onenorthern devon LOCAL CARE PARTNERSHIP

Development Session #2

CREATE outstanding learner achievement IN ALL AREAS

TRANSFORM life chances AND employment prospects FOR ALL

BUILD community and prosperity WITHIN NORTHERN AND MID DEVON AND THE WIDER South West OF ENGLAND

BOOST productivity, innovation AND agility OF businesses AND ORGANISATIONS

TACKLE THE climate emergency

Communities, Health and Housing	Improve physical and mental health outcomes and reduce health inequalities while promoting active, culturally enriched, healthy lifestyles. Work in partnership to reduce crime so people feel safe and secure in their communities.
Our Environment Our Future	Align the Council's activities to meet the carbon neutral operational target of 2030. Deliver clean, well maintained and managed streets, parks and open spaces. Provide high-quality planning and development services. Monitor & Manage coastal and flood defences taking appropriate actions in partnerships with relevant bodies. Waste minimisation and increase reuse & recycling.
Our Council	Provide clear, effective communication and be easily accessible. Deliver quality services to business and residents; understanding what matters to our customers. Be proactive in considering commercial opportunities to secure our financial future while supporting "local" whenever possible. Develop Torridge to be a great place to work and build a career.

- **Put the needs of patients at the heart of its activities**
- **Show clinical leadership in the local health community**
- **Build effective relationships within the local health community**
- **Promote equality and fairness for patient**

Actions and Outcomes

1. Refine ways of working discussion to capture principles in a meaningful way
2. Mapping exercise across priorities re existing Flow approaches
3. Exercise to map out where ‘High Flow’ activity takes place, mapping out a coordinated network ‘wrapping the team around the person’
4. Evaluate High Flow – KPIs?
5. Members to provide feedback for the joint meeting via this link by the 19th of January: https://forms.office.com/e/1JimhDKft2

INTENDED OUTCOMES

- Update to the Board on High Flow
- Greater understanding of some key partner projects
- Better articulation of what needs to change for better partnership working
- Steer on governance direction regarding future projects

- **WHAT APPROVAL AND ASSURANCE PROCESSES WOULD THE BOARD LIKE TO SEE?**
- **WHAT IS THE BOARD’S ROLE IN ENABLING THE SYSTEM CHANGE REQUIRED**

AGENDA

- Update to the Board:
  - Why Flow?
  - What is Flow and High Flow?
  - Progress, challenges to implementation
- Principles of service design from the health equity workshops
- (small groups) Sharing information on current programmes and projects
- (small groups) What needs to change to be better working with our design principles
- (small groups) what approval and assurance processes are needed?

Why is a different approach needed?

A British Red Cross report titled Nowhere Else to Turn highlighted that **high intensity use is greatest in areas of deprivation** and across all age groups it is **associated with issues such as homelessness, being out of work, mental health conditions, drug and alcohol problems, criminality, excess mortality, and loneliness.**

Evidence suggests that individuals who are high intensity users of the Emergency Department may be **more likely to contact multiple other agencies in the health, social care and VCSE communities.**

High intensity use of urgent and emergency care is associated with **missed opportunities to help for non-medical factors** including age, poverty, housing instability, social isolation, loneliness, deprivation, substance misuse, as well as poor physical and mental health. **It is also associated with marginalised individuals who are challenged in accessing planned care.**

The current approach to people who use emergency services frequently does not differ significantly to the approach for everyone else.

This doesn't work for those individuals, it doesn't work for organisations and staff trying to support them and it is costly.

It is a matter of equity not equality

What is Flow?

Personalised support – not one-size-fits-all

Team approach, including the individual

Pulling in support – not referring on

Understanding what matters

Focussing on goals as well as needs

Co-produce a plan

A lead professional listens and seeks to understand what is important to the person they are supporting (the lead professional is the most appropriate professional supporting the person at any one time, sometimes this is obvious, at other times it may need exploring)

What is important can include what matters there and then to the person, what they may have experienced in the past, the circumstances they are living in or their health concern. It is not dictated by the professional.

A High Flow caseworker may arrange Team around the Person meetings (TAPs) where the agenda is based around what matters to the person (based on information shared by the lead professional and individual).

The Flow approach helps develop relationships and service changes in order to effectively identify the root causes of a person's difficulties, identifying their strengths and supporting them and their network to manage better.

