Community Flow End of Year Highlight Report 2023-2024

1. Highlights

- In the year 23/24 Community Flow worked with 377 patients being discharged from North Devon District and who had been identified as potentially struggling to manage their health and wellbeing following their admission to hospital
- 51% of these were Pathway 0 patients and 47% were Pathway 1
- Resulted in speedier discharge in 54 cases
- Prevented a likely readmission within 6 weeks of discharge in 136 cases
- In October 2023 transferred from being hospital based to being based in the Adult Health and Social Care Community Teams – working more closely with these teams to focus on admission avoidance. Currently the referral source split is 55% from the Hospital and 45% from the Community Teams

2. Data

2.1 Data Highlights

The following table shows the key data highlights:

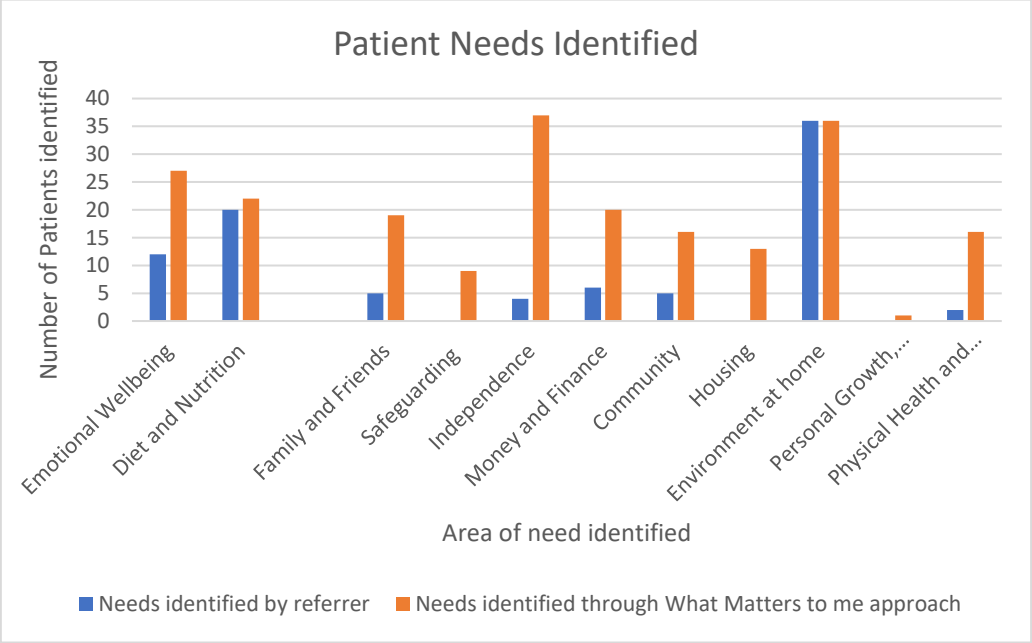
COMMUNITY FLOW DATA POINTS 2023-2024	
Number of new clients referred	**377**
Pathway 0	**51%**
Pathway 1	**47%**
Pathway 2	**2%**
Recent discharge (direct via Community Teams)	**19**
SUPPORT PROVIDED – OUTPUTS	
What Matters to Me conversations taken place with lead professional and client	**292**
Team Around the Person meeting conducted	**8**
Community Around the Person meeting conducted	**2**
One-to-one work with client	**254**
Research undertaken to find solutions for clients	**245**
Signposting, referrals, and direct support to ensure engagement/attendance	**562**
Total Outputs	**1363**

TRUST OUTCOMES	
Number of times Community Flow input resulted in a speedier discharge	**54**
Number of times Community Flow input contributed to a safer/more holistic discharge	**86**
Number of times CF input prevented a likely crisis/ or readmission during the 6 weeks period	**136**
Number of times CF intervention may have prevented a readmission in the future	**196**
Total Trust Outcomes	**472**
PATIENT OUTCOMES – Positive Improvements in Patients' Lives.	
Housing/accommodation	**149**
Physical health (including self-care)	**82**
Mental Health	**55**
Meals, Diet and Nutrition	**116**
Relationships/Family & Friends	**89**
Independence	**294**
Money & Finance	**141**
Community Connection	**44**
Total Patient Outcomes	**970**

2.2. Patient Needs

2.2.1 Identifying Need

Patient needs are identified first by referrers who inform the key worker of the reason for referral. In conversation with the patient, key workers identify further needs based around what matters most to the patient. As trusting relationships are built between key worker and patient, more needs are identified during the key work period. The chart below presents the needs identified by the referrer at point of referral in blue and the needs identified by the key worker following referral through the what matters approach in orange. Data shown is for this quarter.



