

# High Flow

## Report to One Northern Devon LCP

Period: 3 January to 20 March 2024

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## Background

### Introduction to the High Flow / High Intensity Use Programme

From inception in 2012, the [High Intensity Use](#) (HIU) Programme has been designed and developed with people who have lived experience of accessing healthcare regularly. The HIU service in North Devon is commissioned and delivered at local level as the High Flow (HF) programme, regionally led and supported at national level.

Research has shown a clear link between high intensity use of the Emergency Department and wider inequalities. HF supports urgent and emergency care (UEC) pathway pressures whilst at the same time addressing health inequalities and unmet need of people with chaotic lives, helping to free up front line resources and reduce costs.

HF in North Devon comprises 2.5 FTE caseload workers that proactively make contact with the most frequent attenders of the North Devon District Hospital (NDDH) to find out what is happening in their lives and uncover any underlying reasons for ED attendance. High intensity use of ED is associated with non-medical factors including age, housing instability, social isolation, loneliness, deprivation, and as well as poor physical and mental health. For HF, outcomes include reducing health inequalities and a reduction in avoidable emergency department attendances, non-elective admissions or 999 calls.

High Flow is part of [One Northern Devon's Flow Programme](#) that aims to offer person-centred care and support to people with multiple and complex needs.

### National HIU Policy

This programme also serves to meet several national policy asks:

## National Policy



HIU demonstrates that innovations from the front line can be developed into national policy and that impactful innovations can be scaled nationally. HIU has increasingly been included in NHS policies as detailed below:



### **2023/24 priorities and operational planning guidance**

"Continue to deliver against the five strategic priorities for tackling health inequalities and establish High Intensity Use services to support demand management in UEC.



### **23/24 Business plan**

"Support the continued roll out of High Intensity Use services"



### **Delivery Plan for Recovering Urgent and Emergency Care Services and The UEC Framework**

"Systems will continue to roll out High Intensity Use Services, adopt good practice in supporting patients who are experiencing homelessness or rough sleeping, and embedding family support workers in A&E settings to provide additional support to children and families presenting with non-urgent issues."

HIU is a core objective in NHS England Winter Plan 2022 "Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter" and HIU features in the integrated care board assurance framework. In [the 2023 planning guidance](#) on embedding measures to improve health and reduce inequalities.

## Project Mobilisation

The enhanced HF project started in January and included:

- The design of new project documentation, systems and processes, reporting workbooks and caseload trackers.
- Team training on the new approach and way of working, incorporating coaching from Rhian Monteith (ongoing).
- Caseworker training on new administration processes, including project documentation and reporting.
- Restructuring teams - caseworkers now have designated geographical areas to maximise impact and efficiency of travel time and home location e.g. Ilfracombe/surrounding, Barnstaple area/surrounding, Torrridge. This encourages ownership of their 'patch' in identifying which services are available for wider support/linking in and building/maintaining relationships/links in with those organisations/key people and asset mapping.

## New Project Processes

The project requires a greater amount of team and caseworker time dedicated to the various administration processes and the HIU model suggests a split of 60/40 casework and admin time.

Prior to adopting the new national HIU model, which takes its referrals from the ED frequent attenders list only, High Flow had been in existence since January 2020, having been developed by the One Northern Devon partnership and with a Steering Group made up of all High Flow partners who were also able to refer their most intensive service users (D&C Police, SWAST, DPT, NDC, TDC, DCC and RDUHT). The last Steering Group took place in December prior to the new High Flow project going live.

Partnership working remains critical to the success of the High Flow intervention and partners expressed a strong desire to remain fully involved (see next steps).

## Project Outputs

### Population Served

	<b>North Devon</b>	<b>Torrige</b>
Size in Square Miles	419	380
Population 2018, ONS	96,110	68,143
% Living in Rural Areas (settlements fewer than 10,000 residents) 2011 Census	43	58

### Caseload Numbers

The expected caseload number for this period is 14 but the programme is actually working with 18, therefore exceeding this target.

In addition, there have been 6 people supported as wider beneficiaries including family or friends of HF clients that if not also supported may impact on achieving client goals and outcomes.

