onenortherndevon

Person programme

OCTOBER 2022

Executive summary

1. Key successes
2. Key challenges

Reports from the Flow projects

1. High Flow
2. Primary Care Flow
3. Community Mental Health Flow
4. Community Flow
5. Secondary Care Flow
6. Safer Streets Flow

For Board Attention & Discussion

Key successes

1. **Widespread support for the concept**

One Northern Devon is regularly asked to provide information to various organisations across Devon and beyond as examples of how to deliver person-centred care due to its emphasis on understanding what matters to the person and working as a team to support them with whatever support they need at that time.

High Flow, in particular due to our ability to demonstrate demand reduction on public services, has been highlighted at national conferences including the NHS Confederation, Health Finance Managers Association and locally at the launch of the Devon ICB.

2. **Expansion of the model across organisations**

In the last two months, the Flow Programme has further expanded to include a further High Flow caseworker through an Encompass Lottery Bid and a High Flow safer streets caseworker from a Community Safety Partnership bid.

Key challenges

1. **Funding**

Only one organisation has been able to find recurrent funding for the roles (Pain Team, RDUHT) so every year we need to report and request funding for the following year to numerous partner organisations. This takes substantial time which could be better spent delivering the programme.

2. **Recruitment**

We are struggling to recruit to vacant Flow Co-ordinator positions (Community Mental Health Flow, Primary Care Flow). This partly reflects the employment market but also because of the funding we are only able to recruit to fixed-term contracts. In the current climate people are choosing the certainty of a permanent job.

3. Referrals

It can be a challenge in some of the projects to get referrals, despite the service offer being welcomed. We are trying to address this by providing step-by-step guides to the full process as staff are so busy they need to have the process as easily accessible as possible.

one northern devon HIGH FLOW

In January 2020, One Northern Devon launched 'High Flow', a personalised and holistic support programme for the 20 most intensive users of public services in Northern Devon. The High Flow programme aims to better meet the needs of these individuals and use the learning to improve the future system response.
Outputs and outcomes for the previous years can be found here

01 NUMBERS SUPPORTED

Currently 6 clients are supported by High Flow.
1 client is supported High Flow Step-Down.

02 KEY ACHIEVEMENTS

- A number of clients have shown examples of using pathways of support in appropriate ways
- High Flow is being piloted as a Safer Streets initiative in Barnstaple supported by the Police Crime Commissioner and Local Authorities

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

- Ensuring the expanded High Flow team works cohesively despite a variety of funders to ensure clarity of roles and pathways
- Exit review put in place and progression document and learning passport created for clients being exited from High Flow
- High Flow referrals to be opened again in the next 2 months

04 BARRIERS, LEARNING, SUPPORT REQUIRED

- Safety plan to be in place when co-production takes place with clients, work with High Flow Case Worker to understand when this might be required.

HIGH FLOW

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OCTOBER 2022

INPUTS

High Flow Caseworker
High Flow Project Co-ordinator
(Jan 20-Mar 24)

£48,000 per year

OUTPUTS

APRIL 2022 - SEPT 2022

Team Around the Person meetings x 10
What Matters conversations x 16
Connections/Referrals to community services x 4
Connections/Referrals to statutory services x 7
General Money Advice/banking x 1
Food Parcel Given x 22
Form Filling x 11
Housing Advice Provided x 3
Welfare benefits advice x 1
Support to find alternative housing x 2
Support to attend medical appts x 51
Support to contact/attend counselling x 8
Support to manage tenancy/licence x 8
Support to develop self care skills x 17
Support to dependent/co-dependent x 24
Safety Plan completed x 16
Support to meet aspirations x 21
Support to improve employment prospects x 0
Supported training/volunteering x 2
Signposted to external agencies x 9
Support to attend dentist/opticians x 15
Support with recovery journey x 44
Supported into Accommodation x 3
IT support incl. virtual meetings & emails x 8
Client involved in co-production work x 9
Safeguarding meeting conducted x 2

OUTCOMES

APR 2022 -SEPT 2022

Financial Gain Other x 2
Alternative Housing Secured x 3
Bailiff action prevented x 0
Supported to remain in property x 3
Debt managed x 0
Eviction averted/homelessness prevented x 1
External Health Assessment conducted x 8
Financial gain/charitable payment x 12
Home Care/aids/adaptations obtained x 0
Improved living conditions x 11
Improved engmnt w/Health Services x 19
Improved Family Relationships x 4
Improved social skills/relationships x 6
Improved financial status x 0
Improved life skills x 11
Improved meaningful activities x 23
Improved motivation x 38
Improved personal hygiene x 2
Improved physical health x 7
Increased Independence x 17
Appropriately engaging with GP x 10
Successful court action x 3
Moved into employment x 0
Client took own action to address issue x 28
Community activity achieved x 3
Client/dependent supported to live safely x 18
Case condluded successfully x 1