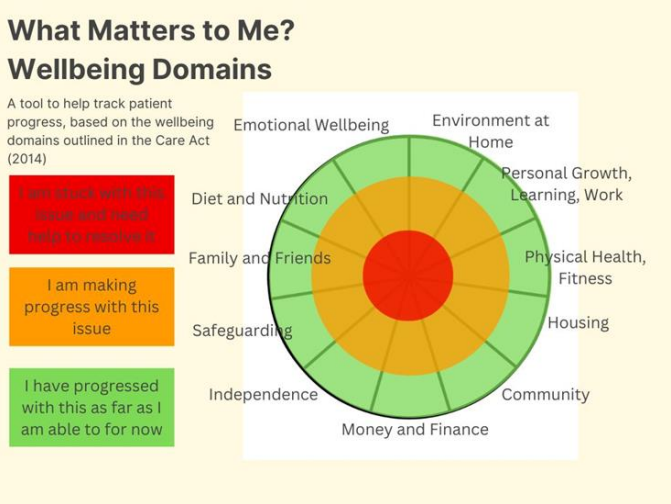
2.2.2 Resolving Needs

To evidence patient progress, Community Flow uses a traffic light system to record changing needs within the 11 wellbeing areas they may explore with a patient.

Red: The patient feels stuck with this issue and needs support to resolve it.

Amber: The patient is making progress or accepting help with the issue. Perhaps they are now engaging with services where before they were not.

Green: The patient feels they have progressed as far as they are able to for now with the issue. The patient has maximised their independence with the issue reflective of where they are in their journey. For example, a patient may have maximised their independence around diet and nutrition by enlisting the support of a volunteer weekly for shopping.



How the Team have been able to progress needs across these domain areas can be seen in Appendix 1 Patients' Progress with Needs

3. Financial Impact

3.1 Delivery Cost Summary

The overall cost to deliver the service in 2023/24 was **£118.860** for a 2.4 WTE caseworkers, 0.6 Manager and a small budget for patient needs. This funding originated from a variety funding sources including ICB, NHS charities Together Grant and legacy OND funding.

There were a number of changes to staff structure and funding challenges which meant that we had to move staff around to accommodate the requirements for balancing delivery with management. Our provider, Encompass South West have been accommodating in terms of cost management and flexibility to enable this to happen.

3.2 Financial Impact / Cost Savings

Data from the NHS England National Cost Collection Dataset 2021/2022 shows that:

- The average cost of a non-elective short-term stay is £801
- The average costs of a regular day or night admission is £406

Using these costs alone the financial impact of Community Flow can be shown.

Discharge expediated

Over the past year, Community Flow has speeded up discharge in 54 instances. Using the data above, and working on the minimum assumption that it speeded up discharge by one day only we can determine that this saved **£21,924.** (54 x £406)

As stated, this is based on a best-case scenario of expediating discharge by only one day, however, given that in these cases a solution hasn't been able to be found prior to Community Flow involvement, the likelihood of speeding up by just one day is very small. The reality is that these patients would have been in for considerably longer – so the saving is likely to be significantly more.

Re-admission avoidance within 6 weeks

Community Flow avoided a potential re-admission within 6 weeks in 136 cases. Using the NHS data above, if all of these are short term only this represents as saving of **£108,936** (136 x £801).