HF allocates 3 new cases per month per FTE caseworker, which equates to 7.5 in total for the project. This is in line with the national recommendation of 3-5 new cases per month per FTE; 3 is recommended for rural areas due to travelling time and lack of services and 5 for urban areas.

Within this, one caseworker has 18 hours on ED homelessness pathway work and the remainder of their hours on HIU ED which means all her homelessness clients will be complex and not short-term.

### Highlights for the Period

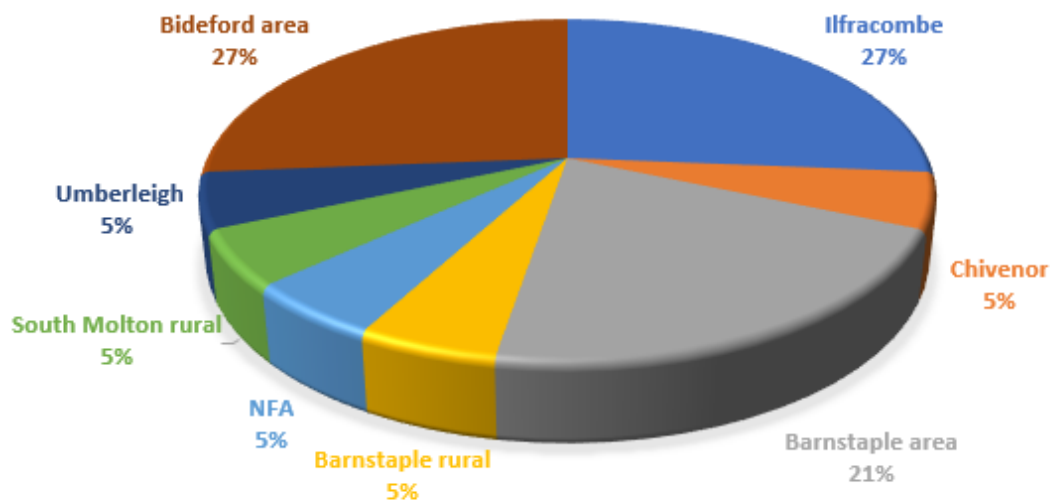


### Demographic

The demographic of people worked with include:

- Average age of 40 with a range between the ages of 18 to 79.
- Clients live on average 12.2 miles from NDDH; with a range of 3 to 22 miles.
- There is a 50/50 gender split

### WHERE HIU CLIENTS LIVE



## ED Activity pre-intervention

In the quarter prior to each person's contact with HF, the cohort of people:

- Attended ED 110 times
- With 14 subsequent non-elective admissions
- And 46 ambulance conveyances to NDDH.

## Summary of the Top 20 Attenders to ED

The information below provides a snapshot of the 20 most frequent attenders on the ED list linked to HF input:

- 35% are actively being supported by HF.
- 25% are exempt from the programme (under-age, out of area, end of life, current support from Encompass Southwest's other services)
- 10% declined support due to health needs self-resolving.
- 10% uncontactable so far but HF will continue to reach through different methods.
- 20% not yet contacted due to lack of capacity of caseworkers but will endeavor to contact next month.

## Client Goals

6 of the 18 people HF is working with have goals they are being supported with, engagement and building relationships is underway across the caseload to identify these and the support needed.

In future reports the progress towards achieving client goals will be included.

## Project outcomes

### Client Outcomes and Outputs

The chart and table in appendices 2.1 and 2.1.1 display the outcomes achieved related to the areas of need that clients have identified, the main areas requiring support have focused on:

- Money and finance
- Mental health and emotional wellbeing
- Physical health (including self-care)
- Personal growth (learning, employment and skills)

Appendices 2.1.2 (outputs chart) and 2.1.3 (outputs table) shows the associated output headers, these are the main areas of support provided by caseworkers linked to the achievement of outcomes.

Appendix 2.1.4 breaks down further the various outputs associated with the outputs chart and table.

For further detail on client's situations, journey, what matters to them and caseworker support refer to appendix 3.0 which includes client case studies for the period.

