

# High Flow – High Intensity User Service Interim Impact Report - August 2024

## 1. Introduction

### 1.1 Background to High Intensity User (HIU) Services

The requirement for all health systems to implement a High Intensity User service was first mentioned in the 2019/20 NHS Operational Planning and Contracting Guidance and again in the priorities and operational planning guidance for 2022/2023.

To support this requirement NHSE developed a model for High Intensity User services which was designed with people who have lived experience of accessing healthcare regularly. The Northern Devon High Intensity User Service model is in line with the NHSE model and has been developed with advice from NHSE.

The HIU support offer was first established in Blackpool in 2015, winning the Kate Grainger award for Compassionate Care in 2018. The programme has since been adopted as a model by NHSE and has spread across ICS – including in Devon where a service currently exists on all localities.

### 1.2 The High Intensity User Service in Northern Devon.

The HIU Service in Northern Devon has been running since January 2024 working with a VCSE provider, Encompass South West. Currently the service is resourced with 2.5 WTE delivery staff and a 0.6FTE Manager.

The Case for HIU Services In Northern Devon

Prior to the HIU Service starting, between September-November 2023 there were 1008 attendances by high intensity users to North Devon District Hospital ED.

48 people attended the Emergency Department more than 5 times in that period.

A significant proportion of those people attending ED had unmet health and social care need. The HIU service aims to demonstrate that attendances to the Emergency Department may have been avoided if those needs were better identified and the most appropriate support offered earlier. This would have improved care for those individuals, reduced costs, increased ED capacity to treat other patients in a timely fashion, and enabled better deployment of resources to meet the local population health needs.

It was considered that the experience of everyone accessing ED would be improved if there were fewer people physically in the building that could have been better served elsewhere.

The main objectives of the Northern Devon HIU Service are:

- To sustainably improve the overall health and wellbeing of the individuals repeatedly using ED.
- To reduce the impact of high intensity users on the NDDH Emergency Department
- To reduce the impact of these high intensity users on wider system partners by utilising the established system partnerships and learning developed through the OND flow programme
- To align the One Northern Devon High Flow programme with the NHSE HIU programme\*

In setting up this service we have utilised a consultancy from the NHSE National HIU Lead, Rhian Monteith, who has provided training for all staff as well as ongoing mentoring. She has been involved with the design of our service providing quality assurance that the original principles and methods of the national HIU service specification are integrated within, and enhanced by, our existing High Flow model.

### **1.3 Current Funding Situation**

HIU Service North will end in 2 months meaning Devon will no longer be compliant in the NHSE requirement for HIU delivery.

Staff delivering the service remained committed to the work and the patients they were supporting, despite facing a cliff edge – and the risk of losing their employment. They have already faced a similar situation in May 2024 when ICB funding uncertainties meant they did not hear that their jobs were safe until two weeks before their contracts were due to end. They will be facing a similar cliff edge again in two months' time – and there is a real risk of staff either leaving or becoming unwell due to the employment uncertainties they face.

This would further mean the service would be unable to operate as additional investment would be needed to train new workers to the required standard. Further with limited time left on any subsequent contracts until Mar 2024, it would be unlikely that the provider could successfully recruit into these roles – meaning delivery would likely stop until March 2025 when next year's locality funding should become available.

### **1.4 ICB Business Case May 2024**

At the end of May 2024 the ICB stipulated that a full business case was needed for continued funding of HIU services. During this period, we were also informed that the initially stated amount available for each locality, through the ICB Population Health Budget, was to be reduced. Further the previously identified allocation specifically for HIU services was removed – meaning that all funding had to come from the locality allocation within the Population Health Budget. This resulted in there being insufficient funds within the locality allocation to cover all the projects already approved by the Northern LCP, including the HIU service.

