Community Connectors

REPORTING PERIOD JANUARY 2022 – DECEMBER 2023

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Introduction

Working in partnership with health and social care providers, the Community Connector service provides a single point of access for clinicians, social care practitioners and patients at Lincolnshire County and Boston Pilgrim hospitals in order to assist with patient flow, facilitating timely discharge and help to avoid unnecessary hospital admission.

Community Connectors are based at both Lincoln County and Boston Pilgrim hospitals, five days a week to facilitate signposting and referring to appropriate services along with offering impartial information and advice to patients and their carers, at what can often be a distressing and confusing time.

Community Connectors support with patient discharge or avoiding unnecessary hospital admission when a patient has been declared medically fit. The coordinators encourage patients and their carers to make informed choices about their health and wellbeing, guiding, signposting or referring them into the services they may need in order to support them to remain as independent as possible.

The Community Connectors Service enables Adult Social Care and clinical teams to refer patients for information and guidance with their non-clinical needs, relieving pressure on the system and increasing patient flow within the hospitals.

Strong links have been developed and maintained with professionals across the system, and a direct pathway is established for accepting referrals for patients who are deemed medically fit for discharge or where, with input from a Community Connector, admission can be avoided.

Not all patients are eligible for support from Adult Social Care; we are able to support and assist these patients and their families or carers. The Community Connector will spend time with the patient and their carer to help them understand their options and facilitate preventative measures. This effectively reduces the risk of further deterioration in the home environment, reducing the likelihood of either readmission or social care intervention becoming necessary.

In January 2022 Community Connectors integrated the accepting of referrals for Hospital Discharge Home Recovery Scheme grants (HDHRS). Subsequently in October 2022 the Community Based Home Recovery Scheme (CBHRS) was introduced in collaboration with the Neighbourhood Teams in order to avoid unnecessary admission from community settings. This scheme offers a grant of up to £1200 with up to 6 weeks of support for those patients medically fit for discharge, where environmental factors in their home may prevent the discharge taking place.

Both of these services are currently funded until 31st March 2024

Overview of Reporting Period

January 2023 – December 2023

This report offers an overview of the period January to December 2023.

As the service has evolved, reporting data collection has increased to demonstrate the value of the service to both the patients and to the system itself.

Where available comparative data sets have been included in this report, however much of the value to individuals and colleagues is demonstrated within the patient stories and feedback received from colleagues within the system.

Key Performance Indicators

Measure 1

Referrals Received

	January to December 2022	January to December 2023	% + Change
Referrals Received	885	1171	**32%**
Ward Visits	861	1178	**37%**
Referrals made	955	1269	**33%**
Signposts made	188	407	**116%**
Patients Age 60+	90%	94%	**4%**

Measure 2

Referrals made on behalf of patients

This data demonstrated an increase in referrals by site.

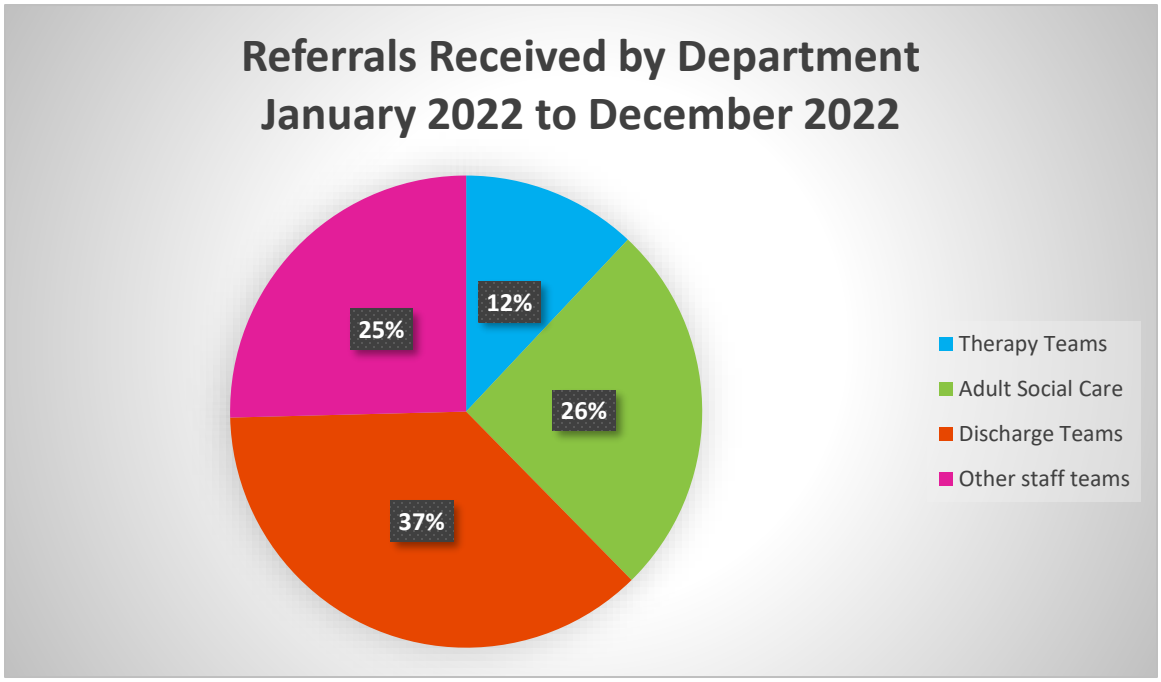
74.6 % increase in referrals from Boston Pilgrim