>>> EXIT STRATEGY

Funding is now secured to March 2024 through iBCF funds. The High Flow evaluation report was sent to all partners to ask for contributions to a step-down service to allow more capacity in the High Flow cohort. Funding has been agreed from TDC, DPT & NL.

HIGH FLOW // CASE STUDY OCT 2022

Therapy went OK...well as well as it can go - it didn't get to me, and I invited a friend over for the evening ... she said that she was going to cook for me.

- Judith (after creating strategies with the High Flow Case Worker to avoid making calls to SWAST)



Judith is 49 and lives alone is in social housing that she keeps very clean & tidy. She has 2 grown up daughters, one is pregnant and recently moved in but they both agreed this cannot be for long and she will be homeless in October.

Judith has a habitual drinking problem that she has used over the years to self-medicate her distress & anxieties around her traumas of sexual assault & the death of family and friends. Most recently her grandchild was still born at full term last year. She firmly believes that 'everyone around her just dies'.

She has previously declined counselling & when she eventually did it was unsuccessful. She came to the attention of both Police & Ambulance services on a very regular basis – intimating suicide / overdose / intoxicated / carrying a 'Bladed Article in a Public Place' (this was a self-harm razor blade). Due to this and drunken / anti social behaviour in public she was taken to court, given a suspended sentence & was placed under Probation. This is due to end in May 2023. As a result, Judith lost her job and has lived on benefits since 2019.

Just before referral to High Flow she had a couple of counselling sessions but this work is very new. Judith is not such a demand on police but is increasing once again in demand for ambulance services. She goes to the GP regularly and has good support however her GP wants her to self-refer to alcohol services which she is reluctant to do.

What mattered to Judith

- Being a grandmother for the baby being born in December & baby not being still born like last time
- Controlling her drinking
- Being a blood donor
- Being able to use different strategies to prevent her from calling the emergency services

What has happened so far?

Judith agreed to the support of High Flow in June 2022 has allowed the High Flow Case worker to support her with GP & probation appointments

The High Flow case worker is also supporting and sign-posting her pregnant daughter.

High Flow has funded a swimming membership & some sessions as Judith finds being in the water very therapeutic. The High Flow Case Worker is initially going with her as she feels unable to go there alone. However the aim is for Judith to get herself there or go with her daughter in time..

SECONDARY CARE FLOW //

AUGUST 2022



'Flow' launched into secondary care in May 2022, with a Flow Co-ordinator based at North Devon District Hospital, as an embedded member within their pain team. The pain team were confident that this role would complement the work of their team who already work in ways that are holistic, are about what matters to the individual and that recognises the causal factors of pain can often be driven by factors that can't be managed purely clinically.

01 NUMBERS SUPPORTED

Currently 14 clients are supported by Secondary Care Flow

2 clients successfully closed

02 KEY ACHIEVEMENTS

Integrated and networked well with lots of community services

03 KEY PRIORITIES FOR THE NEXT 2 MONTHS

Will discuss with hospital having access to a private room when needed

04 BARRIERS, LEARNING, SUPPORT REQUIRED

None

SECONDARY CARE FLOW //

OCTOBER 2022

INPUTS

Pain Team Flow Co-ordinator

£48,000 per year

OUTPUTS

MAY 2022 - SEPT 2022

What Matters conversations x 15
Team Around the Person meetings x 1
Connections/Referrals to community services x 7
Connections/Referrals to statutory services x 13
General Money Advice/banking x 0
Form Filling x 6
Housing Advice Provided x 0
Welfare benefits advice x 1
Support to find alternative housing x 0
Support to attend medical appts x 1
Support to contact/attend counselling x 1
Support to manage tenancy/licence x 0
Support to develop self care skills x 7
Support to dependent/co-dependent x 1
Support to meet aspirations x 30
Support to improve employment prospects x 0
Supported training/volunteering x 2
Signposted to external agencies x 20
Support to attend dentist/opticians x 0
Supported into accommodation x 0
IT support incl. virtual meetings & emails x 2
Client involved in co-production work x 0
Safeguarding meeting conducted x 1