Therefore an HIU service business case for a reduced amount of £49,570 was submitted to the ICB. We highlighted that this left a shortfall of £51,573 and it was indicated to us that this shortfall could potentially come from the ICB's UEC budget – as this budget had been used to contribute towards HIU funding in other areas of Devon – for example Torbay and South Devon

## 2. Latest HIU High Flow Report – July 2024

### 2.1 Highlights

#### 2.1.1 Monthly Headlines

- In this reporting period (Jan-Jul 2024), the equivalent of 2.5 FTE High Flow case workers have supported 24 clients
- This includes 6 new clients
- In the 12 months prior to High Flow engagement, these 24 people have:
  - Attended ED 319 times
  - With 37 subsequent non-elective admissions
  - And 160 ambulance conveyances
- At a total cost of **£159,381.00** (£52,316 ED, £71,225 non-elective and £35,840 ambulance conveyances)

*RDUH 2023/2024 cost references as follows:*

- Average cost of an emergency admission: **£1925**
- Average cost of an attendance to A&E **£164**,
- Average cost of an ambulance conveyance **£224**

#### 2.1.2. Changes in Activity

Metric	Jul-24	Q1	Q2	Q3	Q4	YTD	Cost of demand reduced
New Clients Supported in Period	6	23	8	6		37	
Reduction in ED attendances starting 3 months from intervention beginning (NHSE Target 40%)	90% (21 to 2)	60% (90 to 36)	67% (36 to 12)	90% (21 to 2)	-	66% (147 to 50)	£15,908
Reduction in non elective admissions 3 months from intervention beginning (NHSE Target 40%)	100% (6 to 0)	27% (11 to 8)	65% (26 to 9)	100% (6 to 0)	-	60% (43 to 17)	£50,050
Reduction in ambulance conveyances 3 months from intervention beginning (No NHSE Target)	100% (10 to 0)	60% (43 to 17)	71% (21 to 16)	100% (10 to 0)	-	64% (64 to 23)	£9,184
Clients Ending Support	3	7	10	4		21	

## 2.2Data

### 2.2.1. Monthly and Year to Date Data Points:

Metric	Jul-24	Q1	Q2	Q3	Q4	YTD
Number of wider beneficiaries	4	4	7	5	0	16
Clients who declined	2	22	5	2	0	29
Case concluded successfully	1	2	3	2	0	7
Closed cases due to disengagement	1	2	2	1	0	5
Closed cases due to death	0	0	0	0	0	0
Closed cases (other reasons, i.e. moving out of area)	1	3	1	1	0	5
Number of contacts/interventions with clients	206	629	964	303	0	1,896
Current caseload	23	17	19	22		22

### 2.1.2. Monthly and Year to Date Support Provided

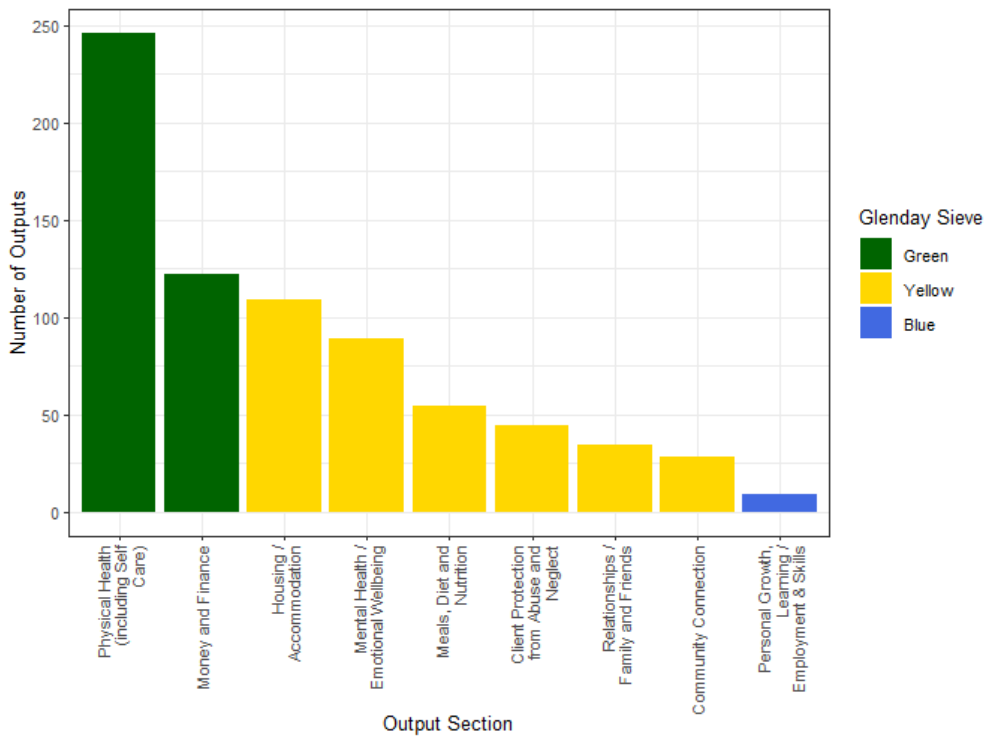
Metric	Jul-24	Q1	Q2	Q3	Q4	YTD
Team Around the Person meeting conducted	0	0	0	0	0	0
Flow meeting with FC & Lead Professional	0	0	0	0	0	0
One-to-one work with clients (per client) number of individual one to one interactions with client	127	162	399	198	0	759
Continued ongoing contacts with professionals (total number of separate contacts)	84	50	178	211	0	439
Caseworker research undertaken to find solutions for clients	17	36	55	28	0	119
Caseworker support to access Personal Health Budget	0	0	0	0	0	0
Caseworker support with Form filling	5	5	6	5	0	16

