WHAT DOES 'COMMUNITY FLOW' PROVIDE?

Non-regulated support for patients discharged from NDDH who have a limited support network and do not have an unpaid carer. This brings the support available to people more in line with the support offered in the Carers Hospital Discharge service and works in tandem with that service. There is a universal, targeted, intensive and longer-term offer personalised to the needs of each patient.

Offer level	Offer	Referral route/entry criteria	Timescales	Community Flow Team Role	Links with other teams	Onward referral options
Universal offer	**Check-in-at-home** Check-in phone call post discharge. Patient asked if they have everything they need (shopping, prescriptions) and whether they need any further support (warmth, debt, housing, loneliness) Information & signposting eg. benefits advice, fire safety home visits, support charities (eg Alzheimers Society and peer support groups)	**Referral routes:** Hospital teams Epic **Entry criteria:** All patients being discharged on Pathway 0 & Pathway 1 & potentially Pathway 2 on discharge home (not on Carer's Hospital Discharge pathway) Includes those with and without community/rehabilitation team support at home.	Within 24 hours of discharge	Community Flow Co-ordinator makes phone call and either provides low-level signposting or will	No links unless concerns raised from phonecall, in which case escalate to appropriate clinical team.	1. No support/low level signposting required. 2. Settle at Home service for those with immediate non-medical needs to support their return home 3. Support at Home service for those with wider, ongoing non-medical needs.
Targeted offer	**Settle-at-home** Up to three visits by a local volunteer after discharge from hospital to help with getting shopping, collecting prescriptions, turning on heating, making a light snack. At the end of the 3 visits (or earlier if needed), a further check-in-at-home call will be made by the Community Flow Manager	**Referral routes:** Hospital teams Check-in-at-home call **Entry criteria:** All patients being discharged on Pathway 0 & Pathway 1 (who aren't on the Carer's Hospital Discharge pathway) who would benefit (identified from check-in-at-home call)	Within 48 hours of discharge (depending on volunteer availability)	OND volunteer visits and supports immediate needs on return home. OND volunteer flags to Community Flow Manager whether more support needs have developed since check-in-at-home call.	Communicate outcome with Short Term Services Team.	1. No support required. 2. Facilitated signposted from Community Flow Co-ordinator 3. Support at Home service for those with wider, ongoing non-medical needs.
Intensive offer	**Support-at-home** Community Flow Co-ordinator has 'what matters' conversation with patient and either: • Brings relevant organisations and opportunities within the patient's community together to support them, eg accessing hobby groups, volunteering opportunities, advice & support agencies. (CAP/TAP) • One-to-one solution focussed casework which aims to help patients achieve what matters to them and takes a holistic view of aspects of their life, such as relationships, managing money, health, leisure, work etc. • Short-term enabling provision. This will be held and arranged by the Community Flow Team. It provides short term unregulated support and goods. For example, domestic support, dog-walking, help with moving furniture, items such as a tablet to be able to maintain family relationships via zoom or to do an online shop.	**Referral routes:** Hospital teams Check-in-at-home call Community Response & Recovery Team Reablement Team **Entry criteria** All patients being discharged on Pathway 0 & Pathway 1 (not on Carer's Hospital Discharge pathway) where there is an appearance of need identified either from check-in-at-home or through the settle-at-home visit.	Up to 6 weeks	Community Flow Co-ordinator delivers intensive casework with patient and co-ordinates the CAP/TAP One Community Developers partakes in the CAP/TAP and identifies local support for individual patient need. Community Flow Provider Co-ordinator identifies providers and arranges for services to be delivered. Also develops a North Devon wide provider network.	Referrals may come from Short Term Services Team. This can be in addition to an existing short-term services offer or a step-down provision. Communicate outcome with Short Term Services Team.	1. No support required. 2. Referral into adult social care for full assessment of needs via CDP 3. Ongoing help at home for those need ongoing practical help.
Long-term offer	**Ongoing help at home** On-going unregulated support as described above. Funded by the patient, or via ASC following a needs assessment with eligibility under the Care Act. TTVS can provide benefits advice to assist where possible.	**Referral routes:** Support-at-home team Community Response & Recovery Team **Entry criteria** All patients who have been discharged but are unable to continue without ongoing help at home.	No time limit	TTVS team provides unregulated care services needed via funding either from patient or adult social care eligibility.	Referrals from Short Term Services Team via Community Flow Manager Work in partnership with any regulated care provision.	1. Adult social care if eligible 2. TTVS financial inclusion project