OUTCOMES

MAY 2022 - SEPT 2022

Financial Gain Other x 0
Alternative Housing Secured x 0
Supported to remain in property x 0
Debt managed x 0
Eviction averted/homelessness prevented x 0
External Health Assessment conducted x 4
Financial gain/charitable payment x 1
Home Care/aids/adaptations obtained x 1
Improved living conditions x 6
Improved engmnt w/Health Services x 0
Improved Family Relationships x 0
Improved social skills/relationships x 3
Improved financial status x 0
Improved life skills x 0
Improved meaningful activities x 6
Improved motivation x 4
Improved personal hygiene x 1
Improved physical health x 2
Increased Independence x 2
Appropriately engaging with GP x 0
Moved into employment x 0
Client took own action to address issue x 0
Community activity achieved x 7
Client/dependent supported to live safely x 6
Case concluded successfully x 2

>>> EXIT STRATEGY

Funding is secured from the NDDH Pain Team substantively for 15 hours per week

SECONDARY CARE FLOW // CASE STUDY OCT 2022



I You have done more for me in two days than anyone else. You are an angel

- Lou, 69 Pain Team Patient

Can I just say a huge THANK YOU for all you have done for Lou…that's huge progress getting the process going for finding her an enabler. And well observed about her memory – I shall message her GP now to see if he can get a check up booked with her as soon as possible.

- Social Prescriber

Lou lives with fibromyalgia and spinal problems, for which she has declined surgery and prefers to manage the pain with medication. Client referred to Secondary Care Flow for community contacts and fibro support groups. On second contact client in extreme distress as pain meds 10 days overdue.

What mattered to Lou

To get some social interaction and support with attendance allowance.
However, overriding pain required support to get prescription delivered.

What has happened?

Flow Co-ordinator made several telephone calls to local pharmacy but had no reply. Contacted local Social Prescriber and was advised this is a huge issue in that community with the store often closed. Access to meds and prescriptions have been an ongoing problem with no solution for some time now. Contacted Lloyds online free prescription delivery service, to gain support with meds. They advised cancelling the £80 delivery fee for client. They advised client will need to download app to change meds if and when necessary, for this free delivery service to work.

In addition:

- Referral made to CDP for care assessment & enabler to support app,
- phoned benefits service re attendance allowance application - which was refused,
- referred to age concern for tele befriender,
- FILO project,
- Ring & ride to go Tesco shopping,
- Tesco's to request a wheelchair pusher.

Social Services are supportive, staying in contact for updates, getting enabler in touch, if able.

COMMUNITY MENTAL HEALTH FLOW // AUGUST 2022



The Community Mental Health Flow service bridges the gap between inpatient care and community support and facilitates more timely and effective discharges by providing enhanced support for people as they continue their recovery in the community.

Outputs and outcomes for the previous years can be found here

KEY OBJECTIVES

Help clients achieve recovery goals
Support to manage benefits, personal budgets & finance advice
Facilitate opportunities for educational, work-related & social activities
Work alongside clinical details of treatment and support plan
Help to secure and maintain housing

CURRENT SITUATION

This work is currently paused as the Community Mental Health Flow Co-ordinator has moved out of the area and MIND in Somerset have been unable to recruit to the post so far.

VCSE partners are reporting that recruitment is currently challenging. OND partners are asked if they have any thoughts on how to overcome these issues which appear to be part of a national issue of employment exceeding demand.

:Looking into alternative options for recruitment.

PRIMARY CARE FLOW //

AUGUST 2022



Primary Care Flow is testing whether the Flow model can work further upstream in a more preventative and targeted way, utilising our existing workforce to provide a more person-centred and joined-up approach. There is no dedicated support worker for patients, instead a Flow Co-ordinator supports professionals to join up support so that it flows around the individual and addresses what matters.

PROJECT STAGE

- Prototype 1 completed with 3 patients and 3 GPs
- Prototype 2 initiated with further patient, further 2 patients/GPs being recruited
- Pilot across 4 x PCNs started in April 2022
- 5 open cases

01 **Outputs and outcomes for the previous years can be found here**

02 Lead professional has 'What Matters' conversation with patient in the context of their circumstances, relationships and past experiences. The patient identifies their goals, alongside what helps and what prevents them achieving them. A 'Team around the Person' (TAP) is formed by the Flow Co-ordinator to support the patient with their individual needs from any relevant service from all sectors including the voluntary and community sector through the 'One Communities'.

