

Secondary Care Flow

Reporting Period Oct - Dec 2024

1.0 Overview

Secondary Care Flow (SCF) aims to support professionals within the pain team by providing person-centred, holistic, joined-up support to people with multiple and/or complex needs by focussing on what matters to them, ensuring non-clinical support needs are met as part of the therapeutic interventions.

Julie Cotton is the SCF Coordinator employed for 15 hours a week substantive.

2.0 Patient Numbers

The table below lists for the period the number of patients referred, closed and the total number assisted from April 2022 to Dec 2024.

| No. Patients Referred in Period | No. Patients Closed in Period | No. Patients Open at End of Period | Total Cumulative Number of Patients |
|---------------------------------|-------------------------------|------------------------------------|-------------------------------------|
| 10 | 5 | 12 | 89 |

(N.B. the above figures include those on a waiting list, 1 in this period)

2.1 Referrals by Clinician and Type of Support

The table below shows the number of referrals for the period received by clinician and support type required to meet the patient's needs.

| Name of Clinician | No. Referrals | Type of Support (TAP, Casework, Signposting) |
|-------------------|---------------|--|
| Jess Guy | 2 | Signpost |
| Alan Bennett | 2 | Signpost |
| Archie Baker | 1 | Casework |
| Chris baker | 1 | Signpost |
| Ruth | 4 | Casework and signpost |

3.0 Project Capacity

A caseload of 10-12 is manageable for the role, at the end of the period the project had 12 open cases and 4 on the waiting list.

4.0 Personal Evaluation Scoring

All patients who on initial contact are identified as requiring casework are asked what their baseline evaluation score is and then subsequently upon discharge.

During the period 5 patients in total were discharged and of these 1 was supported with in-depth casework and both baseline and exit scores were obtained for them and shown in the table below.

(Total scores: 17/25 – 23/25).

| Personal Evaluation Questions | Baseline Score (Average) | Discharge Score (Average) | Difference |
|---|--------------------------|---------------------------|------------|
| Q1. I feel hopeful I can achieve what I want in life. | 4 | 4 | No change |
| Q2. I only have to tell my story once to receive the support I need | 1 | 5 | +4 |

| | | | |
|---|---|---|-----------|
| Q3. I feel I can manage my responsibilities well. | 4 | 4 | No change |
| Q4. I feel my current lead professional/case worker understands what matters to me. | 5 | 5 | No change |
| Q5. I feel supported by relevant services to meet my goals. | 3 | 5 | +2 |

5.0 Project Outcomes and Outputs

Outcomes and outputs for all patients from Oct 2024 to Dec 2024 are listed in the table below, showing the variety of work carried out to aid patients to work toward achieving their goals. (An individual can have more than one output as these are recorded for each separate intervention working toward meeting goals). Appendix 3.0 shows all project outcomes from July 2022 to Dec 2024.

Refer to appendix 1.0 for a case study which provides additional information on a patient's journey being supported by the project to achieve multiple outcomes.

| Case Outcome/Output | Number |
|---|--------|
| Outcome - Improved engagement with relevant health services | 6 |
| Outcome - Case concluded successfully | 5 |
| Outcome - Client supported to live safely | 3 |
| Outcome - Community activity achieved | 3 |
| Outcome - Improved access to meaningful activities | 3 |
| Outcome - Improved living conditions | 2 |
| Outcome - Client supported to remain in property | 1 |
| Outcome - Improved motivation | 1 |
| Outcome - Improved personal hygiene | 1 |
| Outcome - Increased independence | 1 |
| Output - One-to-one work with client | 53 |
| Output - Research undertaken to find solutions for clients | 34 |
| Output - Continued contact with professionals | 23 |
| Output - Signposted to external agency | 8 |
| Output - WMTM Conversation taken place with lead professional | 8 |
| Output - Form filling | 5 |
| Output - OND & client feedback completed | 3 |

6.0 Update and Reflections from Julie

The comments (refer to section 8) from the patients have generated some positive feedback for SCF, where it is evident that the patients feel supported and value the Pain Management service overall.

The incoming referrals have steadily increased. I feel certain that any gaps in referrals are due to Clinicians time constraints, so I am happy to receive basic details and gather more information as required.

