High Flow Report

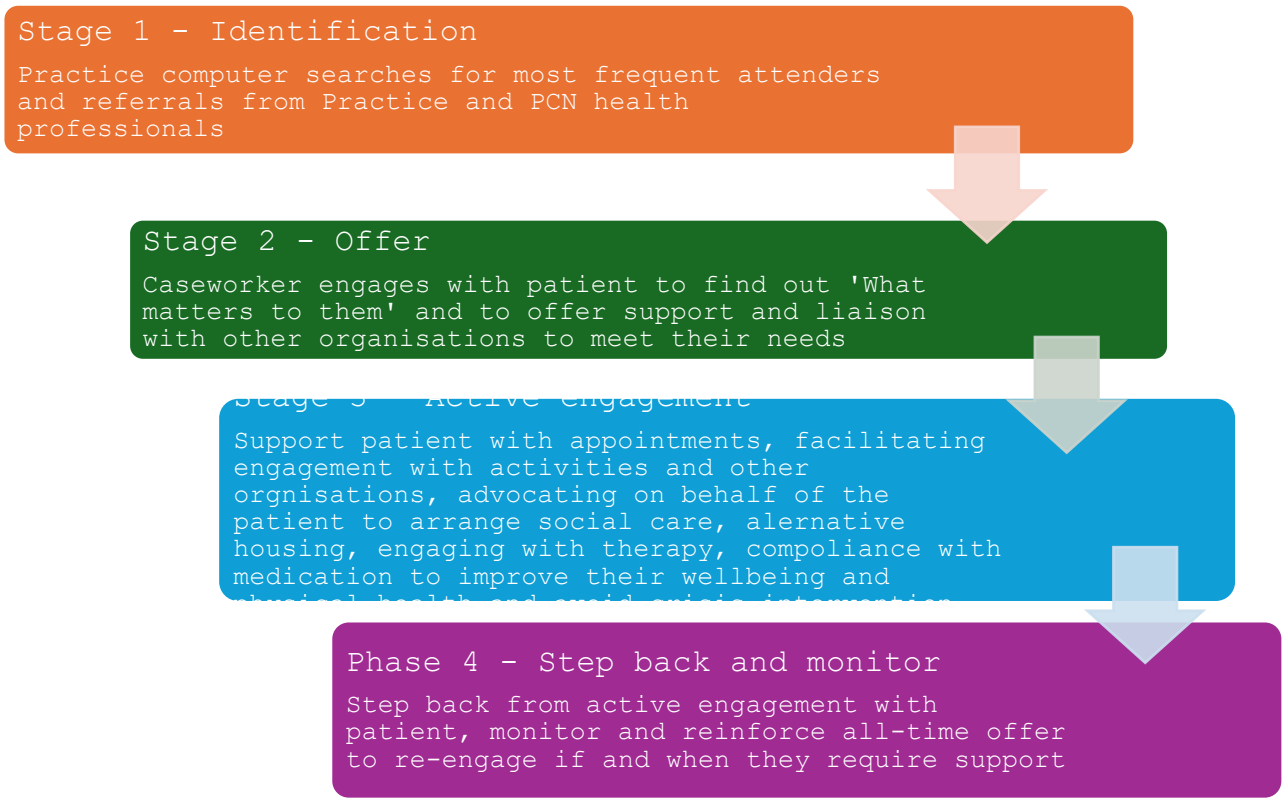
Feb 2025

Introduction

Nexus PCN practices have now been supported by a High Flow case worker for the past 17 months and from a total of 42 patients who have been approached, 86% have taken up the offer. The postholder has been instrumental in building a rapport between some of the most complex patients and finding out what matters to them in addition to the management of their physical health issues. This relationship has resulted in many positive outcomes which have not only benefitted the patient but have also impacted favourably on the many services who endeavour to engage with these patients to meet their needs. This work has helped to reduce health inequalities and transform people's lives, reducing their clinical need on emergency services and thereby freeing up resources. The caseworker has been able to utilise the support offered by the VCSE sector and patients have welcomed a service which more appropriately meets their needs.

The quality of life for patients who have engaged with this service has improved in all cases and their increased wellbeing has had a positive impact on their families and people with whom they engage. All patients who have engaged with the service are given a safety-net and told that they may receive further support as and when required.