Metric	Jul-24	Q1	Q2	Q3	Q4	YTD
Caseworker support with IT incl. virtual meetings, emails etc	2	3	11	2	0	16
Caseworker support to meet aspirations	3	9	13	5	0	27

## 2.3 Outputs and Outcomes

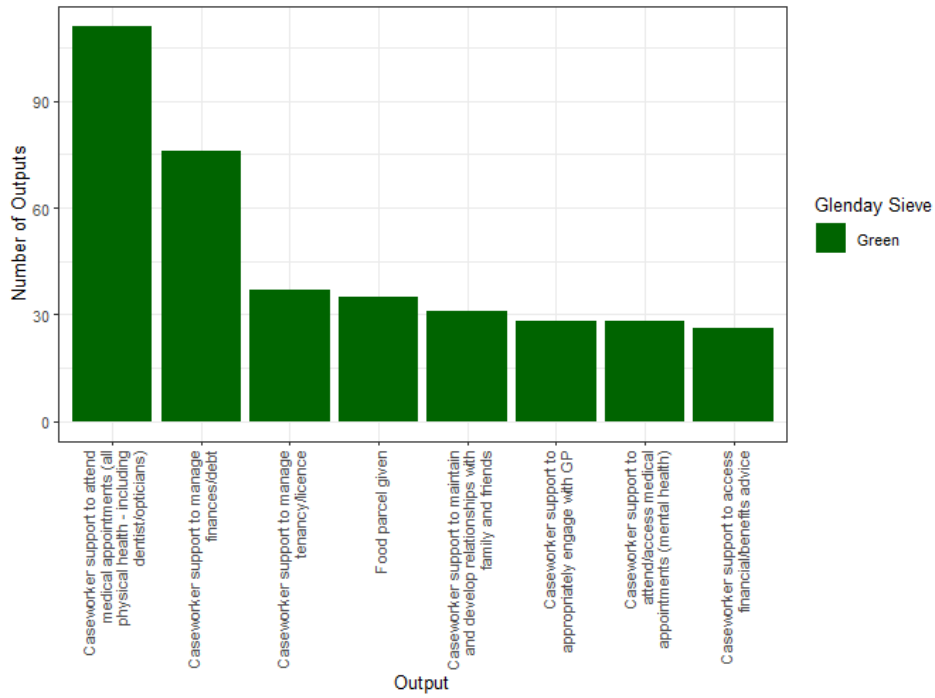
### 2.3.1 Outputs: Sections - Year to Date

