Community Flow July Highlight Report 24/25

1. Highlights

- In the year 24/25 Community Flow has worked with **221** 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
- Resulted in speedier discharge in **9** cases
- Prevented a likely readmission in **63** cases
- Q1 Referral Sources where: Community Teams **91** / North Devon District Hospital Staff **74**
- Q1 Referrals by area (where known):
  - Barnstaple **70**
  - Bliss: **31**
  - Torridge: **38**

  NB Q2 breakdowns reported at next Quarterly Report

2. Data

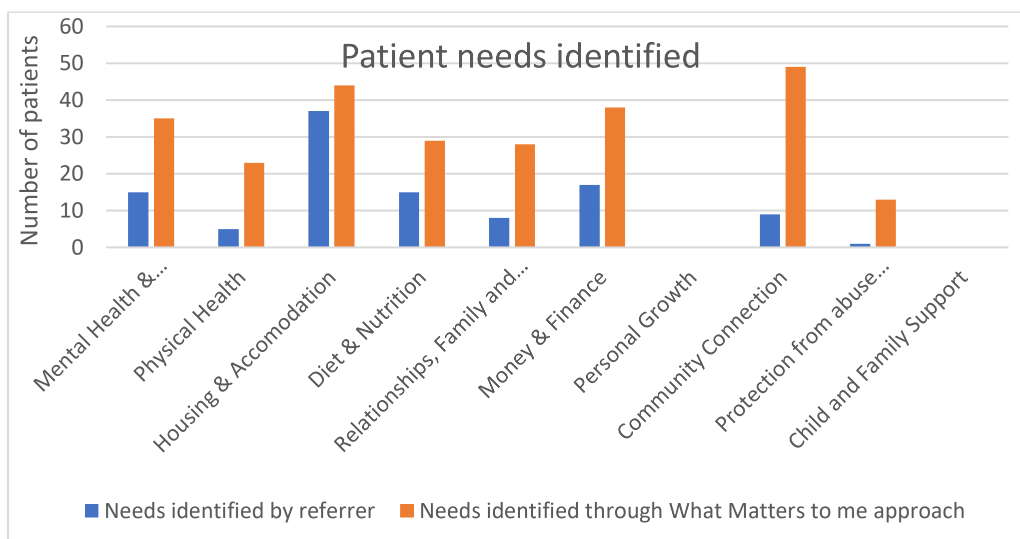
2.1 Data Highlights

MONTHLY DATA POINTS	Q1	July	Year Total
Number of new clients referred	165	36	**221**
Number of wider beneficiaries	20	10	**30**
Total number of people supported for period	162	31	**193**
Clients who declined	11	2	**13**
Total current open cases	-	-	**-**
Case concluded successfully	123	30	**153**
Closed cases due to disengagement	12	3	**15**
Closed cases due to death	6	0	**6**
Closed cases (other reasons, i.e. moving out of area)	9	1	**10**
Client feedback with OND completed	2	0	**2**
Referrer satisfaction forms received	38	0	**38**

Number of contacts/interventions with clients	536	154	**690**
SUPPORT PROVIDED			
WMTM conversations taken place with lead professional and client	304	68	**372**
Team Around the Person meeting conducted	5	1	**6**
Community Around the Person meeting conducted	0	0	**0**
Flow meeting with FC & Lead Professional	0	0	**0**
One-to-one work with clients (per client) number of individual 1:1 interactions	311	154	**465**
Linking in with Community Developer	22	2	**24**
Complex Needs Assessment completed	0	0	**0**
Caseworker research undertaken to find solutions for clients	125	154	**279**
Caseworker support to access Personal Health Budget	0	0	**0**
Caseworker support with Form filling	16	3	**19**
Caseworker support with IT incl. virtual meetings, emails etc	3	1	**4**
Caseworker support to meet aspirations	111	56	**167**
Client involved in coproduction work (total number of separate contacts)			
Successful court action			
Client represented in court			
TRUST OUTCOMES			
Number of times our intervention resulted in a speedier discharge	7	2	**9**
Number of times our intervention contributed to a safer more holistic discharge	13	5	**18**
Number of times our intervention reduced the risk of readmission	47	16	**63**

2.2 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.



