email all ED staff with an update of progress from Week 1.	
Report progress to Project Team.	
Commence work with selected HIUs.	
<b>Week 3</b>	
Rotate posters; replacing with a different style in each area to maintain profile.	
Email all ED staff with an update of progress from Weeks 1 and 2.	
<b>Week 4</b>	
Repeat Week 3.	
Report progress to Project Team.	

## 5.6 Further resources

**All of the below resources can be found on our website.**

### Patient information

- Patient letter
- Form for patient completion without mental health needs
- Form for patient completion with mental health needs
- Patient letter for insertion with the Personal Support Plan

### Documentation

- Personal Support Plan template
- HIU patient worksheet
- Bristol EDITT (Bristol Emergency Department Impact Triage Tool)

### High Impact User Multi-Disciplinary Team Resources

- HIU Project Group Terms of Reference
- HIU Meeting Minute Template
- GP letter template
- GP template for completion

# PART 6

## Structure of the SHarED project and lessons learnt

### Project Structure

The structure for the SHarED project was based on the 'Breakthrough Series Collaborative' model developed by the Institute for Health Improvement. This involved a series of collaborative meetings with coaching, calls and webinars in between. The aim of these meetings was to share successes and failures, understand how barriers have been overcome and to learn from data.

Upon completion of the project, the aim was for a self-sustaining network to be in place for continued learning across the teams, utilising the relationships built through the Breakthrough Series Collaborative approach. The network aim on expanding this when appropriate to include other HIU teams both external to the ED and with other ED HIU Teams across the country.

A monthly project team meeting was held, attended by the Programme and project managers and project support officer at the West of England AHSN and the Clinical Lead and Matrons from the BRI. Quarterly steering group meetings to provide project guidance and governance were attended by the core project team as well as the project SRO, Clinical Lead and communications manager.

### Covid-19

The SHarED project was initially due to launch in early 2020, however with the arrival of the Covid-19 pandemic the project had to be delayed. The pandemic continued to put pressure on all EDs throughout the course of the project. While all teams continued to deliver on their commitments of reviewing and writing plans, additional engagement was limited at times due to conflicting demands on their time and other priorities.

It is recognised that the project data may be impacted by the pandemic, in particular during the second and third peaks in November 2020 and in early 2021. The impact on patient behaviour and their attendance patterns to the ED were likely to have been influenced, as well as the overall staff morale. This will be considered in the evaluation.

### Project Learning

The HIU co-ordinator and clinical lead roles were initially funded for a 16-week period. Initiation and set up of the services took longer than expected and therefore the funding was extended for an additional 12 weeks to enable effective data collection.

As described early in this toolkit, the ICECAP-A survey was felt to be an appropriate tool for assessing patient capability and understanding how the HIU Team can influence an individual's wellbeing. The response rate for the ICECAP-A was very low and there is insufficient data to be able to inform the evaluation. This is likely due to the complexities of the individual circumstances around this patient group. Similarly, attempts were made to understand the experiences of patients under the HIU teams through the completion of patient survey. This elicited only two responses.

Three staff surveys were disseminated in September 2020, March 2021 and September 2021. These surveys aimed to understand if the teams were focussed in the correct areas and to ensure that the project was benefiting the staff working across our Emergency Departments throughout the lifespan of the project. Engagement with these surveys was varying and the low response rates were likely due to survey 'fatigue' and competing pressures.

# PART 7

## Glossary and abbreviations

<b>ED</b>	Emergency Department
<b>ENP</b>	Emergency Nurse Practitioner
<b>HIU</b>	High Impact User
<b>MDT</b>	Multidisciplinary Team
<b>PSP</b>	Personal Support Plan
<b>SHarED</b>	Supporting <b>H</b> igh impact users in <b>E</b> mergency <b>D</b> epartments



# SHarED

[www.weahsn.net/shared](http://www.weahsn.net/shared)