Summary

Both these 'best case' scenarios for discharge expediated and admission avoidance amount to a minimum saving of **£130,860**

Finally, this figure doesn't include the 196 longer term admissions potentially avoided in the longer term due to Community Flow involvement, or the cost of ambulance conveyances, some of the emergency admissions being longer term, or the fact that in reality discharge delays were likely to have been considerably longer than one day.

Therefore, the overall cost savings for Community Flow are likely to be considerably higher.

3.2 Projected costs of delivery 2024/2025

Working with our provider, Encompass SW, have been able to identify £66,539 from existing funding savings to continue Community Flow from April 2024 – Mid September 2024, and have requested match funding of **£72,113.80** to continue this until 31st March 2025 and thereafter consider continued funding for the service as 'business as usual'

	Already Funded	**Funding Required**	**Totals**
Period	April - Sept 22nd 2024	Sept 23rd 2024 – 31st March 2025	
Salaries	£46,630.92	£51,526.68	£91,157.60
Overheads	£5,201.28	£5,685.12	£10886.40
Hosting/Management Costs	£4,706.80	£4,902.00	£9608.80
Disbursement Budget	£10,000	£10,000	£20,000
TOTAL	**£66,539.00**	**£72,113.80**	**138,652.80**

4. Case Studies

4.1 Case Study 1

Case Study April 2024

Connecting to community projects and meaningful activities.

We received a referral for a gentleman (Mr H) in an area of North Devon that is known to be difficult for healthcare professionals to source care and support in and has a population that disproportionately experiences social isolation.

The community flow team has worked closely with the community developer and local One Northern Devon team to address these issues and the town has responded by promoting and supporting local community projects to develop and flourish. The community flow team has supported this by directing people to these projects so that they are sustained by being in demand and any of the usual obstacles people experience which create a barrier to attending are addressed with support from our team.

In this case, an older gentleman (Mr H) has been referred to us by the community therapy team for support with connecting with meaningful activities to reduce his risk of social isolation following a hospital stay. Often it can be the case that a hospital stay, and a decline in overall health, can be enough to break a routine and damage a person's confidence that they become social isolated as a result. In this case we successfully supported to prevent this by liaising with Mr H and his daughter.

Mr H has early signs of dementia and is supported by his daughter in most ways (shopping, collecting medication, sourcing ongoing support) but Mr H's daughter had reported to the community therapy team that she was worried about her father becoming isolated. Knowing that social isolation can worsen existing health conditions and lead to a breakdown of existing natural care and support, the therapy team asked me to contact Mr H and his daughter.

Over a number of sessions I worked 1:1 with Mr H and his daughter to explore the things that mattered to him and I summarised this to send to the One Northern Devon community Developer and the wellbeing team. I received from them an update of all the local activities that might suit Mr H, based on his interests and circumstances. I then compiled this information and explored the projects for suitability before discussing with Mr H and his daughter. The reason it was important to spend time researching the projects first is that often a barrier such as access, lack of inclusivity, cost or location can mean that a project might be ideal for a person on paper, but in reality, it is inappropriate and the person does not attend, leading to isolation and also a sense of despair as they feel they are "incapable".

Mr H showed interest in a particular group and working with is daughter we arranged for him to attend – initially supported by his daughter – which went really well – and he has been attending since then.

We had some great feedback as follows:

"Dad showed great interest in the Wednesday group which is fabulous because its every week.

He is honestly so much brighter on days when he's been out to something.

Many thanks for your support,"

Case Study 2

A (Patient anonymised)
A was referred in to Community Flow by the Community Physiotherapist it was not a discharge from hospital.

Reason for referral. A was unable to complete her shopping due to significant back pain. Her son was unable to help due to his work commitments. A would like some support to help complete her shopping for a couple of weeks while her back-pain settles.

Initial contact. A is suffering significantly with her back pain (she has curvature of the spine) she is quite anxious and worried about taking the pain killers she has been given as they have either made her painfully constipated or caused her to hallucinate. Keyworker suggested she calls her doctor again to discuss her worries further and see if they can provide any alternative medication. A doesn't have any other income apart from her pension and pension credits so I suggested we make a referral to TorAge to support with benefit advice and in particular Attendance Allowance. A was happy for the me to do that. I also suggested that Living Options Devon might be another area of support as they have a telephone support service for people experiencing loneliness, isolation, anxiety etc, A said that sounded good too, I suggested they could also possibly support with mobility aids that may make it easier for her to get around the house.