Intended Outcomes of High Flow

Delivering Outcomes:

- Reduction in ED attendance for individuals supported
- Reduction in non-elective admissions for those supported
- Complex needs for those under High Flow are identified and reduced/better managed
- Wellbeing for those supported by High Flow is improved
- Loneliness for those supported by High Flow is reduced
- Individuals receiving High Flow progress in their stated goals
- Individuals feel they have received a positive experience from the interventions offered
- There is system change to better meet the needs of all people

Some of these should be measured directly:

- A target of 40% reduction in ED attendances in those supported by High Flow
- A target of 40% reduction in non-elective admissions in those supported by High Flow
- Reduction in complex needs assessment scores for individuals s
- Improvement in Warwick-Edinburgh Mental Wellbeing score for individuals supported under High Flow
- Improvement in proxy scores for assessment of loneliness 'I've been feeling close to other people' improve for those supported by High Flow
- Evidence of improvement in goal-based outcomes for those supported by High Flow
- A positive experience reported by individuals supported by high flow in standardised measures / survey

And others will benefit from measuring but are indirect measures:
An increase in the number of staff receiving awareness training of the Flow approach and an increase in the number of staff reporting being able to support individuals more meaningfully following receiving awareness of the Flow Approach

There are additionally important outcomes that are difficult to measure but will be considered in the evaluation:

- Improving communication and partnership working between those involved in client care 24/7 Identifying patterns and 'causal factors' which trigger relapse behaviours in order to shape
- Future commissioning of service and/or demand/capacity planning
- Empowering clients to self-manage to enable sustainable discharge from UEC
- Driving equality and the client voice
- Supporting the development of a robust network of community health, social care, mental health, and police to manage clients, creating true integrated working. Providing a service driven by quality with positive human outcomes observed

Results of original High Flow for 9 clients with full data sets

Decreases in average demand pre and post intervention					
DPT	POLICE	SWASFT	NDHT	PCN	TOTAL
During/Pre	During/Pre	During/Pre	During/Pre	During/Pre	During/Pre
26%	62%	78%	24%	-1%	66%
Post/Pre	Post/Pre	Post/Pre	Post/Pre	Post/Pre	Post/Pre
96%	83%	70%	80%	-11%	78%

KPIs (NHSE/One Devon/OND LCP)	Target	Jan-March 2024 Northern	Cost savings
New clients per quarter (Jan-Apr)	15	19 (126.6%)	n/a
Number of ED attendances in previous 3 months	n/a	156	n/a
Reduction in ED attendances	40%	57%	£10,156
Reduction in non-elective admissions	40%	94%	£28,875
Reduction in ambulance conveys	40%	55%	£5376

Results so far of High Flow since January

So far we have seen a total reduction in activity equivalent to £44,407 when compared to the previous quarter

Root causes and their knock-on effects

Root Causes

- More people with:
  - Increasingly complex lives
  - Increasing comorbidity & multimorb
- Increasingly severe social determinan health, health inequality and mutuall reinforcing co-existing risk factors fo health
- Services increasingly focussed on r lving single cause presentations
- Lack of preventative and holistic interventions
- Those working across health and so l care reporting concern that their individ values did not match the values they ere able to display at work leading to dissatisfaction

Effects

- A small number of people in Devon have a repeating and often escalating number of presentations to the Emergency Department (ED) and other acute resources) indicating that their specific needs are not effectively identified or responded through the current non-personalised service model.
- This creates dissatisfaction in service response for individuals, and furthers a perception of alienation and dissatisfaction for staff who feel that they are unable to effectively treat individuals
- This also leads to a significant direct financial cost to the system and associated opportunity cost (waste).
- Inequality in outcomes are not addressed over time by the current service model for these individuals and therefore inequality tends to increas

Core Problems

- failure to identify systematically ose with unmet need.
- failure to identify the root causes in person's repeated presentation to D leads to a failure to redirect a erson's demand to more appropriate esources
- standard approach supports an uncoordinated, non holistic approach to an individual's life and problems which can exacerbate the very problem the person appears to be presenting with and may fail to engage them in preventative work
- A repeated failure for some people to have their needs effectively addressed in an ED contact leads to disengagement and dissatisfaction
- ED is an expensive intervention with significant opportunity cost and real cost

Change we want to achieve

- Data driven approach prioritising resources towards those with most need i.e. people who attend A&E multiple times, starting with the top 20 and incrementally towards the top 100, per LCP (Focus on ED attendances and non-elective admissions in terms of data and identification of cohort).
- A strengths based and trauma informed approach to the individual that develops a creative, contextual, holistic formulation and plan for that person that includes a “what matters to me” conversation
- The plan for that person is a coordinated, team around the person approach which provides positive outcomes for people, services, and systems
- An assertive outreach approach will be supported and utilised, connecting with people where they are comfortable with professionals they want to relate to, in a person-centred way
- The model of personalised care will be used as an enabler to drive forward culture change and embed shared decision making wider than the High Flow programme
- Support the development of community based support and services across the LCPs – using existing networks and partners where effective services are already in place.
- A financially sustainable model which releases expenditure from acute provision to support community and preventative interventions.