42.9% increase in referrals from Lincoln County

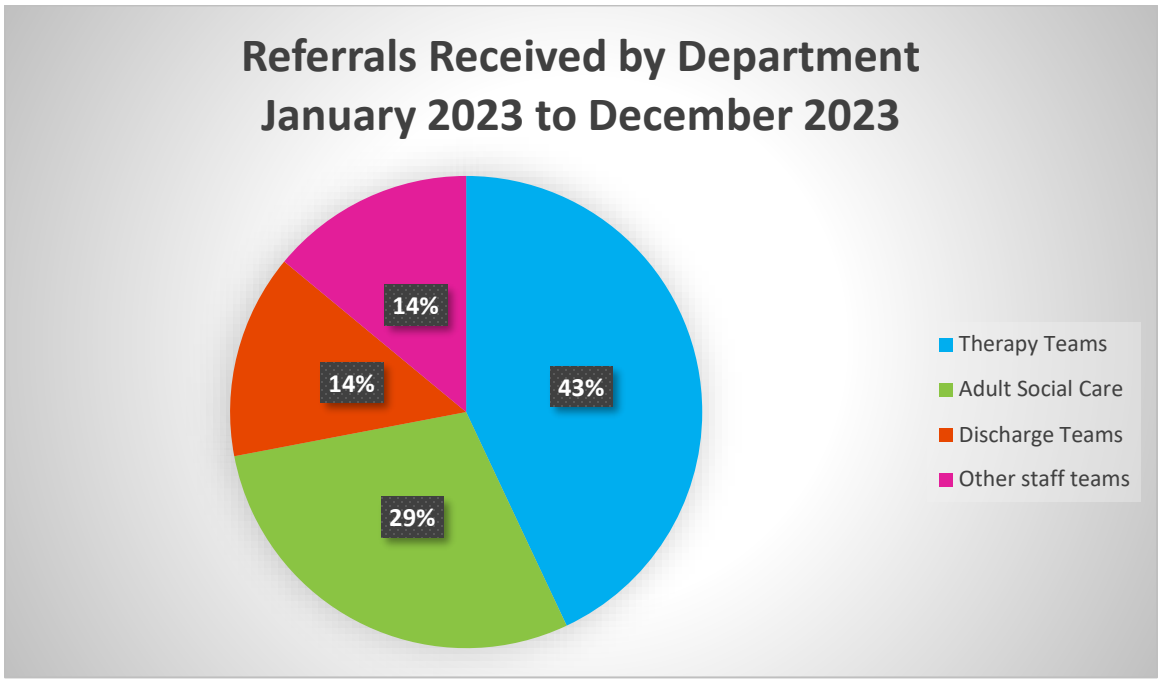
	2022		2023	
Referrals by site	Boston	Lincoln	Boston	Lincoln
	276	609	482	689
Total	**885**		**1171**	

Measure 3

Incoming Referrals Received by Department



Across 2023 therapy teams increased their referrals significantly from the previous year, closely followed by the discharge teams. Adult Social Care also increased referrals, with almost 30% being received through this direct route.



Observations

Measure 1 demonstrates a **32%** increase in referrals received from the year January to December 2022.

This is due to continued awareness raising across health and social care colleagues, as well as increased reliance on the support offered by the service, and consistency of the service with a wider use of the Community Connector team to support with patient flow.

Measure 2 demonstrates the increase in referrals by site, with Boston Pilgrim increasing requests by 74% and Lincoln County increased by 42.9%.

Measure 3 demonstrates the departments referring into the service, and confirms the consistency of their use of the established referral pathway to support patient flow, further reduce unnecessary hospital readmission and support patients to return to their own homes.