I asked if there was anything that would be of help to her and she said that she would like to be able to get outside, she has a small balcony but that's all. A said a wheelchair would help, they do have a lift so she could access outside with it. A didn't feel well enough to follow this through at this point in time so it was noted to follow up at a later date.

I made a follow up call and explained that the OT, Physio or GP can refer her for a wheelchair through the NHS if she still feels she wants one. On reflection A didn't think she needed it at the moment but may need another form of support when walking outside, she says she still feels unstable but the physio wants her to keep trying with one stick only.

I had a quite distressing call to A, she was getting panic attacks, she became very tearful, and I validated how frightening such attacks can be and assured her she wasn't being "Silly" A has found coping mechanisms such as driving herself down to Westward Ho front. A friend is taking A to have her hair done and I acknowledged this is a really positive thing to do for her wellbeing.

I helped A to complete a referral to Talk Works on line, they called her and arranged a time to call and set up regular appointments

A used to attend a choir before her illness however due to her breathlessness she is now unable to reach the high notes. She spoke to the me about a choir she had seen on TV specifically for people with breathing difficulties. I made enquiries and found a music group that runs choirs like this but not in A's area due to funding. I then contacted the community developer who was very keen to support this, she took this to the next One Atlantic meeting. Outcome for this was work in progress with the plan that something could be set up within A's community. A was thrilled this was being followed up remarking "I am famous".

A had a hip operation coming up, she had been overthinking and concerned how she would manage, she couldn't stop herself worrying. She had received a request to take photos of

resources in the home which could be adapted. A didn't have IT. skills to do this or how to e mail the photos on. I made enquiries to TTVS for a volunteer with IT. skills who could support A with this and this was set up. I also made a call to A's physio who suggested the I sent her an e mail and she would arrange for a referral to get somebody to visit A and check what she may need. A lever for A's bed was ordered.

Analysis: A was an active member of her community. Life changing health conditions has impacted on her mental health, the panic attacks may also have been side effects from her medication. The practical support such as financial support was very helpful however and resulted in a benefits increase but A also said that the Flow Caseworker phone support was invaluable at some difficult times and stopped her contacting A&E. One call she stated "I am always so low when you call, maybe that's a good thing?" She is continuing on her journey but the service provided by Community Flow helped her through a particularly tough time.

Case Study 3

B – a gentleman in his 70s, who lives alone.

I met B in the hospital ahead of his planned discharge home. He had been referred to us by a social worker after it had become apparent to her that his home was unsuitable for him to go home to. This would not only create a barrier to a safe discharge but, if he were to go home, result in a readmission in all likelihood.

The nurses on the ward agreed that in order for B to go home safely, his home would need to be cleaned and currently there was no way this could be arranged. When I met B on the ward, I discussed this concern with him. He said he didn't think it was "that bad" but agreed for me to take his house key to pass to a local biohazard cleaning company. It had been reported that his home was unsanitary and needed a specialist to clean it.

The cleaning company was able to visit at the weekend and had completed the clean by Monday in order for B to go home. B was then told, following additional assessment, he would need to then wait for care to become available. He was frustrated that he could not go home and phoned me from the ward to tell me his intention to self-discharge. I explained that the social worker felt it would be safest if he waited for care to become available, but B was adamant that he would be leaving that day.

After liaising with the ward and social worker, with B's permission, we planned for him to be able to self-discharge safely. I met him at home with some essential shopping once he got back and checked that his home was safe and habitable. The cleaners had done a thorough clean and I tested his fire alarms etc and chatted with him for a while. He told me about his condition – Crohn's disease - and how it affected him. I was also able to fit a temporary key safe that the ward had given B to allow emergency carers to let themselves in.

B rang me the next day to say he had run out of sanitary items such as pads and disposable pants. He needs these because of his condition and could not leave the house to buy more. Because he had discharged himself early, a lot of the usual follow up visits had not happened so I contacted the district nurse team who kindly provided me with the items needed to deliver to B.