SCF referrals often initially indicate signposting is required to achieve patient outcomes, but due to what the patient feels they require or need, this can often develop into longer pieces of work, (refer to appendix 2.0 discharge summary for an example) often waiting on forward referrals to other services. This can delay discharging but has not been a problem to date.

During this period, I've received newsletters and communications from the Pain Cafe service, who operate in Cornwall, the organisers are keen for us, to initiate our own Pain Café in North Devon, under their existing model. They are showing success in their model of working with stats and testimonials. The NDDH Pain team have agreed this is a very positive progression, to reinforce the non-medical approach to long term pain and would be an asset to North Devon going forward <https://pain.cafe/> Matt is planning to look into this/funding as a potential project for SCF to manage and recruit volunteers to run it.

The new Barnstaple Fibromyalgia Peer Support Café now has 11 participants attending their drop in café, once each month. This group was set up with two Pain Team patients who attended the HOPE course March 2024. One of the Facilitators is keen to be involved with the HOPE promotional video to talk about how joining the HOPE course has changed her life for the better. She is also keen to become involved in a general Pain Café provision, if the NDDH Pain service are able to go down this route.

Having attended a few promotional events this year, to represent both SCF and the HOPE Programme, I conclude that these have been very beneficial with networking and finding out what is on offer in our local community.

During October 2024 I supported the Litchdon Medical Centre's, nursing team with a similar, three-day health promotional events. These events were good collaboration working and I was able to follow this up with a detailed HOPE attendance chart showing how many of the Barnstaple PCN patients have benefited from joining a HOPE course.

6.1 Key Achievements in Period

- Successfully supporting an elderly lady C who had become unwell and unable to get out of bed, due to the loss of mobility in her leg. She was taken to A & E and advised it was due to a trapped nerve. This lady has a diagnosis of dementia/query Alzheimer's and lives alone. She relies heavily on two neighbours, who are both unwell themselves. She had to rely on them to purchase her some incontinent pads as she could not get to the toilet, nor could she get herself food or drinks. SCF telephoned Pathfinders to explain this situation and discuss her health/dementia condition, requesting a home assessment of need. The Urgent Care Team assessed her as coping. Paramedics were called a further two times and recommended sofa raisers. SCF raised this with the Urgent Care Team who were happy to make the arrangements.
- Successfully closed a longer-term case which included extensive advocacy for a lady and her housing association, involving multiple calls, emails and letters to the Housing Ombudsman, Social Services OT and NDDC. The case was successfully concluded in the period and the works on her home have now been completed (refer to appendices 1.0 and 3.0, case study and feedback).
- Recently advocated for a lady L who suffers hugely with her mental health. L called SCF to explain she cannot see her GP until 23/12/24 (which was 1 month) and she was in some distress. She reported having 'suicidal thoughts'. SCF, with patient consent, contacted her GP to explain her concerns. L reported her GP appointment had been brought forward and was hopeful of receiving some support.
- Attended Shelter housing/homelessness webinars. One of which was very useful, especially as it offered good advice to be used with two current SCF patients to support their ongoing plight.

6.2 Key Priorities for Next Period

To shadow the Wellbeing group sessions, during January/February 2025, led by Jess (OT), to possibly encourage/enable self-referral from the participants at their review stage to SCF for community/social connecting support.

7.0 System Change

A system success / learning index is being utilised to understand any system change opportunities within North Devon in relation to the project.

| Success / Failure | Organisations involved | Details | Steps taken to resolve |
|-------------------|---------------------------------|---|---|
| Success | Pain Café Cornwall – Imaginelf. | Staying in touch with two representatives from the Pain Café Cornwall who are keen to see this model developed across Devon and Somerset. Hopefully developing a Pain Café in North Devon and joining the existing model. | Matt to look at possible funding for the Pain Team to open a Pain Café in North Devon. There will be more discussion around funding to consider joining this existing programme for the Pain Management Team patients in North Devon. |
| Failure | Torrige Housing | Patient living with long term health conditions, wife and two young children, living in unsuitable private rental. Already on Council waiting list but with very low priority/banding to be able to bid for suitable family property. | Tried to advocate on behalf patient with his plight to be offered a higher banding, to apply for suitable housing. Was turned down and provided their policy to pass the patient. |

As a proven successful systems change, SCF and the Pain Team are successfully working together to support patients with both their pain and with their social lives by way of introducing them to community activities, external services that can support with finance and benefits issues, housing and fundraising. The SCF project continues to enable systems change to happen by supporting patients to reach and achieve their 'what matters to me' goals and aspirations.