03 ## RATIONALE

Increasingly patients present to primary care with mental health problems, medically unexplained symptoms, chronic pain and polypharmacy. Although attending with health presentations, factors contributing to these are often not biomedical but social and frequently underpinned by adverse life experiences. Even though their needs would be better served by other services, we have insufficient time or knowledge to link with those agencies. Patients with multiple needs bounce from one service to another - repeating their story time and again and never getting their underlying needs met. Primary Care Flow provides the tools and roles needed to deliver patient-centred care.

PRIMARY CARE FLOW //

AUGUST 2022

INPUTS

Flow Co-ordinator (p/t)
Lead professional time for
What Matters conversations

£20,000 per year

OUTPUTS

APRIL 2022 - SEPTEMBER 2022

Patients referred into service x 3
Total open cases x 18
On-hold cases x 4
Primary care professionals referring x 4
Cases concluded successfully x 1
Flow debrief meetings x 3
Connections made to charitable organisation x 1
General money advice x 1
Welfare benefits advice x 1
Support to contact and attend counselling appointments x 1
Support working towards goals and aspirations x 1
Support with recovery journey x 1
Team Around the Person Meeting Conducted x 3
Referral to MASH/NDADA x 1

OUTCOMES

APRIL 2022 - SEPTEMBER 2022

Alternative housing secured x 1
External health assessment conducted x 1
Financial gain/charitable payment x 1
Improved engagement with health services x 1

04 KEY ACHIEVEMENTS

- Quick Guide to Primary Care Flow completed
- Primary Care Flow had a stand at the BA AGM
- Devon Training Hub in conversations around delivering What Matters conversation training

05 BARRIERS, LEARNING, SUPPORT REQUIRED

- Lack of referrals into the project from GPs, other routes being considered. Oliver Hassall attending Coast & Country PCN meetings to explain process.
- So far we have been unsuccessful in our attempt to recruit a replacement Primary Care Flow Coordinator so have now gone out again with a full year's contract.

>>> EXIT STRATEGY

A further year's funding has been agreed with the four PCNs to pilot Primary Care Flow across Northern Devon. The pilot will aim to test both the effectiveness, efficiency and scalability of the model.

COMMUNITY FLOW

AUGUST // SEPTEMBER 2022



OND Community Flow aims to provide better access to community support and includes the Settle and Support at Home service. The programmes main aims are to ensure:

1. Patients leaving hospital have practical & emotional support to settle at home & avoid unnecessary re-admission.

2. People identified by healthcare professionals receive the non-medical support they need in order to reduce unnecessary medical interactions.

01

NUMBERS REFERRED

- 63 people have been referred into Community Flow since April 2022,
- 59 of which were RDUH referrals, 1 DPT and 2 Community Healthcare
- 3 referrals were declined since April 2022.
- 8 volunteer home visits
- 10 active volunteers fully inducted

02

KEY ACHIEVEMENTS

- Went to interview and recruited one new team member - 1 FTE Community Flow Coordinator/Provider Coordinator
- Conducted a volunteer meet-up event with snacks and drinks
- TTVS have recruited Age Concern as a service delivery partner providing volunteers
- Specific case - involvement of our service managed to successfully resolve huge discharge challenges surrounding a specific patient. Multiple agencies involved - serves as a good case study for our own learning as well as partnership organisations.
- Secured a full page spread in the Community Nursing Bulletin, raising awareness for the service.

03

KEY PRIORITIES FOR THE NEXT 2 MONTHS

- Increase referrals from hospital
- Increase 3rd party volunteer capacity
- Schedule a start date for the new Community Flow Coordinator and go back out to advert for 2 more posts
- Finalise an internal referral system via EPIC for Trust staff to refer into Community Flow (to increase referrals)
- All policies, procedures and agreements to be finalised, enabling the new approved version of the service to run optimally. (Deadline as per proposal: 1st November 22)

04

BARRIERS, LEARNING, SUPPORT REQUIRED

- Lack of geographical spread of volunteers (Ilfracombe, Woolacombe, Lynton & Lynmouth in particular)
- Lack of streamlined internal referral system in progress

COMMUNITY FLOW

AUGUST // SEPTEMBER 2022

INPUTS

1.1 FTE Community Flow Manager
1.1 FTE Community Flow Coordinator

OUTPUTS

APRIL 2022 - SEP 2022

Total referrals: 63
Total referrals declined: 3 (inappropriate)