B said he did not know what he'd do without the support I have given him. He acknowledged his decision to go home early was a risk but with my visits, the risk was greatly minimised and freed up bed space on the ward.

B asked that I joint visit with the therapy team to introduce him to them and looked at local support once B was more settled at home. I also arranged a regular cleaning service for B. He claims PIP which he used to pay for this.

5. Feedback

5.1 Staff Feedback and Testimonials

We routinely request feedback from staff referring into the service. A selection can be found below which support the evidence presented within the above data as well as providing examples of the benefits listed above.

"I referred a patient to this team who needed support with a weekly food shop to potentially avoid a hospital admission. The Team came back to me straight away to say that they were able to help and made contact with the patient the same day as the referral and sorted this".

"Community Flow are a vital resource for UCR, in our fight to avoid un necessary admissions to hospital. They are timely, responsive and flexible. They provide a service that I don't think I could source elsewhere".

"Mrs X was very deconditioned and reported to the OT that she felt lonely. She requested some support regarding travel and to be able to start back at a previous club in the community. One Northern Devon [Community Flow] was able to support the patient in both of these areas"

"I reviewed an elderly patient in the A&E department who had mobility problems and reported feeling depressed at being house bound, being reliant on neighbours to assist with shopping. I made a referral on the day the patient was discharged from A&E and received a reply the next day to say the team had been in contact with the patient, his care agency and voluntary sector to organise a meeting to find a way of supporting him to go out socially and for shopping. It was hoped, as the reason for referral, this would reduce his feelings of depression and loneliness, therefore reducing the likelihood of readmission to hospital."

"I have used the service for many patients that have open safeguarding's and have experienced self-neglect, and the service has supported their discharge with deep cleans and with food shops on the day of discharge; a refrigerator has even been sourced for someone that was at risk of food poisoning and self-neglect upon discharge."

"This service supports some of the most vulnerable adults at NDDH. It has helped us to discharge patient's more efficiently and provide signposting to additional services patients require in the community. One of our patient's had help to organise a deep clean of his property and a pendant alarm. This gave our therapy team more time to deal with other patients who required discharge plans on the ward."

"I had to make a phone call to NL [Community Flow worker] for help recently. I had a palliative care patient who really wanted to go home. His wife needed help to organise the home environment for the right equipment to go in. She had no one to help her and was physically unable to manage. In the space of an afternoon. N was able to contact her, arrange a company to support her, and even find a grant to help pay for the work. She then

continued to support the patient and wife. This was an amazing service that enabled a palliative gentleman to have the chance to return home."

"A palliative patient's cooker was broken and had limited finances to purchase a new one - within a week of myself making the referral to One Northern Devon- Community Flow service the patient had been contacted by them and a replacement appliance sourced. Very impressed".

I feel the things that can be provided by this service, is such a big benefit for all and many people wouldn't manage at home and in their community without this vital service."

"I have found this team to be friendly willing and responsive to meet the needs of the service users that I have referred. They are a very useful asset to have available to the Urgent Community Response Team. some of the services they offer fill part of the void in community care"

"This service is very valuable for many of our patients and bridges a gap in the market to ensure patients feel supported at home but that may not meet criteria for POC. This service helps clinicians streamline their intervention with public and voluntary sector services creating a better patient experience and outcome"

5.2 Patient Feedback and Testimonials

"Not having things like the internet means that you can end up in a real mess because you don't know what services are out there and how things work. It has been really very helpful having someone to understand needs and help me navigate it all and find services I need – and to listen to my concerns and understand"

"It is very reassuring having someone to talk to and for help around all this. I know you can't do everything but even being a sounding board is helpful for me after my wife recently passed. I am looking forward to attending Bowls club thank-you so much for your support in encouraging me to attend"

"You helped take away some of the overwhelming feelings going around in my head, thank you Clare"

I am going to miss your calls. Just being there and I felt you really understood. Really have appreciated your help.