## Client feedback from first 8 weeks

*"I've told the police I have support in place now I have you which is what I need I'm glad"*

***"I am so proud of myself that I don't drink at all like I used to...I was sick and tired of being drunk"***

*"Thank you for not judging me and listening"*

*"Thank you for the love and loyalty you have shown me since we first met. You have been of great practical help too. My discovery journey of self-correction has been revealing and interesting. I have understood and learned much. You could not have been more helpful, flexible and accommodating. Now, I feel settled and on a straight path. Thanks entirely to you. I'm so glad you are my insightful friend. You've been a joy to me ever since we first met"*

***'Speaking to you has really helped me even my mum said it's good for me"***

***"My meds are starting to work and I feel like things are getting better I'm so glad I'm out of the way up here thank you for helping me"***

*"I really like the sound of graded exposure but it needs to be with the right person so probably best if I do it with you!"*

*"When we first met, I was all doom & gloom, now I can think about the future and think more positively!"*

***"It feels good to be in a restaurant having food and not feeling that I have to have any alcohol"***

*"I have £65 left in my tin, which never happens, this is a really good month financially & I think you would agree this is how I SHOULD be looking after my finances, I am so proud of myself & would pat myself on my back if I could!"*

***"Thank you for always looking out for me."***

*"I am so sorry for all my messages, bless your ears! I hope you have a good weekend"*

***"I appreciate you believing in me. It's hard sometimes to believe in myself but I know I have to or else things won't get better"***

*"You have a heart"*

***"You have done more for me in a month than anybody, thank you!"***

*"I would like all of my paperwork to be handed to you and you take over being my social worker"*

***"Thanks for today, I actually really enjoyed myself and had a good laugh too lol, it was nice to have some time together and it not all be about work"***

*"Thank you so much, you did it, and we didn't need to ask other people and wait. Having you to speak to helps my confidence even my mum can see it"*

## Professional feedback

'I can't remember the last time we saw him in ED'  
(ED Staff Nurse Re: a client who was a frequent attender to ED)

'Thank you for taking him on he really needs  
this extra support'  
(Nurse)

'Thank you for supporting XX he does have  
the potential I believe he can do this'  
(Nurse)

SE Social Worker. "We asked Kate if she would like somebody to support her in the next meeting, she said she would like you to be there to support her. "  
(Re: case study A below)

GP Freedom Centre - 'He is looking amazing, and you can tell he's put on weight great work'.

Nurse S Freedom Centre- 'I've never seen him looking this well I'm so glad you have been able to house him' (Re: case study B below)

## Learning

### Emerging Patterns of Need Identified by HF Caseworkers

Experience so far has been that most clients will need in-depth longer-term support e.g. medically unexplained health issues, PTSD, ACEs, long-term mental health issues (which may not have previously been fully supported), attempted suicide, mental health issues in immediate family/children.

Other needs identified include; debt, isolation, childhood trauma and childhood sexual abuse. For some clients the development of trust and building relationships will take time, which is difficult to quantify in terms of timescales.

All clients from the homelessness pathway ED require in-depth support and have multiple complexities, for example a current client has a 20 year history of homelessness, heroin and other substances addiction, requires frequent support with appointments and general daily living (shopping, budgeting, managing finances. Clients who have been homeless and/or rough sleeping can take a significant amount of time to settle into accommodation and manage daily life before positive results and outcomes are seen.

### People who have declined support

Some people contacted from the ED list who have declined support have stated they don't need support and have explanatory reasons for attending ED e.g. blood disorders, leg ulcers etc., and struggled to access healthcare at the weekends, sometimes due to their location.

### Frequent attenders across partners

Discussions are ongoing about how we will continue working collaboratively in the revised format.

Some of this has started already with Police and SWAST working with their data and to date we have been able to identify:

From SWAST's top 15 frequent users

- 8 are on the ED list, of which:
- 3 are being supported by HIU, 3 to be contacted and 2 are exempt

From the Police data:

- None are on the ED list or SWAST data

## Issues and risks

### Identified Barriers to Effective Working by HF Caseworkers

For initial home visits caseworkers need to attend jointly (lone working policy at ESW) which has meant some visits have been held in public places which can slow the support/engagement process needing to find a suitable venue to meet., whereby the client feels comfortable.