How we will achieve this change

Inputs

Encompass (employer):
- 2.5 WTE Flow Case Workers
- 1.0 WTE Flow Project & Line Manager

RDUHT:
- 0.4 OND Service Manager
- ED Clinician (FA Meeting)

DPT:
- Lead Clinician
- ED Liaison (FA meeeting)

NHS Devon:
- BI analyst

OND partners
(RDUHT, DPT, SWAST, PCNs, Police, NDC, TDC, DCC):
- Data providers
- MDT practitioners
- Steering Group members
- Working Group members

OND LCP Board

Activities

Project set-up
- Create governance structure (OND-LCP & ICB relationships) (to include N&E High Flow Steering Group; Caseworker Team meetings; Frequent Attenders meetings, Data Collection meetings)
- Create Service Specification
- Create Job Profiles
- Create comms & engagement plan
- Create data collection plan and ED list (demand data, person data, activity data)
- Information Governance - ensure all partners have signed ISA & DPIA & honorary contracts in place including template consent forms
- Complete Equality Impact Assessment
- Create Reporting Plan
- Create finance & budget plan including resource requirements
- Employment contracts & SLAs with provider
- Create evaluation plan
- Leadership charter created

Project delivery
- Obtaining ED list of top 250 most frequent attenders on a monthly basis
- Interface with partners to highlight potential priority cases (including Frequent Attender meetings)
- Assertive outreach by Flow Caseworkers to people on the list
- What matters to me conversations
- Goal setting - agreeing joint action plan
- 1 to 1 case work, signposting & referrals to support, supporting to attend appointments, advocacy, action planning and progress reviews
- Team around the Person (TAP) meetings organised
- Connecting into community through One Community Developers and other opportunities
- OND LCP Board considers learning from delivery and how to enable systematic change

Project monitoring
Data collection from all partners and ED list
Caseworker completion of case tracker and outcomes document
Inputting outcomes onto Impact Reporting tool

Ouputs

Project set-up
- Project set up documents completed

Project delivery
- Between 40* (for rural areas) and 50 people per year supported by Flow taken from list of top 250 frequent attenders to ED
- 1 to 1 meetings take place in an assertive outreach approach
- What Matters conversations
- Team around the Person meetings
- Community around the Person connections made

Project monitoring
- Report outlining numbers of people, their ED and other public sector attendances and progress on their goals provided monthly to OND LCP and ICB

Evidence quantitative and qualitative data showing:

- A target of 40% reduction in ED attendance in those supported by High Flow
- A target of 40% reduction in non-elective admissions in those supported by High Flow
- Reduction in complex needs assessment scores for individuals supported under High Flow
- Improvement in Warwick-Edinburgh Mental Well-Being score for individuals supported under High Flow improve
- Improvement in proxy scores for assessment of loneliness
- Evidence of improvement in goal-based outcomes for those supported by High Flow A positive experience reported by individuals supported by high flow in standardised measures/survey
- An increase in the number of staff receiving awareness training of the Flow approach An increase in the number of staff reporting being able to support individuals more meaningfully following receiving awareness of the Flow Approach

The learning from the evaluation should be used to:

- Create a financially sustainable model/inform the future sustainability of the service Provide more contextual, holistic and person-centred approaches in other parts of the system
- Support the identification and development of community-based support and services across the LCP by using intelligence gained by High Flow caseworkers about gaps in services Provide evidence for the monetary value of, and the rationale for, releasing expenditure from acute provision to support community and preventative interventions.

In addition, the evaluation will evidence any impact on:

- Improving communication and partnership working between those involved in client care 24/7 Identifying patterns and ‘causal factors’ which trigger relapse behaviours in order to shape future commissioning of service and/or demand/capacity planning
- Empowering clients to self-manage to enable sustainable discharge from UEC
- Driving equality and the client voice
- Supporting the development of a robust network of community health, social care, mental health, and police to manage clients, creating true integrated working.
- Providing a service driven by quality with positive human outcomes observed providing a better system level understanding of the reasons people frequently attending ED and having unplanned admissions, and identify what barriers and enablers were there to achieving the desired outcomes for individuals and the system to inform commissioning decisions.