Glenday Sieve Plot for Output Sections for the Year to Date  
Jan-24 to Jul-24

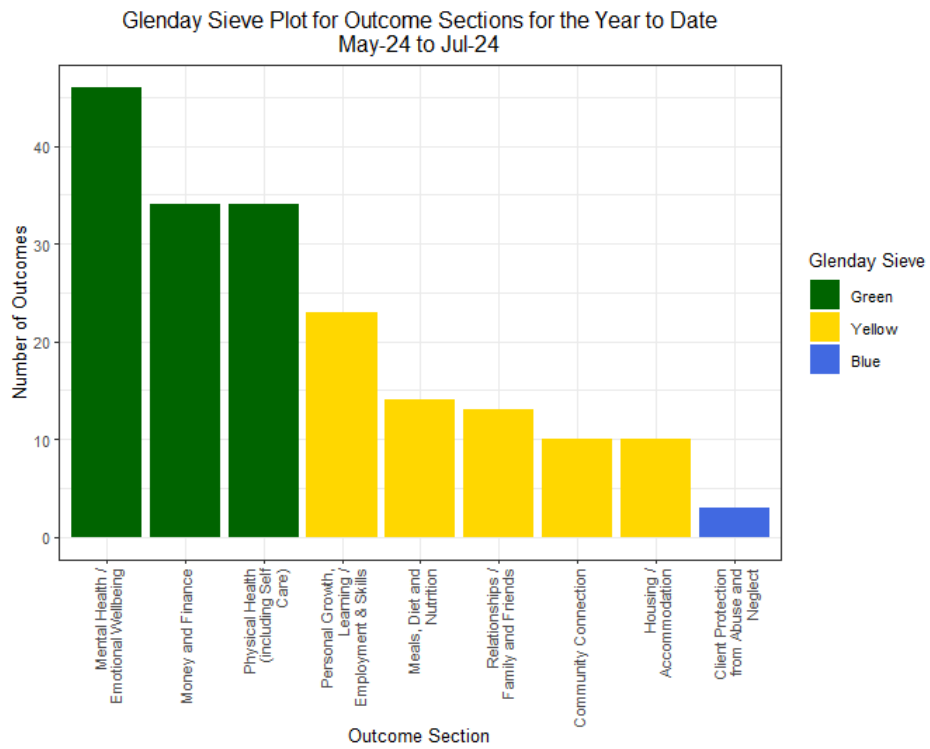


### 2.3.2 Outputs: Sections and Outputs - Year to Date

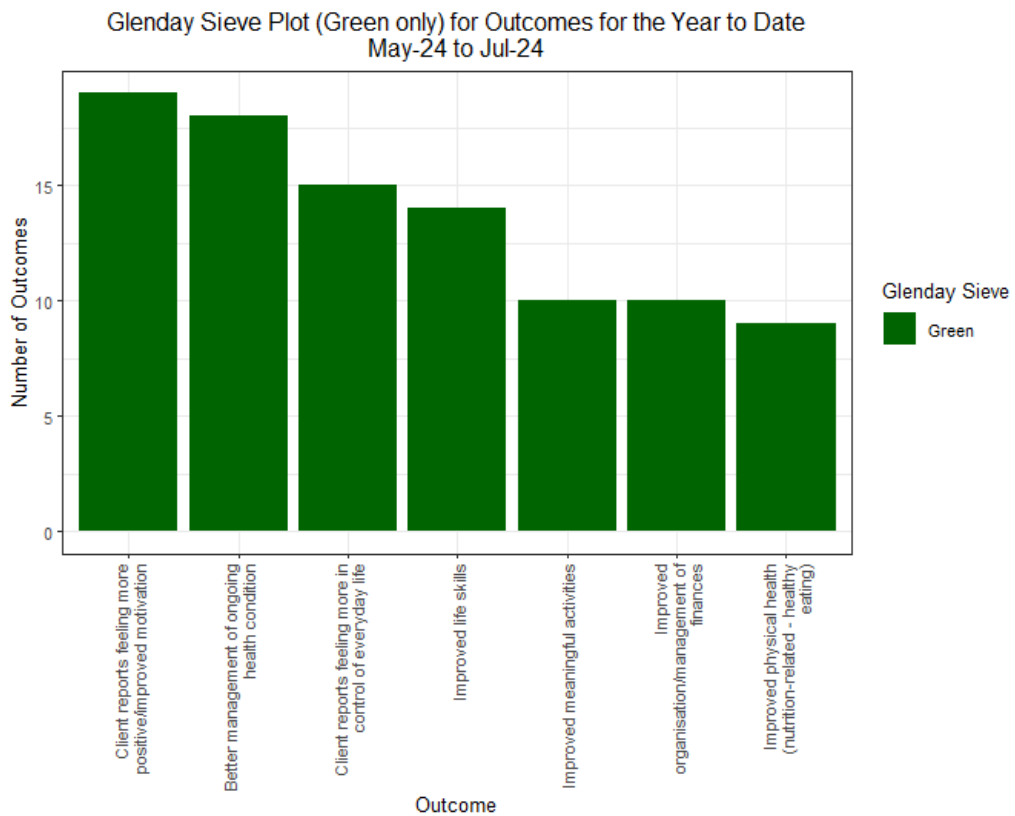
Glenday Sieve Plot (Green only) for Outputs for the Year to Date  
Jan-24 to Jul-24