Total volunteer visits: 8
Total volunteer hours spent on visits: 11 hours 10 mins

Total CF Coordinator phone calls to patient: 94
Total CF Coordinator hours spent phone calls to patient: 38 hours 30 mins

Total CF Coordinator ward visits to patient: 48
Total CF Coordinator hours spent ward visits to patient: 23 hours 15 mins

Total CF Coordinator home visits: 5
Total CF Coordinator hours spent home visits: 8 hours

Volunteers currently active: 10
6 TTVS volunteers
3 RDUHT volunteers

Withdrawn volunteers: 14 (due to volunteer audit by CFM)
5 TTVS
9 RDUHT

CAP meetings: 10
What matters to me conversations: 22

Community Developers Involvement August-Sep 22:

Torrington 100 x1
Holsworthy and District Community Involvement x1
One Barnstaple x3
Live Well in Braunton x1
One South Molton x1

OUTCOMES

APRIL 2022 - SEP 2022

Community connections made:
Community groups/activities (addressing loneliness) x9
Mental Health/wellbeing support groups x1
Money Advice Services x3
Community Developer x10
Social Prescriber x2
Other x1

Onward Referrals:
Community Nursing Team x3
Housing Services x1
Social Services Adult Team x6
Employment services x1
Form filling x1
House Advice x1
Welfare benefits advice x1
Signposted to external organisation x22
Support with recovery journey x1
Client involved with coproduction work x3

Patient Outcomes:
Financial gain - other x2
Support to remain in property x1
Debt Managed x1
External health assessment conducted x2
Financial gain/charitable payment x1
Home care/aids/adaptations obtained x1
Improved living conditions x1
Improved engagement w/health services x2
Improved social skills/relationships x5
Improved meaningful activities x4
Improved motivation x1
Moved into training/volunteering x2
Appropriately engaging with GP x5
Client took own action to address an issue x2
Client/dependent supported to live safely x4

Gaps in provision:
Gaps identified x5
Gaps passed to Community Developer to consider how to fill x3

>>> EXIT STRATEGY

Funding is secured to August 2023 for the Home from Hospital Service from NHS Charities Together funding

COMMUNITY FLOW **CASE STUDY**

// OCTOBER 2022

- Andrew, 69 Discharged home from hospital



Andrew was being discharged from hospital with a short-term care service. While this service was active, Andrew was managing at home and rehabilitating well. He had been admitted to hospital after a fall at home. Andrew is a recovering alcoholic and is doing well in his recovery, he drinks lots of water and is focusing on getting better. He is still finding adjusting to his return home and new routines difficult though. He cannot get to the shops so we agree to send a volunteer to help with this.

Andrew has signs of the early stages of dementia. He refers to this as his “memory problems” and manages by writing things down; important dates, people’s names etc. During his phone calls with Andrew, the Community Flow Liaison Worker (Tom) asks him to write certain things down that are important for him to remember.

Tom supported Andrew to do an online shop. This was collected and delivered by our volunteer as part of their visit. Andrew would not have been able to get any shopping without this help from as he does not have a computer or internet. We can provide this service up to 3 times while looking for a long-term option to support Andrew after our service ends.

Tom looked at Andrew's benefits with him and saw that he could afford a home help service. Andrew met the person from the home help service and told Tom he would like them to support him. Tom provided Andrew with easy to understand information about power of attorney from Age UK so he can ask his family to support him to employ his home help longer term. This has created a sustainable package of care without necessitating a need for social care intervention.

Tom supported Andrew to apply for attendance allowance as he may be eligible for this. It will allow him to increase his support hours if he wishes to, or save up money to spend elsewhere.

The Community Flow service can support him to find help and advice from Alzheimer’s.org – when Andrew is ready, we can make a referral.This will decrease the likelihood that Andrew will struggle if his dementia gets worse, as he will already have more coping strategies. It will make any future NHS or social care interventions less daunting for all involved.

Andrew is at risk of becoming socially isolated. Since he stopped drinking, he has lost contact with many of the people he used to see each day in the pub. He is wary of returning there so when Andrew is ready to consider going out and about, I can ask for information about local groups from the Community Developers.

Our support is coming towards the end of the 6-week period and this is where we would usually end our involvement. Because Andrew had no identifiable social care needs, he was not eligible for long term social care.