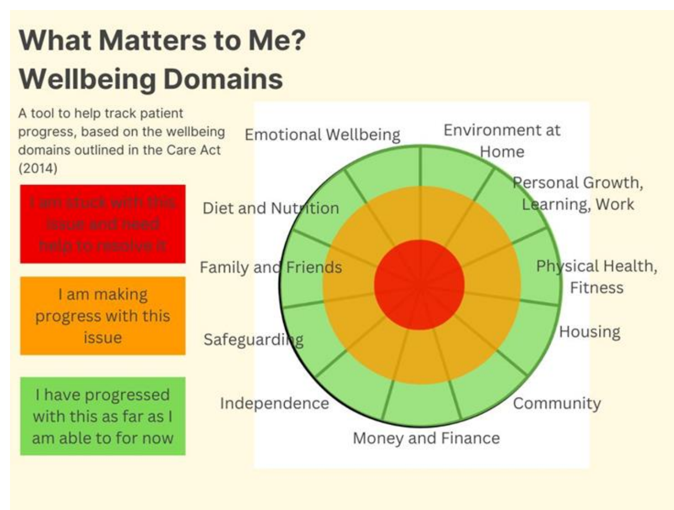
2.3 Resolving Needs

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.

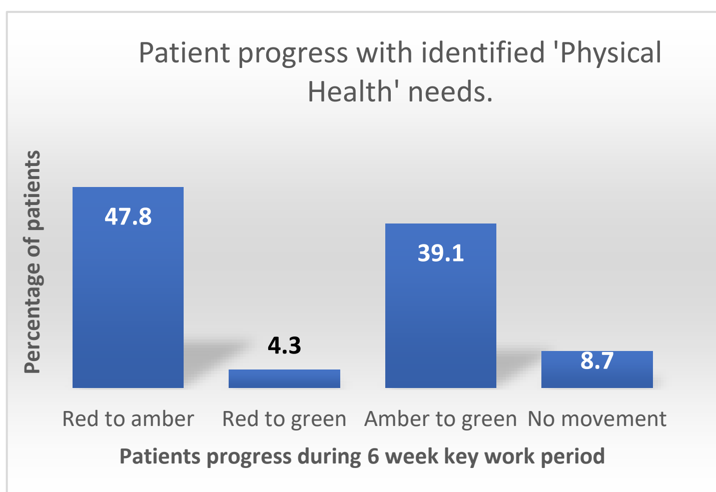
Red: The patient feels stuck with this issue and needs support to resolve it.

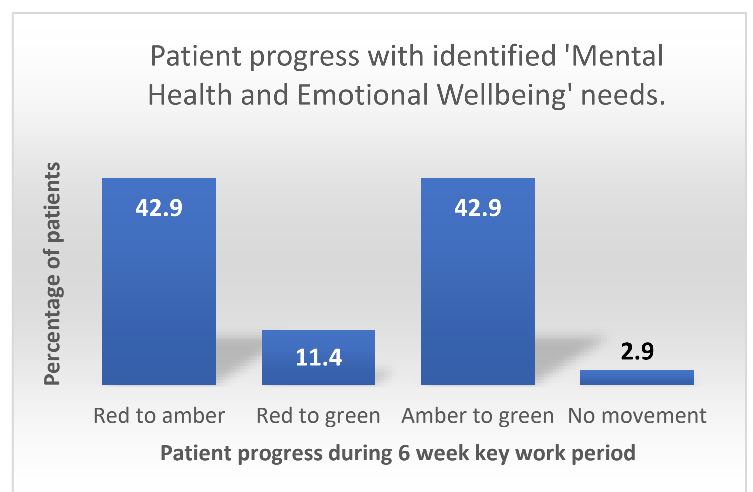
Amber: The patient is making progress or accepting help with the issue. Perhaps they are now engaging with services where before they were not.