Definitely a good service. You have been very helpful. Thank you.

The volunteer from TTVS [to be there when patient returned home from hospital] *was lovely, they checked my alarm was working and made me a cup of tea and I felt really safe.*

Any service that supports patients to not return to hospital soon after discharge is a good thing.

Thank you for your help, I don't think I could have found the help in Lynton on my own. Great idea for a service and I am sure very useful to many local people who are perhaps on their own like me.

Absolutely brilliant, I can't tell you the difference this has made. My goodness there was such a lot to do and of course I couldn't do it could I because of my leg. And this lady you found for me, I would have never have found someone like her, she's absolutely brilliant. You know some people charge £30 an hour to do laundry and ironing and the like and she is

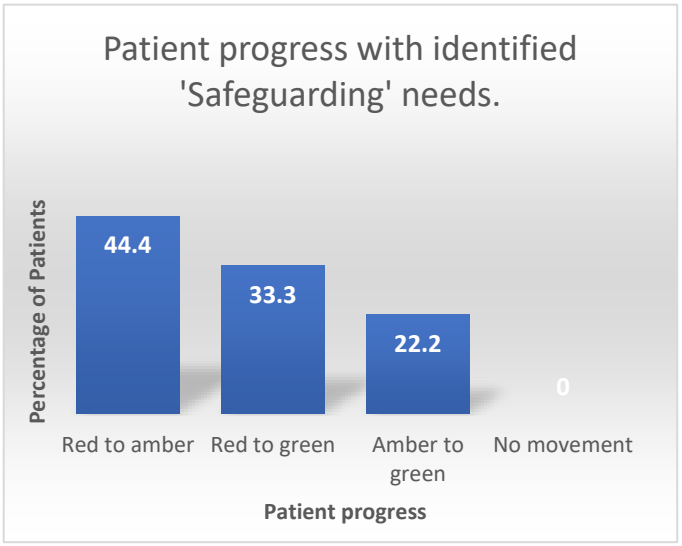
so reasonable and such a lovely person to interact with. I don't know where I would be without this help. I think I would have had to wear dirty clothes or something and no one wants to wear dirty clothes do they, I couldn't afford the prices some people were telling me. She even helps me put it all in the drawers and on the hangers and it feels so organised in there. Absolutely brilliant, I couldn't be happier.

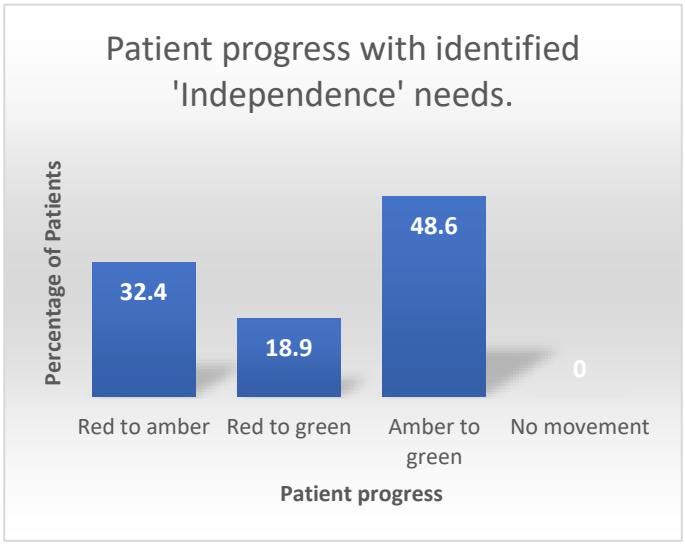
It was nice to know that someone was checking on me and I didn't know about TTVS help- they helped me sort my blue badge out.