The new approach to contacting potential clients has been described as cold calling because those on the list are unaware they will be contacted regarding their ED attendances. Understandably this means that those on the ED list can be difficult to contact and/or decline support from HF.

All caseworkers have historically worked on projects whereby referrals are incoming either by self-referral or from an organisation.

The 'sign-up' rate is lower because of this, however if the same names appear on later lists people who initially decline might accept support in the future.

Caseworkers are learning the best approach when making initial contact and developing confidence in doing this.

IG remains a challenge – we have worked our way through IG issues to enable us to start work on the project in an IG compliant way but we cannot currently work with our non-RDUH partners in the same way and the process we have is not efficient and requires a lot of project manager time that hasn't been accounted for.

## Next Steps

- IG processes will be put in place to allow partner data sharing for the benefit of the individual with their consent.
- High Flow Steering Group will be formed.
- Reporting format and processes will be finalised
- Outcomes will be uploaded to Impact Reporting

Report by Nicola Topham (Operations Manager – Flow)

## Appendices

### Case Studies

#### Case Study – A

##### About the client / background

- Kate is a young women who loves music and art. She is motivated to get well again and has engaged really well and accepted the support from HF. Due to previous trauma and a difficult childhood Kate has struggled with mental ill-health for many years, she also struggles with drug and alcohol addiction, which she uses to cope. Kate had attempted suicide and this further impacted on her mental and physical health. She finds it difficult to engage with her GP and other services and and struggles to remember conversations which makes it difficult for her to feel in control of her life. Kate has many issues with outstanding debt and due to her mental ill health and struggling to engage, the debt has mounted up and become unmanageable. Kate was also at risk of eviction/court action for her housing provider. She was struggling to stay healthy and wasn't eating properly. Kate's child has been taken into care and this is very hard for her to deal with emotionally. She would like to have better contact with her child and would like to be able to have the child live with her again. She would like to learn again and resume her interest in music.

##### What mattered to Kate:

- Getting her debts under control
- Dealing with court action and not being evicted from her property
- Her child
- Going onto a Drug and Alcohol programme
- Feeling in control, feeling well again
- Going on a pattern changing course
- Not being lonely, connecting with the community

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

- We made contact with the housing provider and confirmed that the court action would be put on hold, we explained Kate's situation and we kept communication open between the housing provider and Kate.
- We made contact with Universal Credit and filled in the health questionnaire necessary to receive the increased amount of benefit
- We made contact with a Debt consolidation charity to help support the application that had been put on hold.
- We made contact with the council and applied for a discretionary payment
- We supported Kate to attend a drop in for young women
- We contacted the GP to arrange a face to face appointment
- We provided a Food Bank Voucher and picked up and delivered the parcel
- We helped prepare a budget form
- We researched other available grants