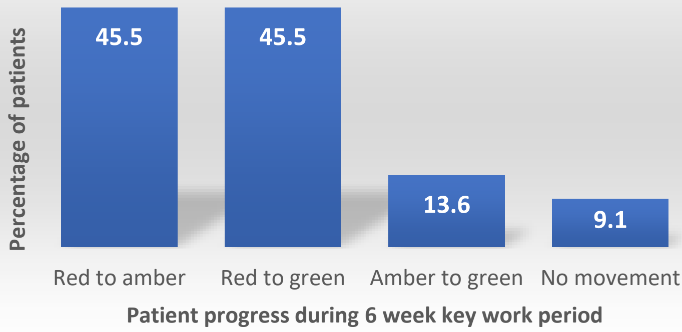
Green: The patient feels they have progressed as far as they are able to for now with the issue. The patient has maximised their independence with the issue reflective of where they are in their journey. For example, a patient may have maximised their independence around diet and nutrition by enlisting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

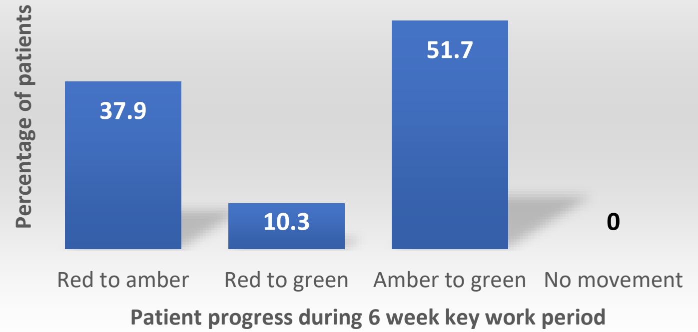


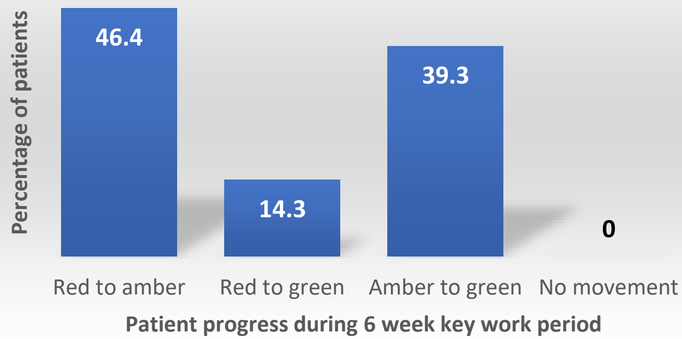
How the Team have been able to progress needs across these domain areas can be seen in the charts bel0w