Our Impact

Impact on people

It is commonly recognised that home is the best place to recover and as an organisation we subscribe to the Home First Partnership as part of our commitment to the health and wellbeing of people across Lincolnshire.

The positive impact on the health and wellbeing of those referred into the Community Connector service is evident due to the team offering a personalised and creative approach, believing that the work we do is All About People. This approach is adopted for every referral received where the benefits of supporting social care staff and clinical teams to empower patients to safely return to their own home to recover from their condition is of paramount importance.

The impact of the time spent by the team with patients is significant, and reflected in the anecdotal evidence we gather either on site, or as a result of follow up calls made several weeks after discharge.

Improved wellbeing:

"Everything you've done for me - something good's come out of it and it's made such a difference to me and my life. You've pulled together all these services and it's all worked out really well. It makes me feel really positive knowing there is something (a service like yours) that is able to support people like you have me."

Increased independence:

Mr P explained how grateful he was to get up and moving again after we sourced a wheelchair for him. "I've always been independent and I just felt stuck. The first thing I did when I saw it was get in it and go outside"

Avoided readmission and improved wellbeing:

I called Gerry some weeks after she had been discharged. She informed me that she had been doing really well since she had come home.

She was "ever so grateful" for the food that we were able to get for her, as she knew she wouldn't have eaten for a few days post discharge otherwise. She said she often felt lonely on the ward, as she didn't have a single visitor, other than myself, for the 5 weeks that she was in hospital. She was very grateful for the time I spent with her on the ward as it helped improve her mood and motivation.

Impact on the wider Health and Care System

The service is widely respected and utilised by the health and care system, with reliance on the support of the Community Connector team as they are now considered to be intrinsic members of the hospital team. Based onsite within the adult social care offices, they are actively improving both patient flow, and the staff and patient experience.

A bed day cost of £483 was provided by Dr Anne-Louise Schokker (LCHS Medical Director Virtual Wards). Although we believe our calculation to be a significant underestimate, if we assume that each referral we have supported has led to a minimum of one day's bed saving for patients either avoiding admission, transferring to a social care bed, or being supported with timely discharge, we can confidently estimate the financial impact on the system would be a saving of

£565,593

over the 12 months January to December 2023. This figure does not include the referrals subsequently referred to the HDHRS funding, where a minimum of 7 bed days is estimated for a successfully supported discharge.

A financial impact cannot accurately be calculated and attributed to the level of support offered to both social care and clinical staff who are able to refer patients to the team for their non-clinical needs in order to achieve a timely discharge or admission. Anecdotal evidence however received by the Community Connectors on a regular basis is documented below:

George Esworthy, Doctor, Shuttleworth Ward "I would like to take the time to inform you of the truly unique and vital services offered by the Age UK team with Lincoln County Hospital.

Being able to offer patients more time than the clinical staff are unable to allows many of their concerns to be addressed and helps to put them at ease as well as identifying key areas where support is required. Furthermore, the service also extends to prepping for discharge and organising additional support/contacts within the community to further aid rehabilitation and a return to normal life, these are services that would otherwise not be fully considered as they do not always form a normal part of our discharge planning.

This service has become a real strength of our department and something that we and our patients have come to rely on."

LCH WARD STAFF "I can't believe you've managed to encourage the patient to receive the support she needs; she was adamant she was only going home with an air mattress".

LCH ADULT SOCIAL CARE – "Thank you so much for helping us with this referral, at least we know she can go home now".

LCH Adult Social Care and Ward staff thanked the team for supporting them with a complex referral, and for spending time on the ward making individual and joint visits to speak with the patient. "The Community Connectors managed to engage well with the patient, who felt he could open up and discuss his discharge. This is something the ward were finding difficult". A Consultant visiting the same patient also thanked the Community Connector for spending time which made his work much easier.

Occupational Therapist – thanked the team for their fast response and support offered to a patient pending discharge

LCH Adult Social Care "We would be lost without you"

Boston Pilgrim Occupational Therapist "It is a great pleasure to work with you as usual, you are always being resourceful and a great help".

Boston Pilgrim Mujidat Agboola Occupational Therapist Integrated Surgery Team

Age UK is a very valued service in the discharge to assess model which we use when discharging patients. The support offered is more than helpful and prevents hospital readmissions also ensuring safe discharges.

I have worked closely with Abbie on a couple of complex discharges, I have lost count of how many.

Whenever we have complex cases on the wards, I always run to Abbie and she always has the answers to ease discharging planning. I can confidently say this service is very helpful to the team.