### 2.3.3 Outcomes: Sections - Year to Date



### 2.3.4. Outcomes: Sections and Outcomes - Year to Date



## 2.4 Patterns of Need and Barriers to Delivery

### 2.4.1 Emerging patterns of need identified by HIU case workers:

- A significant number of clients have varying mental health needs ranging from people who have been under the radar but not quite high enough needs to have the support they feel they need to people living with severe trauma. One caseworker advises that all her caseload have experienced childhood trauma.
- Addiction
- Housing/tenancy support – across the team we are seeing an increasing number of people facing financial challenges and hardship needing support with bills and other financial issues and generally requiring help to maintain their tenancy.
- Physical health – illnesses that seem to be difficult to diagnose/get a diagnosis for and clients have no medical answer. People requiring multiple referrals and tests to try and get answers.

### 2.4.2 Identified barriers and challenges to effective working by HIU workers:

#### **Mental health**

- All caseworkers report that it is regular for people to be on waiting lists for extensive periods (6 – 12 months minimum) and services are under pressure resulting in matters such as closing cases due to 'non engagement' (i.e. initial contact attempts are unsuccessful or don't attend an appointment and no further contact attempts made) which is a barrier for some with mental health needs and who are anxious about answering the phone/don't open mail etc.
- Clients have experienced difficulties being able to see a care coordinator on a regular basis also when their case is open.
- As the project wraps support around people, HIU advises services if a client has mental health issues and/or a decline in either mental or physical health and has any contact/communication issues, anxiety around attending appointments or problems with affordability. Caseworkers frequently facilitate this and often attend appointments to start/progress support.

#### **GP appointments and ED attendance**

- All caseworkers report that frequently clients are waiting 4-5 weeks for an appointment often to be seen by a locum or part time GP that doesn't always understand the client, this leads to caseworkers and clients going round in circles explaining needs/history etc.
- Some clients have attended ED due to not being able to get a GP appointment.

#### **Pharmacies and ED attendance**

- Caseworkers are reporting a link between pharmacies and ED attendance due to issues such as medications being out of stock, leading to some clients calling 111 and being advised to go to ED, an example is a client with bipolar disorder who was unable to collect medication as it was out of stock, they panicked and went to ED.

#### **Cost of living**

- Caseworkers have seen clients dealing with additional hardship, which leads to a myriad of daily living issues directly relevant to HIU for some clients supported is the unaffordability to travel to appointments, this has also been challenging in rural areas with either no or infrequent public transport.

Current experience in the delivery of HIU is that factors including those mentioned above are resulting in higher levels of complexity requiring cases to remain open for longer than would be anticipated.

### **Project Funding**

- Funding to date has been short-term, initially from January to June 2024 and currently to October 2024, this is challenging for caseworkers and the project in general due to feelings of insecurity about the future of both the teams' roles and the project.

## **2.5. Case Study**

### **About the client / background:**

- K is an intelligent and funny person who tries to help anyone he meets he is in his late 20s and has faced significant challenges in life due to prolonged alcohol and drug use which has been ongoing since the age of 12 due to childhood trauma.
- His lifestyle has led him to rough sleeping which is directly linked to ED admittances.
- He has struggled to maintain relationships, particularly with his brother and other family members.
- His mental health has deteriorated, contributing to difficulties engaging with support services and addressing substance use. Despite all of these challenges he has shown a desire to change his situation and regain control of his life.