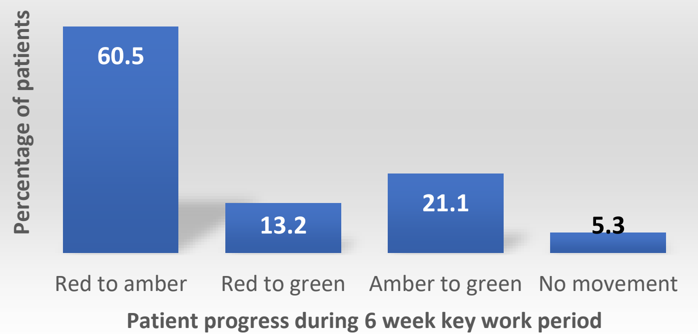


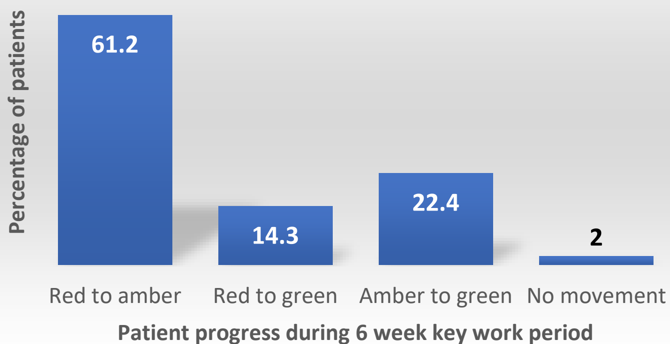


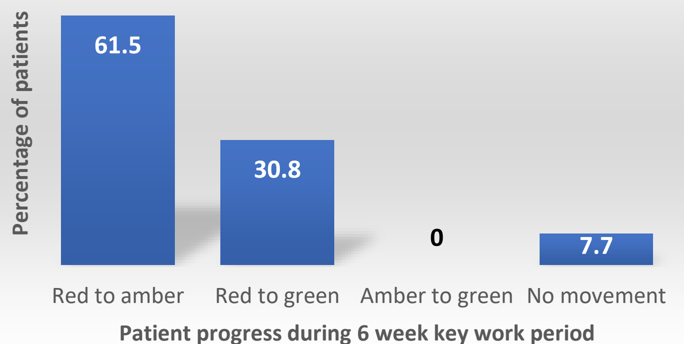

Patient progress with identified 'Housing & Accomodation' needs.
Percentage of patients
45.5
45.5
13.6
9.1
Red to amber
Red to green
Amber to green
No movement
Patient progress during 6 week key work period


Patient progress with identified 'Diet & Nutrition' needs.
Percentage of patients
37.9
10.3
51.7
0
Red to amber
Red to green
Amber to green
No movement
Patient progress during 6 week key work period


Patient progress with identified 'Relationships, Family and Friends' needs.
Percentage of patients
46.4
14.3
39.3
0
Red to amber
Red to green
Amber to green
No movement
Patient progress during 6 week key work period


Patient progress with idenitifed 'Money & Finance' needs.
Percentage of patients
60.5
13.2
21.1
5.3
Red to amber
Red to green
Amber to green
No movement
Patient progress during 6 week key work period


Patient progress with identified 'Community Connection' needs.
Percentage of patients
61.2
14.3
22.4
2
Red to amber
Red to green
Amber to green
No movement
Patient progress during 6 week key work period


Patient progress with identified 'Protection from abuse and neglect' needs.
Percentage of patients
61.5
30.8
0
7.7
Red to amber
Red to green
Amber to green
No movement
Patient progress during 6 week key work period

3. Case Studies

3.1 Case Study 1

J

J was referred into the Community Flow Project by the hospital pathfinder team who reported that the gentleman was struggling to maintain home environment and was happy to pay for formal support.

J was 61 years old and had recently been admitted to hospital due to exacerbated COPD. A safeguarding had been raised due to concerns regarding the home environment, self-neglect and potentially financial abuse.

In discussions with J he expressed a feeling of overwhelm regarding the situation and also still struggling with his physical health. J was readmitted to hospital within two days of being referred into community flow for exacerbated COPD. It was at this point that the Community Flow Key Worker was able to discuss his case with his CREADO nurse who the Community Flow Project Manager had begun to make connections with and visit weekly. The CREADO nurse informed the Key Worker of the extent of the home environment and in discussions with and consent from J shared photos of the home environment with the key worker.

It became apparent that the home environment was a contributory factor to the exacerbated COPD and readmissions to hospital. With J’s consent, the Community Flow Key Worker contacted a local biohazard cleaning company and arranged for them to visit the property to provide a quote for the works. J was unable to cover the costs of the clean due to recent financial abuse incident which had the involvement of the police. The hospital discharge team informed the Key Worker that without the clean they had assessed the home environment as unfit for J to return home to and therefore J would need to go to short term placement until the environmental issue could be resolved.

The Community Flow Key Worker therefore approached several organisations to enquire about grant funding to support J with the costs of an environmental clean and made applications and letters of support for funding to enable his discharge home from hospital. The Community Flow Key Worker was successful in the application to The Gibbons Trust for financial support for the clean to go ahead.