Identification and Management of Patients



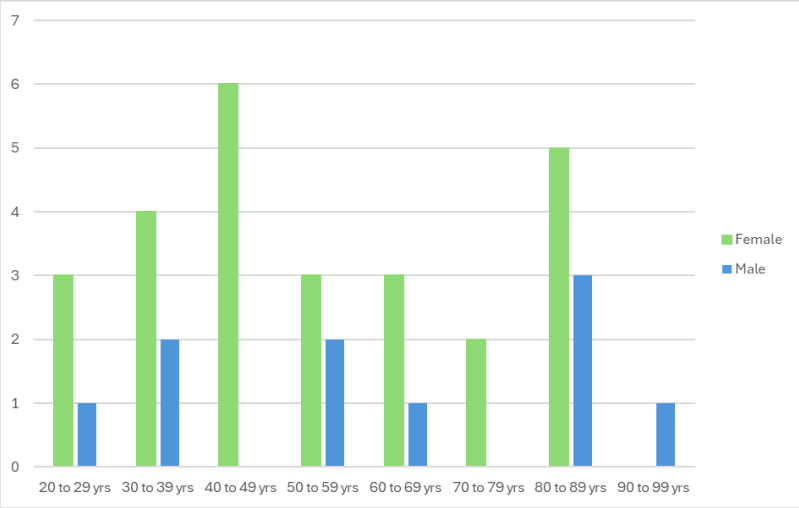
Progress Update

Currently, as at the end of January 2025, there are a total of 20 patients on the active caseload. Ten of these patients are having weekly appointments as they have significant need; the remainder are engaging less frequently.

In the last quarter 5 cases were moved from the active case list and are requiring no further support at this time. One of these patients has since moved out of the Nexus PCN area and another has unfortunately died.

There has been a steady number of referrals being received by the caseworker; initially these originated from practice system searches, but these have increasingly been sourced from GPs, practice nurses, OTs, dietitians and the Health and Wellbeing team.

Number of patients who have accessed support from the High Flow caseworker by age and gender



Collaboration with other health professionals

The High Flow caseworker has, in her role, been able to link in with other professionals and facilitate conversations to best meet the needs of the patients. She has attended MDTs advocating for patients with the clinical psychologist, DPT chaplain and ED Social Prescriber and contributing to conservations to put in place services and planning care for the patients concerned. She has then been able to feed back accurate and timely information to the patient's GP and practice nurses so that all parties are informed and can work together to provide the necessary support without duplication of effort.

She is continuing to build links with all the other ARRS roles in the PCN, seeking advice from the pharmacy team, OT's, dietitians, SPLW's and physios around best options for patients as and when appropriate. She attended a practice event recently to speak with their staff team to further explain her role and give an overview of progress with the project, illustrating this education session with relevant patient case studies.

She has accepted the offer of attendance at recent ED and AMU HIU meetings and has an open invitation for further meetings, building on and developing the important relationship between primary and secondary care. She has also attended meetings with HIU professionals across the city including CoLab and The Moorings.

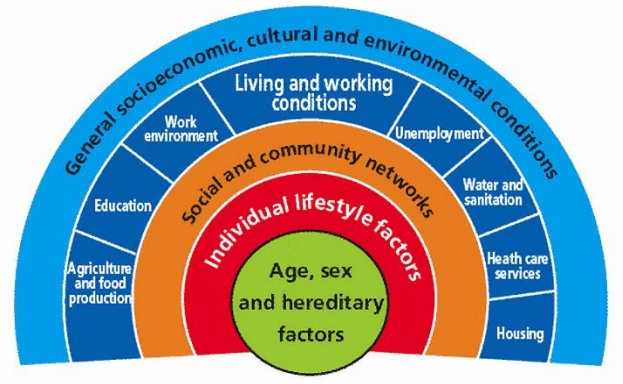
Collaboration with other organisations

- Royal Devon University Healthcare (especially ED)
- Exeter City Council
- Devon Home Choice
- Secondary care services
- Devon Partnership Trust
- SAFE Foundation
- Community Services
- Community Mental Health Services
- Local Pharmacies
- Nexus PCN GP practices
- Community centres
- Church community activity organisers
- Adult Social Care
- Citizens Advice
- Age UK
- CoLab
- The Moorings
- Christians Against Poverty
- Together Drug and Alcohol Services

Benefits to patients and impact on services

It is well evidenced that the majority of people access health services through primary care and this is the first point of contact for c. 90% of all registered patients.