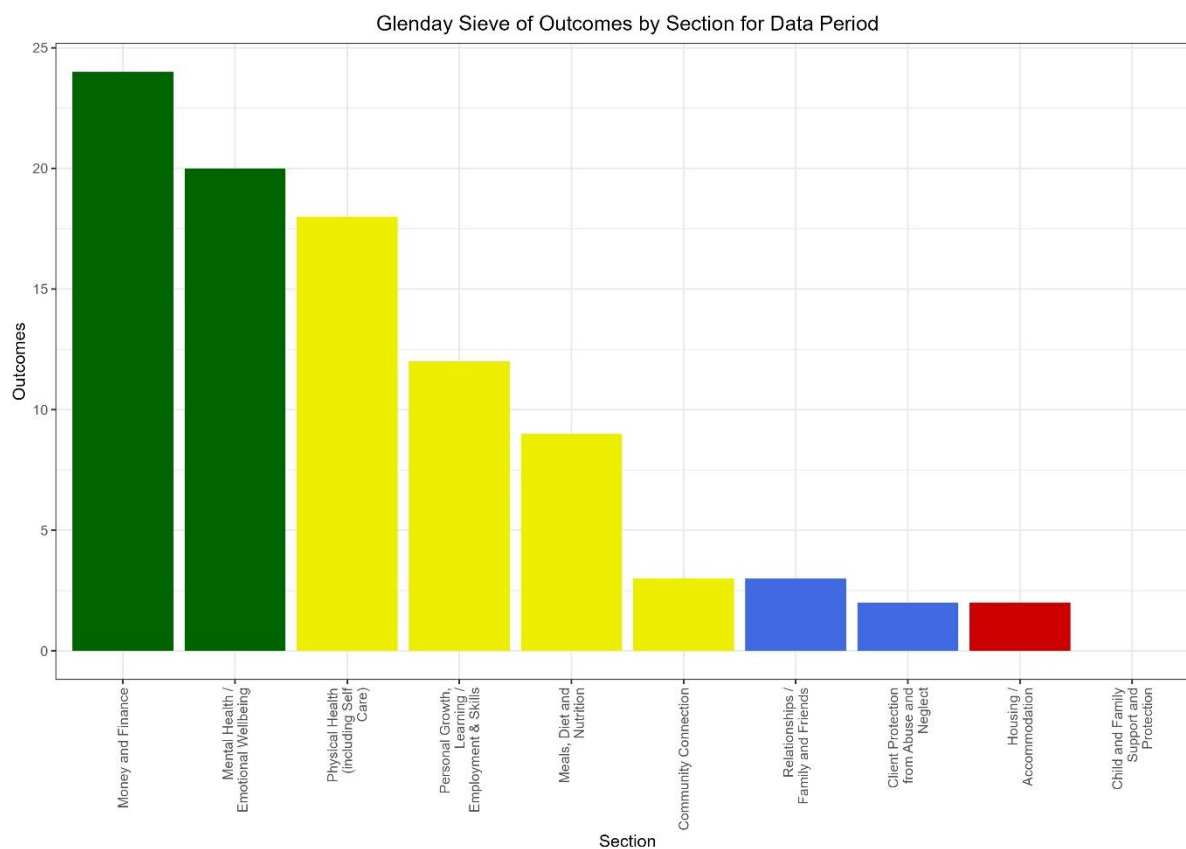
<p>Client feedback &amp; did the project work meet their expectations:</p> <ul style="list-style-type: none"> <li>• The client has thanked me multiple times, she is still recovering and this might take more time.</li> </ul>
<ul style="list-style-type: none"> <li>• What have we measured (e.g. outcomes / outputs / other if applicable): <ul style="list-style-type: none"> <li>• Length of Engagement to date since consent: 6 weeks</li> <li>• WEMWBS Score (start/finish/difference): 17</li> <li>• Outbound / Inbound Referrals: A&amp;E</li> <li>• Main Outcome / Outputs Achieved <ul style="list-style-type: none"> <li>○ Money and Finance</li> <li>○ Housing and Accommodation</li> <li>○ Mental Health and Emotional Wellbeing</li> </ul> </li> </ul> </li> </ul>