Cleaning was carried out as a priority by the cleaning company and J was able to return home from hospital without having to first go to a temporary placement. Following J’s return home, the Key Worker linked him in with an ongoing cleaning company for support to maintain the environment. J was able to pay for a weekly cleaner now that the work was to maintain rather than resolve the environment. The Key Worker also connected J with Navigate WiserMoney for support with applying for attendance allowance and carrying out a benefits check. J was granted attendance allowance from this outcome which supported him to pay for his weekly cleaner.

J reported feeling more in control of his everyday life and that he had felt “weighed down” by the environment at home and had “given up”. By building a trusting relationship and using active listening skills and working collaboratively with the discharge team and CREADO nurse, the Key Worker was able to identify J’s needs and support him to overcome the barriers to being discharged home. At the end of the Key Working period J reported feeling

more in control of everyday life and in particular felt a positive impact on his mental health now he no longer felt overwhelmed by the tasks at home.

Had Community Flow not been involved with this patient then he would not have been able to return home from hospital, or if he was discharged home the environment in his home would have continued to exacerbate his COPD which could have put him at risk of readmissions- he had already had one readmission when he was discharged to the same environment previously. Community Flow's input directly enabled the hospital to discharge him home and by supporting him to connect with ongoing cleaning support avoid the situation reoccurring. Furthermore, social care reported that they would likely no longer need to be involved following community flow's intervention. The duty social worker stated: "That's great, thanks for confirming. It's likely Social Care will no longer need to be involved, but my manager will make the definitive decision. Many thanks for achieving this outcome for J".

3.2 Case Study 2

Mr H

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.

We had a "what matters" conversation 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 researched the projects myself before sending this information to Mr H's daughter.

The reason it was important to research 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”.

We had some great feedback as follows:

“Dad showed interest in the Wednesday group and I'm up with him next on Wednesday 1st May for an early morning Dr's appointment so I plan to take him along to the meeting that week. If he likes it that will be fabulous because its every week.

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

I will also talk to him again when I'm up about the other things on your list and try and instigate those if he is still minded to try them.

Many thanks for your support,”

4.3 Case Study 3

Mr J

Mr J was referred to our service for support having moved to a new area and needing help with unpacking and sorting out. I had previously supported Mr J after he had a fall in his previous home and had been admitted to hospital. I had helped Mr J to return home by arranging a cleaning service and liaising with his landlord to make the house safe for him to return to. I had found funding to do this and it made a difference to the time it took to discharge Mr J from hospital.

Mr J told me that they were pleased to have moved into a new house which was more suitable for him, but told me that he was worried it might take time to settle into a new neighbourhood. Mr J has lived much of his life abroad and has lots of stories to tell and enjoys conversation.

I asked one the TTVS volunteers, who lives locally, if they could go to see Mr J at home and tell him about local events and groups that may interest him. Mr J was happy to be contacted by the TTVS volunteer and is looking forward to meeting them.

One thing that was concerning Mr J was the unpacking that was needed to make his house feel more like a home. I contacted a local handyperson who our service is linked with and we have used before. They are a trusted local person who is happy to do odd jobs and is reasonably priced. Mr J was able to cover the costs of this and work directly with the handy person once we had asked them their availability and costs for this job. The handy person was able to remove an old, broken fridge and sort out some of the heavier items in boxes, allowing Mr J to manage the rest of it.

Whilst the practical elements were certainly necessary in this case, the underlying element of social isolation was also very apparent. It seemed to me that Mr J’ safety had been considered as a priority when alternative accommodation was found for him, to avoid future falls and ensure he was not readmitted to hospital. However, the referrer was obviously concerned about the impact this would have on Mr J’ mental wellbeing and connection to his community. Moving to a new area can be isolating, especially when you have little or no control around accommodation (i.e. social housing)

I was able to take this into consideration once I began working with Mr J, and he now has a few contacts in his local community. He also knows a few reliable local services that he is able to contact independently after our 6 weeks has ended.

We made a difference to the systems in place that reduce risks around physical harm, but also reduced risks around social and mental health by considering what was important to Mr J through our conversations with him.

I believe Mr J would have continued to feel isolated. He would have felt depressed and alone and the health impact would potentially lead to readmission.