Examples:

- Collaboration with a patient's GP and advocating on their behalf with their best interests in mind, to tackle suicidal thoughts.
- Inviting SCF patients to join the HOPE programme to learn how to better manage their chronic fatigue, stress management, goal setting, pacing, healthy eating etc.
- Advocating on behalf of the patients with multiple agencies, including following and challenging organisations complaint procedures.
- Researching for alternative activities in the community to support engagement and discourage isolation/loneliness.
- Completing onwards referrals in the patients' best interests.

Ongoing barriers and challenges:

- Obtaining voluntary support for under 65 years – this remains an ongoing issue.

- SCF time management can be challenging when caseload is full, with 15 hours each weekly allocated to it.

8.0 Comments from Patients discharged in this period

| | |
|----------------|---|
| 20/11/2024 (B) | "Thank you once again for all your hard work and perseverance" B. |
| 11.2024 (V) | "Thanks again for all your support and for just being you, you are really making a difference in my life" (peer support café research). |
| 5/12/24 (T) | The wet room has been done! It all happened very swiftly after yet another asbestos survey. I assumed it would be next year but I think the council pushed things through quickly. It has been bedlam but I'm thrilled with the result and it's making life so much easier and safer. I've been able to use the money from Sanctuary to replace stuff in the bathroom damaged previously and get additional cupboards. No mould now! Fingers crossed it all stays that way... Thank you once again for everything you have done. You really stuck in there! You really have made a difference ♥ Kind Regards, T. (See appendix 3 for feedback). |
| 17/10/24 (D) | "Thank you very much, I am keen to join the groups and realise that being more social is also important to me" D |
| 10/2024 (S) | 21/10/24 "thank you very much for your time and support in doing that call and form, much appreciated" s. 29/10 I really appreciate your support because no one has helped me with this before. |
| 23/12/24 (L) | "my pharmacist has noticed a decline in me and wants to report it to my GP. I told her how amazing you have been in helping me". |

9.0 Comments from Professionals

| | |
|---|--|
| 4/12/24 (Dave) | " Hi Julie thanks for the update sounds like this was a bit of a battle but the outcome was a great 1 in the end. Thanks for your time and effort on this 1 " Dave |
| 30/10/24 from Ruth in relation to info I shared | "Thanks so much for this Julie, it really is excellent". |

Appendices

1.0 Case Study (conclusion on June 2024 case study)

About the client / background:

- Referred due to total lack of heating in Sanctuary property January 2023. Two economy heaters broken the 3rd condemned by Sanctuary prior to December 2022. After many requests via client, Sanctuary supplied two small fan heaters, only warm when positioned directly in front of person.

What mattered to the client:

- Client reported her health is badly affected by zero heat inside the property. She suffers with diabetes / psoriatic arthritis / left and right total hip replacements, persistent pain. On top of her house stresses, her daughter at Uni became seriously unwell due to self-harming. Heating was finally installed September 2023 with advocate support of SCF and the damp, crumbling wall and mould was worked on.
- Unfortunately, this left the results of long-term damp damage which required decoration to remove unsightly stains. Sanctuary commissioned outside workmanship but this was delayed time and time again. Client was unable to battle with them and required ongoing advocate to come to a resolve.

What happened:

- Client reports she contacted Sanctuary Housing Association many times, since **2020** to report damp, mould, crumbling wall and zero heating in the property.
- SCF initially emailed Sanctuary in December 2022 to report client living conditions, cold, damp and mould due to no heating throughout the winter months.
- SCF escalated request to complaint in **January 23**, when client reported 7 degree temperature inside the property. Quoting housing act etc.
- SCF followed up with requests of support to no avail.
- **Feb 2023** SCF telephone again and waited 42 mins on hold to speak with Sanctuary repairs/complaints dept. Sanctuary rep reported no date is booked yet booked for repairs. Escalated to Urgent with complaint. SCF requested they make contact with client asap.
- **8/3/2023** received a call from Sanctuary to say the works have now been approved. Two contractors have been instructed to complete the work. One for the walls and one for the heating repairs.
- **September 2023** after multiple attempted communications to secure date for works, and multiple broken promises, the wall was finally repaired, they reported the mould and damp was resolved and heating was put into the property.
- Requested reassurances that if the mould and damp should return, they would act upon it in a timely manner – not a 3-year waiting time.
- **October 2023** client reported the mould had reappeared in bathroom, and she was very distressed. Contacted Sanctuary to request further repairs, removal of mould stains under silicone on windows in the property so client can employ a painter to improve her living conditions. Low compensation offered, which would not cover a painter's work, but no mention of repairs.
- **January 2024**, after multiple requests to Sanctuary, a **Housing Ombudsman** complaint letter was sent, to seek support with the repairs. Resulted in stage 2 complaint being made.
- **March 2024** a new Sanctuary Complaints Officer was assigned and investigating the case and complaints so far.
- **May 2024** After multiple prompts to delays, repeated Complaints Officer questions answered and photographic evidence re-examined, it was agreed that two more outside contractors were to be employed to complete the repair to client's property. Plus, an increased offer of compensation to the value of £1,700 was made.
- **May 2024** the initial works began but uncovered questionable asbestos inside the property, so the works are again on hold until a survey can be concluded 19th June 2024.

- Client discussed involvement with OT to provide suitable outside stepping and awaiting Sanctuary permission to complete bathroom assessment for suitable adaptations.
- After no communication from Sanctuary, long delays, SCF contacted the complaints officer to find the asbestos was recorded as negative in July, but no one was notified until Sept 24. SCF also found that permissions were granted for Council to do adaptations to property and passed this on to client.
- **Sept 2024** a second complaint/update was sent to the **Housing Ombudsman**.
- **October 2024** Client involved with OT and advised they will be providing bathing adaptations. Still no word from Sanctuary.
- **November 2024** client reported the Council have employed Pearce Construction to complete bathroom works and will be commencing December 24. This intervention has taken the responsibility away from Sanctuary to repair bathroom from recurring mould and damp. Agreed to close case.

Client feedback & did the project work meet their expectations:

- Client is very appreciative of the support from SCF. She reports she could not have managed the communications/complaints herself. She reports she has no faith in Sanctuary and fears this situation returning in the future.

Referrer feedback & did the project work meet their expectations:

- Glad SCF took tough tack/complaint (comment from Dave).

What have we measured:

- Output - Support working towards goals & aspirations
- Output - Support to manage tenancy with multi complaints
- Output - Safeguarding referral made to ND Council
- Output - Research undertaken to find solutions for clients
- Output - One-to-one work with client
- Output - Housing advice provided
- Output - Form filling
- Output - Continued contact with professionals
- Output - Connected with Community Developer
- Outcome - Improved physical health once mould removed
- Outcome - Improved motivation
- Outcome - Improved living conditions
- Outcome - Client supported to remain in property
- Outcome - Client supported to live safely

What did we learn:

- That dealing with Housing associations is very frustrating, difficult and requires stamina.

Quotes and other feedback (from professionals, clients, others involved in support of client)

| | |
|----------|---|
| Client T | <p>5/12/24 " The wet room has been done! It all happened very swiftly after yet another asbestos survey. I assumed it would be next year but I think the council pushed things through quickly. It has been bedlam but I'm thrilled with the result and it's making life so much easier and safer. I've been able to use the money from Sanctuary to replace stuff in the bathroom damaged previously and get additional cupboards. No mould now! Fingers crossed it all stays that way...</p> |
|----------|---|

| | |
|---|---|
| | Thank you once again for everything you have done. You really stuck in there! You really have made a difference ❤️ Kind Regards,T |
| Professional (State organisation & name of professional) | <p>DS – Pain Clinician.</p> <p>“Very nice work. These issues with housing really need to be dealt with - even Gove was on it. I'm pleased you've taken a firmer approach and if i can add anything else I will. I'm sure ██████ is pleased someone is acting as an advocate for her. Thanks very much”.</p> <p>Cheers Dave.</p> <p>8/3/23 “fabulous - very nicely done. She will also be delighted. Another feather in your cap Julie”. Dave.</p> <p>4/12/24 “hi Julie thanks for the update sounds like this was a bit of a battle but the outcome was a great 1 in the end. Thanks for your time and effort on this 1 stop” Dave.</p> |