It would be a nightmare if this is stopped. We can only ask for more nothing less please. Thank you

Estimated Return on Investment

Contract Value	£135,222
Savings to NHS/Social Care	£565,593
Return on investment	**£430,371**

Service Delivery

Successes and Accomplishments

Over this period the service has increase its impact with a 32% increase in accepted referrals, and has become further entrenched within the NHS/Social care environment, with the team being relied upon to deliver both supported discharge, admission avoidance, and financial and practical support for patients returning to their own homes through HDHRS and CBHRS. A small team of 4 full time equivalent staff has led to a significant number of successful discharges/admission avoidances and alleviated added pressure on adult social care.

We are fortunate to have an established and experienced team who are all dedicated to the role and fully commit to supporting patients in ways which help them maintain or regain their independence and reduce their reliance on Lincolnshire's health and social care system.

Challenges and Barriers

Due to the short-term nature of the contract, staff resources can be difficult to maintain and as each funding period approaches its end, experienced team members are forced to consider alternative

employment. This can lead to resignations, generally in the last quarter of service delivery, making it almost impossible to refill vacancies which have been previously held by valuable colleagues. Although we understand this is the nature of short term funding, longer term commitments with the intention to continue the funding advised at the earliest opportunity would without doubt significantly reduce the risk of talented staff losses.

The service has incorporated delivery of the HDHRS/CBHRS grant scheme, with a separate funding stream which does not include staffing costs. Without the Community Connector service, we would be unable to deliver the grant scheme as we would not have the staff onsite to accept referrals and carry out the work necessary to purchase services and equipment to support discharge or avoid admission from community settings.

Future Focus

To maintain these services funding is necessary from 1st April 2024. This commitment will allow us to continue to support health and social care professionals achieve timely discharge and admission avoidance through Community Connectors. Should the grant funding be made available for HDHRS and CBHRS, the team would be well placed to continue to facilitate the promotion and delivery of the HDHRS/CBHRS grant funding.

In order to deliver this service for the financial years 2024/2025 and 2025/2026, investment is required to continue to deliver 166 hours of Community Connector presence on the Lincoln County and Boston Pilgrim hospital sites.

The cost to deliver this contract with the staffing levels below would be:

2024/2025 £166,684

2025/2026 £172,307

Community Connector	Lincoln County	Boston Pilgrim
Service Manager	35 hours	
Coordinator		35 hours
Coordinator		20 hours
Coordinator/Administrator	28 hours	
Coordinator	28 hours	
Coordinator	20 hours	
Total Weekly Hours	**166**	

Patient Stories

GEORGE

George is 66 years old and was admitted to Lincoln County Hospital suffering with confusion and poor mobility which had resulted in multiple falls at home. George had high blood pressure, osteoarthritis, hydrocephalus and confusion. Concerns were raised by EMAS on admission due to self-neglect and unhygienic living conditions.

Referred to Community Connectors by Adult Social Care, George was medically optimised, but concerns were raised about the state of his property. George would need support with cleaning and de-cluttering to make his home safe to return home to. George was offered a package of care but refused, explaining that his son cared for him at home.

Adult Social Care visited George on the ward, he was suffering with some confusion and at times became agitated, but agreed to accept support and understood that he needed help in the home. Our Community Connector went to visit George, and offered to support with the clean by applying for the HDHRS grant. George consented, but asked that we contact his son who lived with and cared for him. During one visit George broke down, he was worried about his son and admitted that they were struggling and the situation at home was out of control. He was reassured that he would be offered support.

We made several attempts to contact George's son, eventually getting in touch and whilst speaking with Matt, it became clear that the family were struggling. Matt explained that he lived with his father in the family home which was a council flat. They had lived there for 16 years, and when they first moved in the property had some damage which was never resolved. The toilet was broken and there was mold in the property. In addition, Matt's mum had been a smoker and the walls to the property had discolored over the years. Matt said that he had cared for his parents, and his mum had died approximately 1 year ago. Matt was struggling to cope with the loss of his mum. He explained that whilst caring for her, at times he had struggled to keep the home clean, and the property had deteriorated.

Matt is a young man in his 20's. He worked full time and was independent, but after losing his mum, struggled to care for his father and continue to work. He explained that George repeatedly fell when Matt was out at work, which clearly worried him. He said he felt responsible and worried that his dad would fall whilst he was away from the home, so eventually he stopped working and has now used up all his savings and has no income. Matt also mentioned that he had struggled with the state of the property and this had negatively affected his mental health. Matt rarely goes out of the house, he has very few clothes, and focusses on caring for his father. Our Community Connector spent a long-time discussing how they could support them, but Matt initially struggled with the idea that anyone would enter the property to clean as he was concerned about the transfer of germs. Matt said that his health had deteriorated, he mentioned that his legs were sore and weeping, and he was struggling to cope and felt that he needed support. He explained that he knew what he needed to do but wasn't sure where to start, and was happy to accept any help we could offer. Matt was very low in mood and the Community Connector grew concerned about him during the conversation.