Next steps are to look at Mr J' financial situation as this has been impacted by the house move and was something Mr J was initially reluctant to discuss.

4. Feedback

4.1 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.

Referrer testimonials

-I am a Specialist Medical OT working with a variety of patient needs on an acute medical ward. I know for a fact that several of my patients would have had delayed discharges and may not have remained at home as successfully. The team at One Northern have always been hugely supportive, most recently helping a palliative patient with no local family access belongings from his property that he could no longer access, before he went into placement. I have seen first-hand the help they have given and what it has meant to patients and their relatives who so often feel unable to see a way forward and work out how they can sort things out themselves. I am especially thankful for one patient whom One Northern supported by arranging and funding furniture removal and a few repairs to allow a palliative man to return home to his wife. In a rural area with a large elderly population, services like One Northern need increased funding and availability. Their service saves money by enabling people to stay home.

-As a social worker in North Devon we are lacking services that can be creative and find solutions that aren't care. This service can offer an approach that we don't have from limited prescriptive services available. I believe this service supports people to stay independent and stay away from hospital and reduces a care need. Great response to requests I have made, please continue with this service.

-It would be supportive if the team was bigger with a wider scope to support with the overbearing need of social workers and their lack of availability due to staffing and large caseload. It is these types of services that support patients to remain in their homes and promote their Independence, thus reducing burden on acute health services. Please

prioritise funding to support initiatives that both rehabilitate back to community and prevent re admission.

4.2 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.

5. Appendices

Appendix 1. What is Community Flow?

Community Flow supports patients discharged home from hospital with little or no independent support and who have been identified by clinical or care staff as potentially find managing their recovery and ongoing health and wellbeing difficult after being discharged from Hospital usually due to issues in their wider lives. Recently the Community Flow Team have become embedded in the Community Health and Social Care Teams – one worker per locality team.

Community Flow aims to support patients to improve their own health and wellbeing, link them into their communities, help them build sustainable support networks and function as independently as possible. It also aims to enable safer and sustainable discharges, avoid unnecessary readmission and reduce reliance on health and social care services.

Caseworkers apply the Flow methodology of working with patients (see video below), focussing on the things that are important to that person, within a holistic approach to exploring how they manage their life - encompassing:

- Physical Health
- Emotional health
- Housing/accommodation
- Family, friends and relationships
- Finance and Income
- Employment and Education
- Community access
- Self-care, diet and nutrition.

[NB These areas also align with the Care Act 2014 Outcomes]

Key aspects of the provision:

- Person centred care: A primary focus on what is important to that person within the above areas – goals rather than ‘needs’
- Assertive outreach model: 1:1 caseworker solution focussed support over a six-week period – a focus on relationship building and understanding - then working together to solve problems. Turning ‘needs’ into ‘goals’
- An asset-based approach: Looking at the potential resources a person has within their life as well as their own strengths
- Community partnership: Linking the individual into their community and actively supporting them to access opportunities (As distinct from basic signposting, which often is not enough to secure engagement and commitment)
- Integration and Collaboration: Pulling together and co-ordinating a team around that person – rather than multiple separate and independent interventions

<u>Benefits of Community Flow</u>:

To the individual:
- Improves health and wellbeing
- Reduces the risk of health inequalities
- Reduces loneliness and enables the individual to feel connected to their community
- Increases control over everyday life
- Looks to maximize income opportunities
- Looks to maximise independence
- Addresses poor housing/accommodation issues

To the Trust:
- Improves patient experience of hospital discharge
- Reduces likelihood of unnecessary re-admissions to hospital
- Can enable faster and safer discharges for people medically fit
- Supports community teams to be able to focus on clinical needs
- Helps connect Trust staff with others involved in their patient's care

To the system:
- Supports sustainability of clinical health interventions
- Joins up and improves efficiency of healthcare interventions
- Reduces the cost burden of health inequalities
- Reduces likelihood of social care costs (areas worked on link to Care Act 2014 outcomes)
- Contributes to hospital flow with the benefits to the rest of the system that that brings