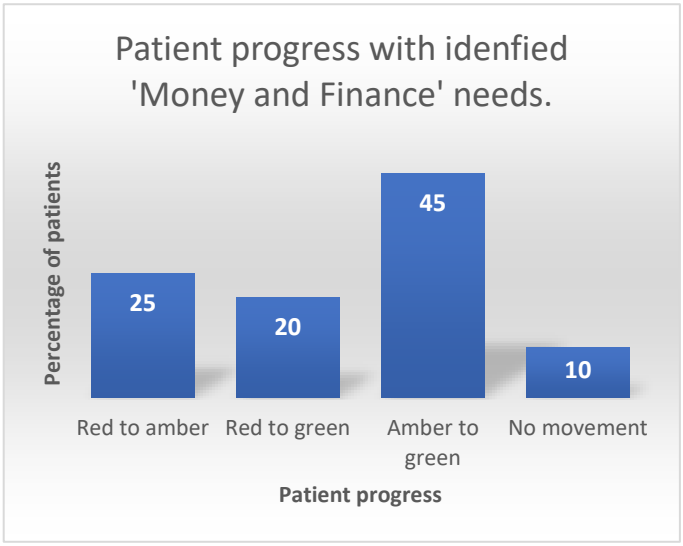
6. Appendices

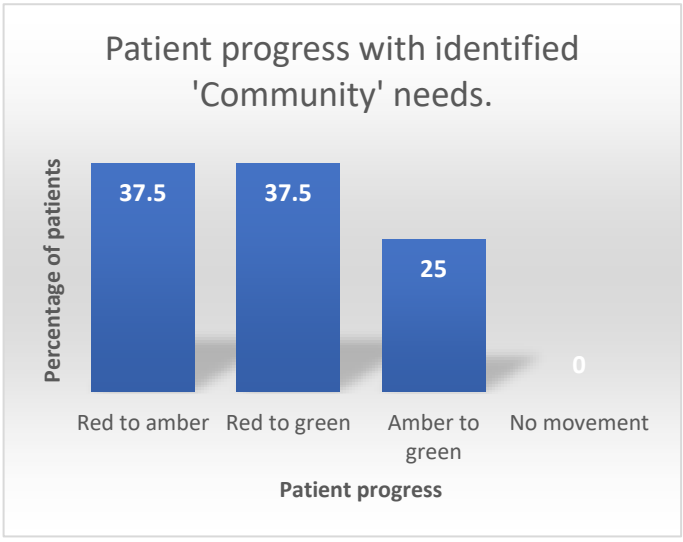
Appendix 1 – Patient Needs Progression Within the Wellbeing Domains

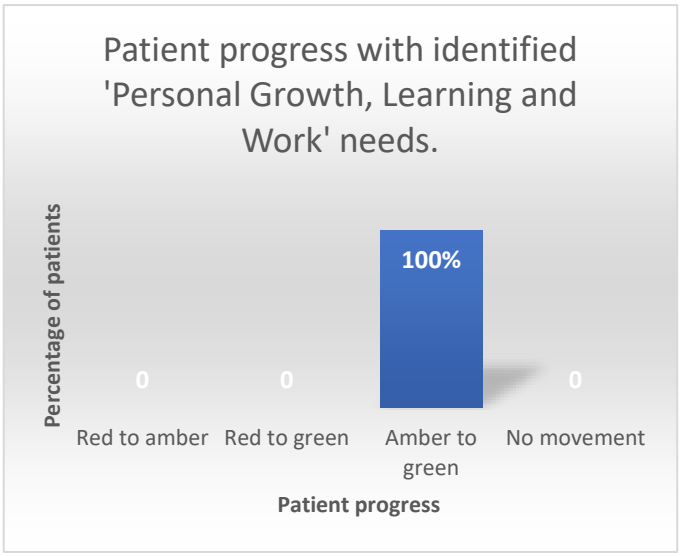
The following table show how Community Flow have enabled patients to progress their needs through the traffic light system, described in section 2.2.2: Resolving Needs