## Case Study - B

<p>About the client / background</p> <ul style="list-style-type: none"> <li>• Luke possesses various strengths that make him stand out among others. He is an individual who is highly respected and admired by many for his exceptional qualities. His strengths lie in his personality and character, he always tries to make everyone laugh around him and talks to every person he meets with no judgement. Luke would give his last penny to someone in need which makes it a great honour to support him.</li> </ul>
<p>What mattered to the client:</p> <ul style="list-style-type: none"> <li>• Luke's main goals were to stay housed, stay clean from drugs and to maintain all of his appointments which benefit him in his recovery and day-to-day life.</li> </ul>
<p>What happened / What did we do:</p> <p>We supported Luke by accompanying him to his appointments and offering moral support, supporting him with any paperwork e.g. council tax, bills so he can maintain his tenancy and stay housed. We also supported the client with his drug and alcohol appointments and aided him through his recovery process so he has felt supported and not alone as he does not have many friends or family in the area who are not using drugs which can be triggering for the client.</p>
<p>Client feedback &amp; did the project work meet their expectations:</p> <ul style="list-style-type: none"> <li>• Luke is very happy with the support he has received from the project and the support which is ongoing</li> </ul>
<ul style="list-style-type: none"> <li>• What have we measured (e.g. outcomes / outputs / other if applicable): <ul style="list-style-type: none"> <li>• Length of Engagement to date since consent: 10 weeks</li> <li>• WEMWBS Score (start/finish/difference): The first score is 41 we do not have a finish score yet as the client is still being supported by the project.</li> </ul> </li> </ul> <p>Main Outcome / Outputs Achieved</p> <ul style="list-style-type: none"> <li>• Physical Health</li> <li>• Meals, Diets, Nutrition</li> <li>• Housing/Accommodation</li> <li>• Support to attend appointments.</li> </ul>
<p>What did we learn (complete if applicable):</p> <ul style="list-style-type: none"> <li>• Relationship building is key, especially with clients who have been in and out of homelessness for years.</li> </ul>