It is also acknowledged that health inequalities are unavoidable as an individual's health is determined by several factors: genetics, lifestyle, healthcare received and the impact of wider determinants such as the physical, social and economic environment. These wider determinants appear to have the largest impact on an individual's health.



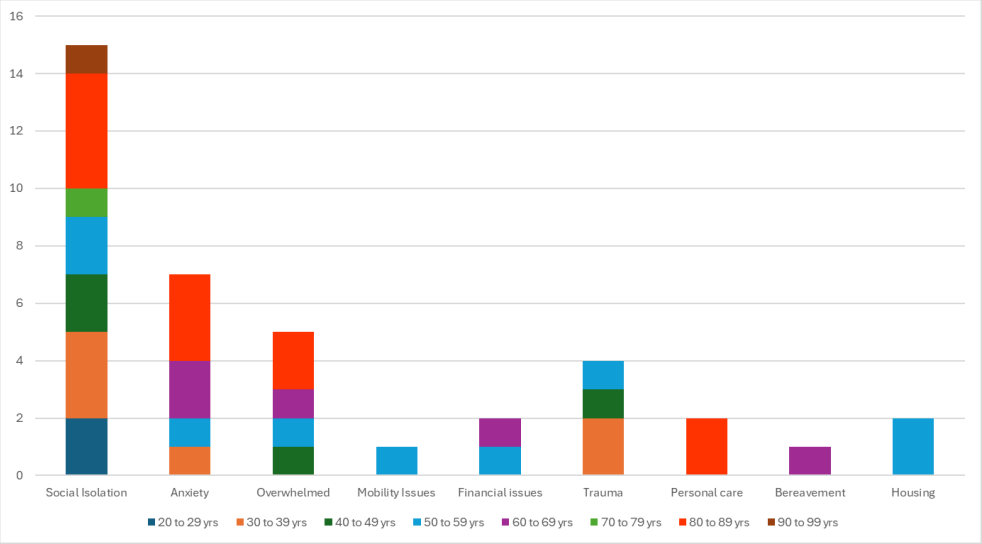
The Determinants of Health (1992) Dahlgren and Whitehead

The introduction of a High Flow caseworker in primary care is an endeavour to help the patient focus on the social determinants of health which they can influence to improve patient outcomes and reduce the likelihood of unplanned, emergency admissions to secondary care. Whilst it would be both optimistic and unrealistic to think that the caseworker can influence all emergency situations related to the sociodemographic determinants of health, evidence shows that the number of these can be reduced.

Data analysis of the issues that impact on health outcomes from the caseload in primary care has shown that social isolation is a major issue and impacts significantly on mental health and wellbeing. However, it should be noted that this is data from a population of registered patients, and these findings may not reflect data from other settings.

Issues highlighted from patients supported by High Flow caseworker by age group

(NB Many patients present with several different issues)



Time is one of the most important factors in the relationship building between the patient and the caseworker. Frequently, patients are reluctant to engage as they feel that their concerns have previously not been heard and other people will try and enforce services upon them thinking they know what is best for the patient. It takes time and gentle persuasion to build trust and for the patient to believe that the caseworker is there to support them to deal with the challenges they face.

The links that the caseworker builds with other agencies and the people within these organisations is another building block which enhances trust. Having the necessary services in place to offer people when faced with adversity is hugely important. Advocating for people who struggle to have their own voice and being able to speak with people in organisations where relationships are already in place is vital. It is these relationships which help to meet the needs of the patients and bring longer-term gains to the whole of the NHS and other agencies.

Highlighted below are a selection of case studies which demonstrate potential whole system gains and reduction of risk in patient harm.