"10% of someone's health is directly influenced by the NHS, the greatest influence is from someone's socio-economic context"
(RDUH Health Inequalities Strategy Section 4.2)

Return on Investment:

Data provided by the Devon BI team shows that:

- that the average cost of a non-zero day LOS emergency admission (admitted via ED) at the RDUH for all sites between 1st April 2023 and 31st March 2024 was **£3,078**
- The average cost of a zero-day LOS emergency admission (admitted via ED) at the RDUH for all sites between 1st April 2023 and 31st March 2024 was **£773**
- The average cost of these admissions during this period was therefore **£1925**
- the average cost for a single excess bed day for patients with no criteria to reside at the RDUH from all sites between 1st April 2023 and 31st March 2024 was **£268.**

Using these costs and the data contained in Table 1 above, the value for money of Community Flow can be shown.

Discharge expediated:

In the year 2023/2024, Community Flow speeded up discharge in 54 instances. Using the data above, and working on a minimum assumption that it speeded up discharge by just one day only we can determine that this saved a minimum of **£14,472.** (54 x £268)

This is based on a financial worst-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. Taking a hypothesis where the input of Community Flow speeds up discharge by 4 days equals **£57,888** and is very close to covering the cost of investment. There is confidence in this hypothesis from staff feedback that these patients are often 'stuck' in hospital and they are unable to find a quick solution to speed up discharge without input from the Community Flow team.

Re-admission avoidance within 6 weeks:

Community Flow avoided a potential re-admission within 6 weeks in 136 cases. Using the data above, this represents as saving of **£261,800** (136 x £1925).

Both the scenarios for minimum LoS discharge expediated and admission avoidance amount to a minimum saving of **£276,272.** However, this figure doesn't include the 196 admissions potentially avoided in the longer term due to Community Flow involvement, or the cost of saved ambulance conveyances, or the fact that in reality discharge delays were likely to have been considerably longer than just one day. Therefore, the return on investment from Community Flow are likely to be considerably higher.

Notes on methodology:

The way the impact of all the flow programmes has been captured has developed overtime. At inception, Community Flow followed the same approach as the other Flow programmes, capturing usage data and counting outcomes and outputs. Overtime we have been able to develop this for all the Flow programmes – for example redefining and categorizing outcome/outputs. Further we are currently working with IMPACT reporting to develop a way of showing the financial value created, based on available research, of the outcomes that have been achieved.

For instances where we have speeded up discharge, these have been relatively easy to identify and have been case where a patient has no criteria to reside, but is unable to return home until a specific issue has been sorted – unsuitable accommodation, or the organisation of an essential food shop as the person has no food or the ability to sort this in the short term.

For data relating to re-admission avoidance, in many cases it's hard to accurately predict whether a re-admission has been avoided – particularly in the longer term as there are many variables that could affect this. Where possible we have been guided by the clinical/care practitioners involved.

For example, where the patient has presented as being in crisis during the 6-week period, and we've needed to engage clinical /urgent care staff, a judgement has been jointly made that without this the patient would have likely had to be re-admitted.

Where a patient has had no means to organise food shopping or collection, a judgement has been again jointly made as to whether they could effectively maintain a healthy diet or not and in cases where this would have been unlikely a further judgement has been made as to whether the patient's health would have deteriorated as a result, with likely re-admission. This applies to other situations such as being unable to collect and manage prescriptions, or manage the necessary domestic hygiene to remain safe. Or where they have simply become overwhelmed and not able to effectively manage their own self-care.

For instances where we have preventatively worked on wider socio-economic factors in a patient's life, such a loneliness, or housing/accommodation, again a judgement call has been made by the worker as to whether if they had not been involved this could have had a significant longer term detrimental effect on the individual's health, and/or their ability to manage their conditions. Any cost savings attributed to this have not been included in the estimations in this business case – but should certainly be considered.

We would like to do further research around this by tracking cases over a long time period to explore the benefits of any preventative action.