Following the phone call, the Community Connector immediately raised concerns about Matt with Adult Social Care, and the two teams continued to work together from that point. Matt was immediately contacted and urged to speak to his GP and an appointment arranged. An urgent referral was made to the mental health team, and both Matt and George were referred to Wellbeing Lincs for support once George returned home.

Matt was also referred to Carers First and a request was made to complete an urgent benefits check. It was clear that George and Matt needed both practical and emotional support. Housing was also contacted and made aware of the concerns in the property which would need immediate attention.

The HDHRS grant of £631.44 was awarded by the panel and the clean went ahead. During the process our Community Connector Team continued to work alongside Adult Social Care, maintaining regular contact with both George and Matt. The cleaning team also made additional calls to reassure Matt prior to the clean, and talked him through the process, allowing Matt to stay in control of the situation during the day of the clean.

Immediately after the clean George was discharged home. Community Connectors contacted Matt shortly after George was discharged. Matt explained that George had initially struggled, but was slowly recovering and had recently managed to get out of the flat and walk to the shops by himself. Matt said that he was still struggling to cope in the home but his health had improved. The Community Connector continued to offer support.

Community Connectors organised support to continue to clean the property via Discharge Buddies, a commissioned service delivered by AUKLSL where a need is identified for further ongoing, time limited support can also be offered such as de-cluttering and housework to avoid trips and falls, life-style support, accompanied attendance at future appointments and support with essential tasks for daily living.

In addition to the referrals already made, Matt and George said that they would like new beds/bedding, once the cleaning was complete. The Community Connector continued to support and obtained prices for furniture, which the family could now afford as they had not had to fund the clean.

The Community Connector liaised between the family and the furniture supplier. Matt was also interested in decorating some of the rooms in the flat. Again, the Community Connector obtained quotes and this work was planned.

Community Connectors supported George by providing the HDHRS grant and by organising the clean. George's discharge was not delayed and he was able to return home. George was able to return home to a much cleaner and de-cluttered home which would also reduce the risk of falling.

In addition, the support offered to Matt prevented his health from deteriorating further, which could potentially avoid a further hospital admission. The support offered to the family has made a positive difference to their home environment and their wellbeing, offering both practical and emotional support, as well as a financial review to make sure they are receiving all the benefits they are entitled to.

Matt is receiving the support he needs in order to provide ongoing care and support to his dad.

Matt and George continue to be grateful for the support offered to them.

The outcome of the intervention by the Community Connector team was a bed saving of 7 days which amounted to a saving of £3,381.

PHILLIP

Phillip is 80 years old with a medical history of type 2 diabetes, hypertension, high cholesterol, prostate cancer and atrial fibrillation. He was referred to the Community Connector Team by an Occupational Therapist, requesting support with a Telecare referral. Initially this appeared to be a straight forward referral, and the team visited him on the ward the same day. They spent some time talking to Phillip, who explained that he had fallen whilst at home and had spent 18 hours on the floor, unable to call for help.

It was only when he was discovered by a family friend, that he received medical attention and was admitted into hospital. This was clearly distressing for him and he was very nervous about returning home.

Phillip explained that his wife had died 12 days ago, he was visibly upset and just wanted to go home so that he could continue to plan her funeral. The referrer had expressed concerns about the risk of further falls and asked us to encourage the patient and support with his discharge. With Phillip's consent we immediately made an urgent referral for Telecare, and a lifeline was fitted the same week prior to his discharge. Knowing that he would be safe and have support in place, Phillip was much more confident to return home. After some discussion he agreed to support from Discharge Buddies, a commissioned service delivered by AUKLSL where a need is identified for further ongoing, time limited support such as de-cluttering and housework, to avoid trips and falls, life-style support, and support with essential tasks for daily living. Shopping and cleaning were arranged through this fund, to allow some recovery time and enable him to concentrate on planning his wife's funeral.

Although this was a straight forward referral it demonstrates the difference the Community Connector Team have on people's lives, and the support offered providing reassurance both to the patient and the ward staff when planning to discharge patients. The OT thanked the Community Connector Team for their quick response and support offered to help Phillip avoid readmission.

END