Case Studies

Case study 1

Patient demographic

80 year old male

- Years of minimal contact with health services
- Broken back – necessitating hospital admission
- Reluctant to actively seek support
- OT visited 1 month since hospital discharge
- Had not left flat since discharge and was weak, diet and personal care both poor
- Friend helping with shopping and collecting medication, but unreliable
- Missed several hospital appointments
- Refusing to answer phone or engage with services

Caseworker intervention

- 'What Matters to Me' conversation highlighted that he wanted to attend his appointments but was overwhelmed by the process of arranging transport as he was phobic of the phone and often kept it switched off and was unable to access voice messages and texts.
- Generally happy with his own company and his only desire was to be able to get back to going to his local pub where he liked to sit, read the paper and watch the world go by every afternoon.
- He had had a small number of social connections at the pub and the staff would support him with little issues with his phone.
- Supported the patient to contact surgery and hospital transport and then taxis so that he could access appointments.
- Organised pharmacy delivery and ordering food from supermarket by phone as he has no internet.
- Supported him to find a pick up/ drop off laundry service as he could no longer carry clothes to the laundrette.
- Liaised with the pharmacy team and GP about some of his medications which he had concerns about taking. Took time to explain the information enabling him to feel more in control of his decisions.
- Supported him with use of his phone and facilitate with communication around dietician appointments.
- Accompanied him on a few short walks from his flat gradually building his confidence.
- Community rehab visited and this further built his confidence in his ability to get out locally and back to his local shop. Before long he felt able to walk to his local pub and shop and was back to feeling that he could manage independently.
- When the Dietician first met him he was 46.5kg which suggested a weight loss in the last month of 17.3%. After 6 months of input he now weighs 62.5 kg, a weight gain of 43.4%. He attended his last dietician appointment in person at the surgery.

Reduction in risk of patient harm

- Compliance with medication
- Loss of weight
- Reduction in wellbeing and disengagement from services

- Increased risk of falls

Case study 2

Patient demographic

42 year old female

- Single parent of four children – 3 now living independently
- Has bipolar, mood disorder, obesity, gynae issues, trauma
- Lives in social housing with 4 year old son
- Safeguarding concerns re ex-partner who lives nearby and is alcohol dependent
- Low mood, hoarding issues and financial concerns

Caseworker intervention

- Support to patient in managing son's sleep routine including her signing up for online parenting course
- Re-engaging her in social activities
- Supporting her to contact CAP debt advice service

Reduction in risk of patient harm

- Prevent patient spiralling into increased debt
- Establishing bedtime routine for son before he started primary school so he had stability and boundaries
- Improved wellbeing feeling supported and engaged in social activities

Case study 3

Patient demographic

56 year old male

- Alcohol dependent with liver cirrhosis, ascites, COPD, varices, asthma and a number of other issues.
- Recently vision has been a major problem with bilateral cataracts
- Unable to read any correspondence and therefore has frequently missed appointments
- Has had his PIP payments stopped due to him not responding to services when contacted
- Living in second floor flat rented from a housing association
- High risk of falls

Caseworker intervention

- Supported in re-applying for PIP payments, respond to Ophthalmology letters
- Cataract surgery arranged
- Referred to OTs and dietitian resulting in social care referral.
- Supported to register with Devon Home choice resulting in move to ground floor flat.

Reduction in risk of patient harm

- Missed hospital appointments impacting on both the patient and secondary care

- Move to ground floor flat decreasing risk of falls and harm to patient

Case study 4

Patient demographics

36 year old male

- Renal cysts, asthma, depressive disorder and sleep apnoea.

Caseworker intervention

- Conversation initially highlighted his primary goal was weight loss
- Through gentle probing it became apparent that he had suffered from domestic abuse in a previous relationship and that this trauma should be a primary area of focus.
- Agreed to a referral to the SAFE foundation.

Reduction in risk of patient harm

- Patient has been feeling empowered and positive and this has given him more ability to follow through on other goals such as eating more healthily, increasing exercise and reconnecting with some old friends.
- Decreased risk of poor health outcomes
- Increased wellbeing and engagement with social activities

Priorities for next 6 months

- Continue raising awareness of role
- Continue developing relationships with external organisations
- Build on collaborations with VCSE sector organisations
- Establish further metrics to evidence benefit to patients and gains to other agencies.