2.0 Discharge Outcomes

| Patient name: R Referring Clinician: Archie Baker . | Times seen/contact | Outcomes | Comments |
|--|--------------------|---|---|
| <p>This lady is looking for if there is any funding stream for a new electric wheelchair, has currently is out of action due to a battery problem and a safety issue. She has had complex hip surgery and significant widespread pain.</p> <p>Overall Goal: R lives with debilitating arthritis of both shoulders, left replaced. (add from clinic list...) R can only walk 10 yards. R lives alone with her dog. R owns the property / has stairlift and is an ex NHS department manager. R lives on state pension, a small NHS pension and DVLA for past 15 years. R has saved and has just over the £23,500 threshold but paying for the adaptations will clear her funds out, leaving nothing for emergency. She feels money is tight. R needs to instal better bathing equipment due to her lichen sclerosis of the vulva, and multiple infections - needs to be able to sit in bath, currently has a bath upstairs with mechanical bath seat, but she is struggling to get legs over the bath now. shower in situ downstairs. R has a privately purchased electric wheelchair 6years old; the battery is not working, it tips on slopes and she feels is it unsafe. R also has an electric scooter which she can go out on but cannot go into shops as too large. R doesn't drive so wc does not need to fold to go in the boot. R had an NHS OT who said they can't support an electric wheelchair. R has never been assessed by CDP - Social Services OT for electric wheelchair or home adaptations. This would be a criteria of funders so agreed to refer to CDP for assessments.</p> <p>WMTM: To continue to be as independent as possible, and the use of electric wheelchair will provide her the ability to go inside local shops for groceries.</p> <p>Referral made:</p> <ul style="list-style-type: none"> • Referral to CDP for assessment of electric wheelchair and bathing adaptations for health July 2024. • Researched for suitable wheelchair to provide example to CDP. • Referral chased up September 24 and advised the referral will now go to Health OT for assessment, as deemed a reablement case. • Referral to Cinnamon Trust for volunteer dog walker whilst she recovers. <p>Outcome: R had x3 separate admissions to hospital with breathing issues and was very poorly. (covid) Post second admission she was appointed a Health OT. SCF contacted OT to ask if she will be conducting the two assessments.</p> | <p>X14</p> | <p>Output - WMTM Conversation taken place</p> <p>Output - OND & client feedback completed</p> <p>Output - One-to-one work with client</p> <p>Output - Form filling</p> <p>Output - Continued contact with professionals</p> <p>Output - Signposted to external agency</p> <p>Outcome - External health assessment conducted</p> <p>Outcome - Increased independence</p> <p>Outcome - Improved engagement with relevant health services</p> <p>Outcome - Case concluded successfully</p> | <p>Discharged from SC FLOW casework support with option to return when appropriate. Via re-referral</p> |

| | | | |
|---|--|--|--|
| <p>OT reported she will be assessing the bathing adaptations and has referred R to Exeter mobility for a wheelchair assessment. Funding not required in this instance so discharge SCF support.</p> | | | |
| <p>Discharge Date: 30/10/24</p> | | | |