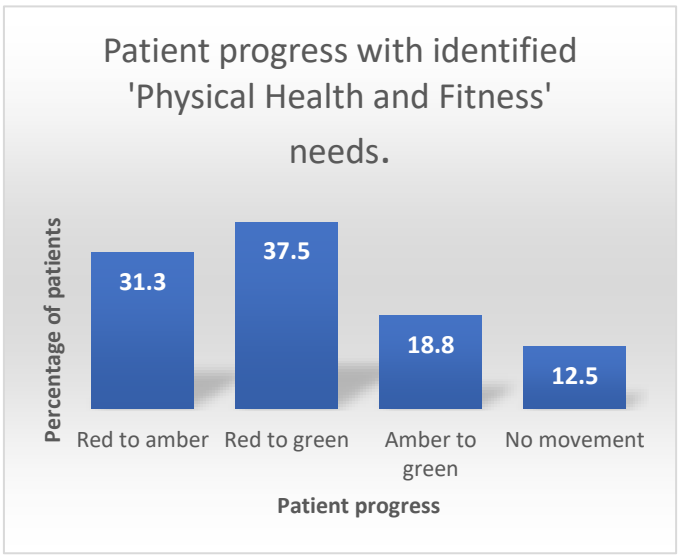


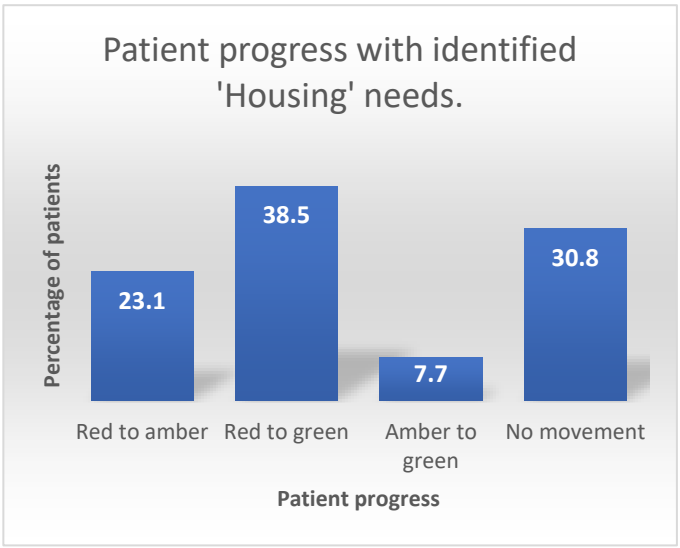


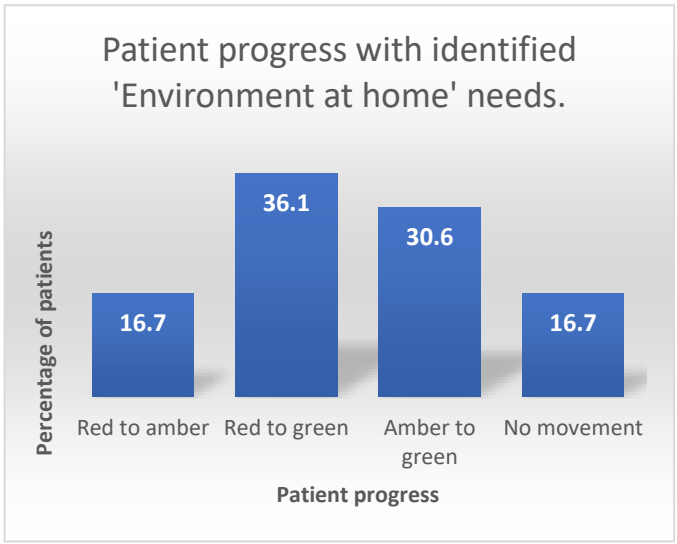





Patient progress with identified 'Personal Growth, Learning and Work' needs.
Percentage of patients
0
0
100%
0
Red to amber
Red to green
Amber to green
No movement
Patient progress


Patient progress with identified 'Physical Health and Fitness' needs.
Percentage of patients
31.3
37.5
18.8
12.5
Red to amber
Red to green
Amber to green
No movement
Patient progress


Patient progress with identified 'Housing' needs.
Percentage of patients
23.1
38.5
7.7
30.8
Red to amber
Red to green
Amber to green
No movement
Patient progress


Patient progress with identified 'Environment at home' needs.
Percentage of patients
16.7
36.1
30.6
16.7
Red to amber
Red to green
Amber to green
No movement
Patient progress