## Outcomes and Outputs Data for the Period

### Main Outcome Labels Chart

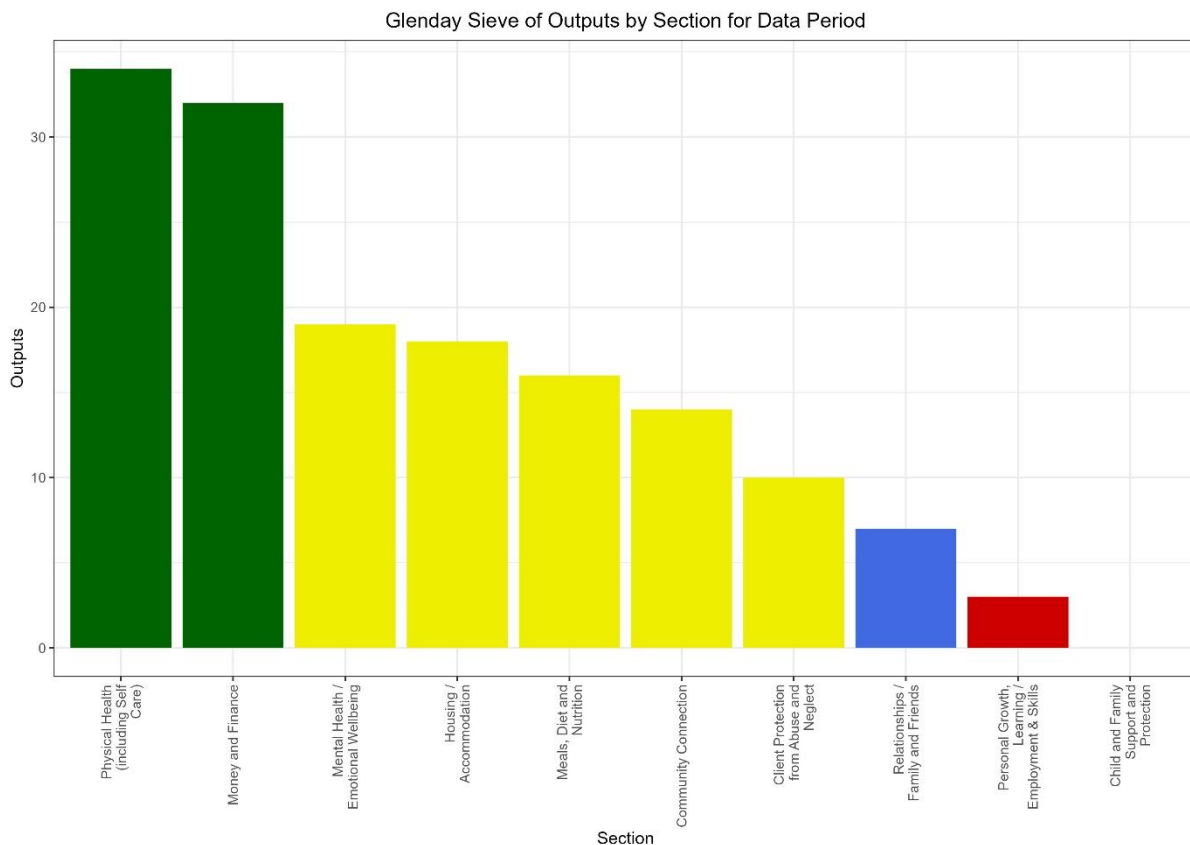


### Main Outcome Labels Table

SECTION	Outcomes	% of Outcomes	Cumulative % of Outcomes	Glenday
Money and Finance	24	25.8%	25.8%	Green
Mental Health / Emotional Wellbeing	20	21.5%	47.3%	Green
Physical Health (including Self Care)	18	19.4%	66.7%	Yellow
Personal Growth, Learning / Employment & Skills	12	12.9%	79.6%	Yellow
Meals, Diet and Nutrition	9	9.7%	89.2%	Yellow
Community Connection	3	3.2%	92.5%	Yellow
Relationships / Family and Friends	3	3.2%	95.7%	Blue

SECTION	Outcomes	% of Outcomes	Cumulative % of Outcomes	Glenday
Client Protection from Abuse and Neglect	2	2.2%	97.8%	Blue
Housing / Accommodation	2	2.2%	100.0%	Red
Child and Family Support and Protection	0	0.0%	100.0%	Red

## 2Main Outputs Chart



## Main Outputs Table

SECTION	Outputs	% of Outputs	Cumulative % of Outputs	Glenday
Physical Health (including Self Care)	34	22.2%	22.2%	Green
Money and Finance	32	20.9%	43.1%	Green
Mental Health / Emotional Wellbeing	19	12.4%	55.6%	Yellow
Housing / Accommodation	18	11.8%	67.3%	Yellow

SECTION	Outputs	% of Outputs	Cumulative % of Outputs	Glenday
Meals, Diet and Nutrition	16	10.5%	77.8%	Yellow
Community Connection	14	9.2%	86.9%	Yellow
Client Protection from Abuse and Neglect	10	6.5%	93.5%	Yellow
Relationships / Family and Friends	7	4.6%	98.0%	Blue
Personal Growth, Learning / Employment & Skills	3	2.0%	100.0%	Red
Child and Family Support and Protection	0	0.0%	100.0%	Red

### Breakdown of Outputs Table

Metric	Outputs	% of Outputs	Cumulative % of Outputs	Glenday
[Money and Finance] Caseworker support to manage finances/debt	18	11.8%	11.8%	Green
[Physical Health (including Self Care)] Caseworker support to attend medical appointments (all physical health - including dentist/opticians)	17	11.1%	22.9%	Green
[Meals, Diet and Nutrition] Food parcel given	10	6.5%	29.4%	Green
[Money and Finance] Caseworker support to access financial/benefits advice	8	5.2%	34.6%	Green
[Community Connection] Caseworker supported to access community opportunities and facilities (both recreational and all local services)	6	3.9%	38.6%	Green
[Community Connection] New connections/referrals to community groups/activities (addressing loneliness)	6	3.9%	42.5%	Green
[Housing / Accommodation] Caseworker support to manage tenancy/licence	6	3.9%	46.4%	Green
[Mental Health / Emotional Wellbeing] Caseworker support to attend/access medical appointments (mental health)	6	3.9%	50.3%	Yellow
[Client Protection from Abuse and Neglect] Caseworker support for	5	3.3%	53.6%	Yellow