### **What mattered to the client:**

- Finding a stable place to live. It will provide the foundation needed to address other challenges and is a big goal of his.
- He is committed to reducing and eventually stopping alcohol consumption. With the support of the drug and alcohol centre and Encompass Southwest, he is making progress, but this remains a longer-term goal.
- Accessing mental health services is critical for his continued progress. Encompass is actively working to connect him with the right professionals, as this is very important to him.

### **What happened / What did we do:**

When K first came into contact with us, he was in a vulnerable position. His substance use had alienated him from family, and he was overwhelmed by the prospect of seeking help. He found it incredibly difficult to attend appointments alone due to anxiety and mental health struggles. He was also facing a court case and ongoing probation obligations that he found difficult to manage.

Recognising the critical need for substance use intervention, we connected him with Together drug and alcohol services. Understanding his anxiety and reluctance to go alone, we accompanied him

to appointments so they could be maintained. This support was crucial in ensuring that he could engage with the treatment services, as his anxiety made it impossible for him to attend on his own.

Mental health was a significant barrier to recovery. We have made safeguarding referrals and are currently speaking to mental health professionals to find the right support for him. While this process is ongoing, we have provided support through regular check-ins, listening to his concerns, and offering reassurance during times of distress to prevent further deterioration of mental health.

With a looming court case and the need to adhere to probation requirements, he was under immense pressure, we provided practical support by ensuring he could attend his court appearances and probation meetings, including reminding him of upcoming dates, provided transportation when needed, and accompanying him to appointments to offer moral support. His relationship with his family, particularly his brother, had broken down over the years due to lifestyle choices. We started communications between him and his family, encouraging small steps towards rebuilding trust. While this relationship is still fragile, there has been progress and he is expressing a desire to reconcile with family.

He has made significant strides since engaging with Encompass Southwest. He regularly attends drug and alcohol support appointments, has been consistent with probation meetings, and is gradually rebuilding relationships with family. However, challenges remain, particularly in securing permanent housing and accessing specialised mental health support.

His journey so far is a testament to the resilience and determination of individuals facing significant challenges. While he still has a long way to go, the support we have provided has been instrumental in helping him navigate the complexities of his situation. We remain committed to supporting him as he works towards achieving his goals, with the ultimate aim of helping with the transition from rough sleeping to a stable, healthy and more sustainable life.

**Client feedback & did the project work meet their expectations:**

K has expressed several times how grateful he is for our support he has received, we are still working with him.

**What have we measured:**

- Length of Engagement to date since consent: 5 months (case remains open)
- WEMWBS Score (start/finish/difference): Start 16
- ED and non-elective admittances as well as ambulance conveyances have slightly decreased during the time High Flow have been supporting, however, until he is housed admittances are likely to continue.

**What did we learn:**

I have learnt it is very difficult to locate clients while they are rough sleeping as it is very easy for them to lose their phone, so extra time is needed to track down clients who are rough sleeping.

**Quotes and other feedback:**

<b>Client</b>	'I'm glad someone is finally helping me I feel like no one cares'
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## 2.6. Feedback

### 2.6.1. Feedback from clients

Morning Becky, it was lovely to meet you yesterday. Thank you so much for your help.

It is just good to know you are there if I need to talk to somebody, if I call the Moorings, it might be somebody that I don't know.

I am feeling a lot better than I did before

Thank you for trying to help my brother he really needs this help from you it means a lot

I'm glad someone is finally helping me I feel like no one cares

Thank you so much, this really has been helpful.

You've been a massive help today thank you so much

Thanks for coming, you are an angel

You've been a massive help today thank you so much

### 2.6.2. Feedback from professionals

Becky, having reviewed the Order, we have to approach anyone from her mental health team who is supporting her. Now I know this does not strictly apply to yourselves as far as the 'mental health team' is concerned, but she tells me it is only you she is seeking help from. (From the Solicitors involved in the case).

Morning Katie,

Excellent, thank you for discussing this with her.

(NDC Housing Options)