onenortherndevon

Secondary Care Flow

Reporting Period July - Sept 2024

1.0 Overview

Secondary Care Flow (SCF) aims to support professionals in 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 cumulative number assisted from April 2022 to Sept 2024.

No. Patients Referred in Period	No. Patients Closed in Period	No. Patients Open at End of Period	Total Cumulative Number of Patients
9	**9**	**10**	**78**

(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	4	Signpost
Matt Lund	1	Signpost
Alan Bennett	2	signpost
Archie Baker	1	casework
Dave Sanders	1	signpost

3.0 Project Capacity

A caseload of 10-12 is manageable for the role, at the end of the period the project had 10 open cases and 1 on the waiting list.

4.0 Personal Evaluation Scoring

All patients who on initial contact who are identified as requiring casework are asked what their baseline evaluation score is and then subsequently upon discharge. During the period 9 patients in total were discharged and of these 7 were supported with signposting and/or an element of casework that manifested whilst working with them and 2 required in depth casework.
1 patient completed the discharge evaluations, which are shown in the table below.

Personal Evaluation Questions **VM**	Baseline Score (Average)	Discharge Score (Average)	Difference
Q1. I feel hopeful I can achieve what I want in life.	2	3	+1

Q2. I only have to tell my story once to receive the support I need	2	4	+2
Q3. I feel I can manage my responsibilities well.	1	3	+2
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.	2	3	+1

5.0 Project Outcomes and Outputs

Outcomes and outputs for all patients from July 2024 to Sept 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 2.0 shows all project outcomes from July 2022 to Sept 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 - Case concluded successfully	9
Outcome - Community activity achieved	4
Outcome - Improved access to meaningful activities	4
Outcome - Improved engagement with relevant health services	3
Outcome - Improved motivation	3
Outcome - Improved physical health	2
Outcome - Appropriately engaging with GP	1
Outcome - External health assessment conducted	1
Outcome - Improved family relationships	1
Outcome - Increased independence	1
Output - One-to-one work with client	55
Output - Continued contact with professionals	24
Output - Research undertaken to find solutions for clients	22
Output - WMTM Conversation taken place with lead professional	8
Output - Signposted to external agency	3
Output - Form filling	2
Output - OND & client feedback completed	2
Output - Support working towards goals & aspirations	1

6.0 Update and Reflections from Julie

The comments (see 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.

During this last quarter, the incoming referrals slowed down and with mention of this at MDT’s, this steadily increased. I feel certain this is due to Clinicians time constraints, so I have on occasion received simple referrals via email and contacted admin for copies of clinic entries to complete the referrals myself, with Clinicians guidance.

SCF referrals continue to initially indicate signposting is required for patient outcomes, but by human nature of what the patient feels they require or need, this can often develop into

longer pieces of work, often waiting on forward referrals to other services. This can delay discharging but has not been a problem to date.

During this period, I made contact with a Pain Cafe service, who have set up multiple Pain Cafes across Cornwall, with a new venue in Bude. I shared their website with the team, and the organisers were subsequently invited to our MDT to share their story and information. The team agreed this is a very positive progression, reinforcing the non-medical approach to long term pain and would be an asset to North Devon going forward https://pain.cafe/
This is in line with SCF's recent interactions to support two Pain Team patients to set up a Fibromyalgia peer support group for likeminded sufferers, after being introduced to one another during a HOPE course (see leaflets appendix 2).

In September I attended two promotional events to represent both SCF and the HOPE Programme, one held by the Pain team for National Pain Awareness Month, and the other held by Encompass Southwest to highlight/showcase the FLOW services locally. During this event I was able to network on behalf of the HOPE Programme, highlighting the need for more Facilitators to come forward and for local businesses to consider giving their wellbeing staff the opportunities to facilitate HOPE for the local community.
I am now planning to support Litchdon Medical Centre's, nursing team with a similar, three-day event during October/November.

6.1 Key Achievements in Period

- Successfully supporting a lady who had become very withdrawn due to three family members deaths. She was referred to Clarity Group Workshops. This helped her immensely and she learnt to put herself first and not her troubled family who pull on her support with their ongoing life crisis and turbulence. She plans to attend another of their group workshops. She also attended the HOPE course and went on to support another Pain Team patient to set up the Fibro Peer Support Café in Barnstaple.
- Successfully located a donated Tens machine for a patient in need of trialling this for her nighttime pain.
- Successfully supported a gentleman who lives with Parkinson's and ca, plus his wife to join the good boost water mobility class, and trial a seated movement class. Multiple suitable activities where shared and introductions were made to the three, he was most interested in.

6.2 Key Priorities for Next Period

To continue to encourage the clinicians to make new SCF referrals when required.

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 – ImagineIf.	Two representatives from the Pain Café Cornwall attended the MDT to share their set up of this new model across multiple sites across Cornwall. They are keen to see this	Located by SCF and introduced the programme to the team, using the website. Hopefully, there will be more

		develop across Devon and Somerset.	discussion around local funding to consider joining this programme for the Pain Management Team patients in North Devon.
Success	RDUH Voluntary Sector	SCF have now joined the RDUH Voluntary Sector who will induct our HOPE lived experience volunteers	Though this is a HOPE system change, it directly involves the Pain Management Team patients who come through the HOPE programme and go on to become lived experience HOPE volunteers.

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, services that can support with finance and benefits issues 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:

- Referring and collaboration with Social Services with the best interests of the patients in mind.
- 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.
- Research and venue visits with patients to locate the best space for peer support group in Barnstaple (fibro)

Ongoing barriers and challenges:

- Obtaining voluntary support for under 65 years – this remains an ongoing issue.
- Overcoming communication difficulties with Sanctuary housing, regarding property repairs and compensation – which seemed to be resolved but more delays are ongoing and Housing Ombudsman informed on two occasions.
- SCF time management can be challenging when caseload is full of 15 hours each week allocated to it.