3.0 Client Feedback

| <p style="text-align: center;">Patient Feedback End Questionnaire</p> | |
|---|------------------------------|
| <p>First Name: T</p> | <p>Last Name: [REDACTED]</p> |
| <p>Preferred Contact: tele/email/text</p> | <p>NHS Number:</p> |
| <p>Regarding your Secondary care flow process:</p> <p>How have you found the flow process as a whole (what's gone well/not so well)? I have found the whole process and contact with Julie Cotton to be excellent. It has been a very lengthy and frustrating process however, due to the poor communication, delays and generally poor service by Sanctuary Housing Association, and their inability to act and resolve the many issues raised in anything like a timely manner. Julie has provided exceptional support to me throughout, on both a practical and emotional level. She has communicated with both Sanctuary and the Housing Ombudsman on my behalf when I simply felt exhausted and helpless by it all. Julie was entirely professional yet tenaciously pursued them to get appropriate action and works done at my home that had been neglected and ignored by them for over three years. I definitely could not have got things resolved without her support. I felt listened to and didn't feel so isolated and alone in dealing with an organisation that didn't seem to care and wasn't even prepared to fulfil its legal obligations as Landlords.</p> <p>Do you think there's anything we can do to improve the flow process? I currently cannot think of any improvements. Regular updates and two-way communication was maintained throughout, and I always felt I could contact Julie to discuss progress every step of the way</p> <p>What improvements have you seen in your general wellbeing because of the flow process? I have heating that works, and the mould and damage caused by lack of proper heating for an extended period of time has been resolved. It has made an enormous difference to have that comfort at home, mentally and physically. I am so relieved that it is over. I had been feeling very powerless before the help and intervention of the Flow process</p> <p>Do you feel you have achieved what matters to you that you discussed in your first WMTM conversation? Yes definitely. It also gave me the confidence to enquire about help at home via the OT to improve my situation further. I had needs assessed and have just had a wet room installed and will be having improved, safer access installed to the front of the house. Julie was also able to liaise with Sanctuary regarding this and speed up their response for permissions from the Council.</p> <p>Do you have any compliments or complaints? I can only commend Julie on her resilience and perseverance and total professionalism in dealing with Sanctuary Housing in particular. I had completely run out of energy and become frustrated with their attitude....worsening depression and struggling to cope with pain associated with</p> | |

chronic health conditions.

Is there anything else you'd like to add?

Julie has made Sanctuary fulfil their obligations so that I no longer have to also endure health difficulties in a cold damp mouldy house. She has made such a lasting impact, and I am extremely grateful!

One Northern Devon Team Member: Julie Cotton

Date: December 2024

3.0 Cumulative Outputs and Outcomes (May 2022 to December 2024)

| Case Outcome | Number |
|---|--------|
| Outcome - Improved engagement with relevant health services | 38 |
| Outcome - Improved access to meaningful activities | 36 |
| Outcome - Community activity achieved | 31 |
| Outcome - Improved motivation | 28 |
| Outcome - Improved living conditions | 26 |
| Outcome - Client supported to live safely | 22 |
| Outcome - Increased independence | 21 |
| Outcome - Improved physical health | 12 |
| Outcome - External health assessment conducted | 11 |
| Outcome - Improved social skills / relationships | 9 |
| Outcome - Client supported to remain in property | 4 |
| Outcome - Eviction averted/homelessness prevented | 4 |
| Outcome - Financial gain charitable grant / payment | 4 |
| Outcome - Improved personal hygiene | 3 |
| Outcome - Appropriately engaging with GP | 2 |
| Outcome - Client took own action to address their issue | 2 |
| Outcome - Improved family relationships | 2 |
| Outcome - Financial gain other (not charitable) | 1 |
| Outcome - Improved life skills | 1 |
| Output - One-to-one work with client | 312 |
| Output - Support working towards goals & aspirations | 249 |
| Output - Research undertaken to find solutions for clients | 215 |
| Output - Continued contact with professionals | 207 |
| Output - WMTM Conversation taken place with lead professional | 83 |
| Output - Signposted to external agency | 77 |
| Output - Form filling | 49 |
| Output - OND & client feedback completed | 44 |
| Output - Connected with Care Co-ordinator | 40 |
| Output - Support to develop self-care skills | 20 |
| Output - Progression review of client goals | 18 |
| Output - Connected with Community Developer | 16 |
| Output - Connected with Wellbeing Link Worker | 16 |
| Output - Support with recovery journey | 9 |
| Output - Flow meeting (with FC & LP) | 7 |
| Output - Homecare/aids/adaptations obtained | 6 |

| | |
|---|---|
| Output - Housing advice provided | 6 |
| Output - Connected with Social Prescriber | 5 |
| Output - Support given to co-dependent / dependent | 4 |
| Output - Support to contact & attend counselling appointments | 4 |
| Output - Support to manage tenancy / licence | 4 |
| Output - Support to attend medical appointments | 3 |
| Output - IT Support (virtual meetings & emails) | 2 |
| Output - Support with training/volunteering | 2 |
| Output - Safeguarding meeting conducted | 1 |
| Output - Safeguarding referral made | 1 |
| Output - Safety plan completed | 1 |
| Output - Support in finding alternative accommodation | 1 |
| Output - Team around the person meeting conducted | 1 |
| Output - Welfare benefits advice given | 1 |

Report by:
Julie Cotton and Nicola Topham