PROGRESS, CHALLENGES AND BARRIERS

Progress

- 2.5 FTE High Flow Caseworkers in place and funded until July 2024
- High Flow team completed training with national HIU lead & mentoring
- Honorary contracts in place
- Clinical lead in place
- Meetings held with ED Frequent Attenders leads
- RDUH BI providing ED list of frequent attenders (needs further tweaking)
- High Flow model adopted by RDUHT East
- Reporting and evaluation measures and processes almost completed
- Plans being developed to capture patients' inequality markers (SDOH) within the patient record

PROGRESS, CHALLENGES AND BARRIERS

Challenges and barriers

- Funding not confirmed beyond July 2024
- Eastern locality were unable to recruit for the role so Encompass are providing temporary cover
- Information Governance - no central support and is causing delays
- Ensuring we keep partners' involvement and support in ED focused model
- High rate of contacts not consenting to support (different model)
- Activity capturing - we are unclear about what can be captured through an ODD request, we currently request the data from each partner every quarter)
- Currently unable to capture health inclusion markers required in NHSE model

Potential cost reductions for High Flow

	Reduction in attendance by those on programme				
	40 %	30%	20 %	10 %	0 %
0 % take up	0	0	0	0	0
25 % take up	£13261	£9946	£6630	£3315	0
50 % take up	£26522	£19892	£13261	£6631	0
75 % take up	£39784	£29838	£19892	£9946	0
100 % take up	£53045	£39784	£26522	£13261	0

CO-PRODUCED PRINCIPLES OF HEALTH EQUITY SERVICE DESIGN

FIRST DRAFT FROM TABLE DISCUSSIONS

PRINCIPLE 1

PERSON-CENTRED

Provide person-centred services - focused on what matters to the individual, not service

PRINCIPLE 2

CONSIDERS PERSON'S CONTEXT

Work in ways that support the 'whole person' including their wider circumstances

PRINICIPLE 3

WHOLE PLACE

Work in ways that support the 'whole place' and recognise rural and coastal challenges

PRINCIPLE 4

CO-PRODUCED

Co-produce solutions with the people and communities affected

PRINCIPLE 5

TARGET RESOURCES TO HIGH IMPACT AREAS

Distribute resources equitably and where they will have the most impact

PRINCIPLE 6

COLLABORATION & SHARED LEADERSHIP

Promote shared leadership and join forces across the system towards a common aim

PRINCIPLE 7

BUILD ON GOOD PRACTICE

Build on existing areas of good practice

PRINCIPLE 8

THINK LONGER TERM

Think longer term and ensure adequate resources are allocated towards prevention

PRINCIPLE 9

COMMUNICATE

Get better at communicating with each other across the system

in small groups - take a project from each partner designed to help improve the lives of those in Northern Devon please help the other partners understand its purpose and impact (with reference to Health Equity principles and Flow principles)

feedback - take a project from each partner designed to help improve the lives of those in Northern Devon please help the other partners understand its purpose and impact (with reference to Flow principles and Health Equity Design Principles).

HOW HAS HIGH FLOW DONE AGAINST OUR OWN PRINCIPLES?

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Values Based Approach Core enablers identified by Devon ICS

1. Creating the conditions for person-centred care
2. Increasing digital maturity
3. Outcome measurement for person-centred care
4. Shifting to financial models that drive value
5. Strategic commissioning and planning
6. Supporting our workforce
7. Innovation and Improvement
8. Organisation development, culture and leadership
9. Communication, education, and engagement

in small groups - take 3-4 design principles and help us all understand the barriers and enablers for future working

	What we want for people	Requires what from organisations	Requires what from leaders	Requires what from partnerships and the system	What changes should we make **now**, in **three months**, and in **three years**
PRINCIPLE 5	**TARGET RESOURCES TO HIGH IMPACT AREAS** Distribute resources equitably and where they will have the most impact				
PRINCIPLE 8	**THINK LONGER TERM** Think longer term and ensure adequate resources are allocated towards prevention				
PRINICIPLE 3	**WHOLE PLACE** Work in ways that support the 'whole place' and recognise rural and coastal challenges				
PRINCIPLE 9	**COMMUNICATE** Get better at communicating with each other across the system				

feedback - take 3-4 design principles and help us all understand the barriers and enablers for future working

(small groups)

What is One Northern Devon LCP's role in addressing the 'system failures' and barriers that are identified through High Flow and the other partner projects delivering person-centred support?

What approval and assurance processes would the Board like to see?

(small groups) What approval and assurance processes would the Board like to see?

Actions and Outcomes

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close