<b>Metric</b>	<b>Outputs</b>	<b>% of Outputs</b>	<b>Cumulative % of Outputs</b>	<b>Glenday</b>
client/dependent supported to live safely				
[Meals, Diet and Nutrition] Caseworker support to independence with nutrition (shopping/food prep etc)	5	3.3%	56.9%	Yellow
[Relationships / Family and Friends] Caseworker support to maintain and develop relationships with family and friends	5	3.3%	60.1%	Yellow
[Housing / Accommodation] Caseworker support to remain in property	4	2.6%	62.7%	Yellow
[Mental Health / Emotional Wellbeing] Caseworker supported to access support groups (MH)	4	2.6%	65.4%	Yellow
[Money and Finance] New connection to DWP regarding benefits advice/application	4	2.6%	68.0%	Yellow
[Physical Health (including Self Care)] New connections to statutory health services (including OT, physiotherapy etc)	4	2.6%	70.6%	Yellow
[Client Protection from Abuse and Neglect] Caseworker support to develop self-care skills (neglect)	3	2.0%	72.5%	Yellow
[Housing / Accommodation] New connections/referrals to Housing Services	3	2.0%	74.5%	Yellow
[Mental Health / Emotional Wellbeing] New connections/referrals to VCSE mental health services /wellbeing support groups	3	2.0%	76.5%	Yellow
[Physical Health (including Self Care)] Caseworker support to access drug and alcohol services	3	2.0%	78.4%	Yellow
[Physical Health (including Self Care)] Caseworker support to appropriately engage with emergency services, including A&E	3	2.0%	80.4%	Yellow
[Mental Health / Emotional Wellbeing] Caseworker support to contact/attend counselling/Talkworks or similar	2	1.3%	81.7%	Yellow
[Mental Health / Emotional Wellbeing] New Connections to GP regarding mental wellbeing concerns	2	1.3%	83.0%	Yellow

<b>Metric</b>	<b>Outputs</b>	<b>% of Outputs</b>	<b>Cumulative % of Outputs</b>	<b>Glenday</b>
[Mental Health / Emotional Wellbeing] New connections/referrals to Community Mental Health Team (statutory)	2	1.3%	84.3%	Yellow
[Money and Finance] New connections/referrals to VCSE finance support	2	1.3%	85.6%	Yellow
[Physical Health (including Self Care)] Caseworker support to access external health assessment	2	1.3%	86.9%	Yellow
[Physical Health (including Self Care)] Caseworker support to appropriately engage with GP	2	1.3%	88.2%	Yellow
[Physical Health (including Self Care)] Caseworker support to source new clothing	2	1.3%	89.5%	Yellow
[Client Protection from Abuse and Neglect] Caseworker safeguarding meeting attended	1	0.7%	90.2%	Yellow
[Client Protection from Abuse and Neglect] New connections/referrals to Police	1	0.7%	90.8%	Yellow
[Community Connection] Caseworker supported to access public transport or other local transport options	1	0.7%	91.5%	Yellow
[Community Connection] New connections/referrals to Social Services Adult Team	1	0.7%	92.2%	Yellow
[Housing / Accommodation] Caseworker support to access housing advice	1	0.7%	92.8%	Yellow
[Housing / Accommodation] New connections/referrals to Hoarding/normal cleaning service	1	0.7%	93.5%	Yellow
[Housing / Accommodation] New connections/referrals to Social Services Adult Team	1	0.7%	94.1%	Yellow
[Housing / Accommodation] New connections/referrals to charitable support/VCSE	1	0.7%	94.8%	Yellow
[Housing / Accommodation] new connections/referrals to General Home Safety Services (not by Fire Service)	1	0.7%	95.4%	Blue

<b>Metric</b>	<b>Outputs</b>	<b>% of Outputs</b>	<b>Cumulative % of Outputs</b>	<b>Glenday</b>
[Meals, Diet and Nutrition] New connections/referrals to other ongoing shopping service	1	0.7%	96.1%	Blue
[Personal Growth, Learning / Employment & Skills] Caseworker support to begin employment	1	0.7%	96.7%	Blue
[Personal Growth, Learning / Employment & Skills] New connection to education/training opportunities	1	0.7%	97.4%	Blue
[Personal Growth, Learning / Employment & Skills] New connections/referrals to Social Services Adult Team	1	0.7%	98.0%	Blue
[Physical Health (including Self Care)] New connections to dentist	1	0.7%	98.7%	Blue
[Relationships / Family and Friends] New connections/referrals to Social Services Adult Team	1	0.7%	99.3%	Red
[Relationships / Family and Friends] New connections/referrals to VCSE (social leisure groups /support etc)	1	0.7%	100.0%	Red