8.0 Comments from Patients discharged in this period

3/7/24 (BW)	"Thank you for your calls and help" B.
6/8/24 (MR)	"oh I am so grateful for this Tens machine. I am hopeful it will ease my leg pain and help me sleep at night. Thank you" MR.

11/7/24 (ZB)	" thank you Julie for all your support. I will be joining Holsworthy pool this afternoon. I am still considering liquidating my small business as its too overwhelming to cope with" Z
18/7/24 (CH)	"thank you Julie, you help has been very quick and good"
23/9/24 (RM)	"Without your help, none of this would be happening. Thank you again and I will keep you informed of progress. Regards, R"
19/9/24 (D&A W)	"Thank you for all of the information you have sent through. We have joined the good boost and really enjoy it. We went to one of the move it or lose it chair base classes, but it was a bit of an effort for him. We plan to try the chair yoga in a few weeks. We both appreciate your support with finding a suitable activity"

9.0 Comments from Professionals

27/8/24 (Ruth)	quote in response to leaflet sharing… "Thanks for these Julie, they are fantastic. What an amazing service and what a fabulous job you are doing!" Ruth.
23/7/24 (Matt)	"Thanks, Julie, for your ongoing and great support for CH. This sounds like a good plan, appreciate the update" matt
1/8/24 (Alan)	"Thanks Julie!"

Appendices

1.0 Case Study (anonymised) DW
Sept 2024

1. About the client / background: taken from referral; ML

Ongoing low back pain. Parkinson's. Prostate cancer with bony mets

1. **Objective: To explore options for community-based exercise, previously attended the Parkinson's ex class though this was too high level**
2. **To look at whether support or options for exercise in water are also needed**

2. What mattered to the client: SCF initial contact.

D lives with Parkinsons and history of prostate ca.

D reported WMTM is to get rid of stiffness and pains.

Lives in own property with wife and has stairlift in situ.

Uses 4ww to mobilise. Can only walk the length of small room without aid.

Wife is a great support, and he could not manage without her help daily.

D previously joined Parkinson exercise group but found it too high level.

Previously enjoyed hydrotherapy.

Discussed Good Boost water tailored exercise. D interested in water exercise.

Also interested in LTC exercise class, if not too strenuous.

Discussed move it or lose it classes in Pilton or Newport. Either chair or standing.

Discussed chair yoga at library. Wife (A) reported she would be interested in that too.

Emailed all above exercise details to D&A for consideration plus the Braunton Live life well booklet, which holds multi activities. Made contact with lose it or move it and chair yoga to be sure suitable for D and to introduce him to the sessions.

Initially considered a signposting which developed to activity services introductions.

3. Client feedback & did the project work meet their expectations:

D&A were very grateful for the emailed activity descriptions and proactive in trialling them all.

- Joined the good boost water classes and continued to attend.
- Tried the move it or lose it chair class but found it high level and tiring.
- Planning to trial the chair-based yoga post SCF discharge. Intro made.
- Planning to trial some of the other activities in the Braunton booklet.

4. What have we measured (e.g. outcomes / outputs / other if applicable):

Outcome - Community activity achieved

Outcome - Improved access to meaningful activities

Outcome - Improved engagement with relevant health services

Output - Continued contact with professionals

Output - One-to-one work with client

Output - Research undertaken to find solutions for clients

Output - WMTM Conversation taken place

7. What did we learn (complete if applicable):

Many clients are proactive but still require more than signposting and prefer a gentle introduction to the different services that are on offer in the local community.

8. Would the client be happy to take part in supporting our evaluation? Options include: filmed interview, recorded (voice-only) interview, written interview

Happy to ask, if deemed appropriate in future.

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

Clients' wife on his behalf	19/9/24 "Thank you for all of the information and introductions you have sent through. We have joined the good boost and really enjoy it. We went to one of the 'move it or lose it' chair base classes but it was a bit of an effort for him. We plan to try the 'chair yoga' in a few weeks. We both appreciate your support with finding a suitable activity"
Professional (State organisation & name of professional)	ML

Appendix 2.0 Barnstaple Fibromyalgia Peer Support Café leaflets x2

julie cotton template tri fold flyer fibro peer cafe 15.8.24.pdf

and

Fibro peer cafe A4 13.8.24.pdf

Appendix 3.0 Cumulative Outputs and Outcomes (May 2022 to September 2024)

Case Outcome	Number
Outcome - Case concluded successfully	52
Outcome - Improved access to meaningful activities	34
Outcome - Improved engagement with relevant health services	32
Outcome - Community activity achieved	29
Outcome - Improved motivation	28
Outcome - Improved living conditions	24
Outcome - Increased independence	20
Outcome - Client supported to live safely	19
Outcome - Improved physical health	12
Outcome - External health assessment conducted	11
Outcome - Improved social skills / relationships	9
Outcome - Eviction averted/homelessness prevented	4
Outcome - Financial gain charitable grant / payment	4
Outcome - Client supported to remain in property	3
Outcome - Appropriately engaging with GP	2
Outcome - Client took own action to address their issue	2
Outcome - Improved family relationships	2
Outcome - Improved personal hygiene	2
Outcome - Financial gain other (not charitable)	1
Outcome - Improved life skills	1
Output - One-to-one work with client	264

Output - Support working towards goals & aspirations	249
Output - Continued contact with professionals	183
Output - Research undertaken to find solutions for clients	183
Output - WMTM Conversation taken place with lead professional	75
Output - Signposted to external agency	73
Output - Form filling	44
Output - OND & client feedback completed	41
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