Community Flow

Enabling faster, safer and sustainable discharges, avoid readmission and reduce reliance on health and social care services.

Organisation:	**One Northern Devon LCP**
SRO/ Department Lead:	**Katherine Allen/Lou Higgins**
Project Manager:	**Simon Rapsey**
Other Departments Consulted:	**RDUH Health and Social Care Community Teams.**
Business case register reference:	

	Name / Forum	Signature	Date
Prepared by:	Simon Rapsey		
Reviewed by:	Andrea Beacham/Jeff Chinnock		
Approved by:	Katherine Allen		

	Business Partner Name:	Signature	Date
Finance Implication Sign off:			
Estates Implication Sign off:			
IT Implication Sign off:			
HR Implication Sign off:			

Contents

1. INTRODUCTION

This business case for Community Flow in Northern Devon proposes that £72,000 of the ringfenced health inequalities/prevention funds enables the delivery of this service which supports safe and effective discharges from hospital from now until March 2025.

The key aims of Community Flow are to enable faster, safer and sustainable discharges, avoid readmission and reduce reliance on health and social care services.

In addition to this business case, two other business cases from the OND LCP being brought to the DIG for approval in May (presented in the table below) to show how the locality seek to use Northern Devon's entire allocation of £159,000.

The three proposals have the full support and been agreed by partners through the governance of One Northern Devon LCP.

A fourth request for FAME will be brought to a future meeting (as wasn't originally in locality funding allocations and hasn't been through the LCP governance process. It will be brought alongside all locality business cases for FAME). In addition, the reduced funding allocation for the locality does not fully cover the full year costs for HIU Flow so the shortfall will be sought from other sources.

	Health Inequalities programme	Purpose	Indicative allocation	Comment
1	High Intensity Use (£49,570)	High Flow HIU ED service	£49,570	Maintains the current High Flow service and case workers supporting frequent users of ED until mid October 2024. Without this funding the contracts and service will end at the end of June 2024. Other sources of funding to maintain the contract until the end of the financial year will be sought.
2	Supporting Hospital Discharge (£59,430)	Community Flow service	£59,430	Maintains the current Community Flow service and case workers supporting patients who have been discharged from hospital or at risk of readmission until the end of March 2025. This allows time to gather the data and evidence needed to enable this work to be embedded into BAU service delivery in RDUH
3	Place-based community partnership infrastructure to tackle health inequalities (£40,000)	One Communities Support	£20,000	Funding for One Communities Programme Support Officer for 2 days p/week (Band 6 inclusive of on costs) to end of March 2025
			£10,000	5 x Community Developer 1 month contract extension (FTE £28,596.10) to keep current 5x Community Development Officers (employed through VCSE partners) in post until Lottery funding is available (1 August 2024)
			£10,000	National Lottery match funding for external evaluation partner to evaluate the benefits of the One Community model
4	Falls and Frailty Prevention (£10,000)	FAME	£10,000	To continue the FAME provision in North Devon (targeting those most at risk) - to be brought to future DIG as part of Devon-wide business case
	Total allocation to North LCP:		£159,000	

Table 1: Full One Northern Devon LCP allocation of £159,000 breakdown.

The three proposals have the full support and been agreed by partners through the governance of One Northern Devon LCP as follows:

- OND Health Inequalities Group (Clinical Lead Dr Oliver Hassall) agreed recommendations - 13th February 2024
- The Northern LCP Programme Group (Chair Becky Harty) agreed the recommendations for approval - 21st February
- The OND LCP Board (Chair Lou Higgins) approved the recommendations - 27th February 2024

The three proposals have the full support and been agreed by partners through the governance of One Northern Devon LCP.

Community Flow supports patients discharged home from hospital who have little or no independent support and who have been identified by clinicians as potentially finding it difficult to manage their recovery and ongoing health and wellbeing after discharge.

'Failed' discharges are usually caused by factors outside of the influence of health and social care.

With this funding the LCP will evaluate the full impact of Community Flow and propose a recurrent funding stream based on the system cost savings from avoided failed discharges, reduced statutory input into discharges and the improved health and wellbeing of patients.

2. STRATEGIC FIT & CASE FOR CHANGE

2.1 Business needs to be addressed and the changes required

The Health Foundation report (2017) states that only 10% of an individual's health is directly influenced by the NHS and that the far greater influence is from someone's socio-economic context.

Many people are successfully discharged home from hospital without any formal care or support, or the support of a family member or friend.

Often, a patient is medically fit for discharge but unable to go home for which results in an extended length of stay. The reasons are all socio-economic and range from substandard accommodation, landlord issues, the patient not having a means to shop for food, or to collect prescriptions.

These generally fall outside the remit of reablement/social care and apply to patients on both P0 and P1 pathways. Community Flow has demonstrated that it can address these issues so that discharges are successful because people leaving hospital are better supported in their own homes/communities.

The key aims of Community Flow are to enable faster, safer and sustainable discharges, avoid readmission and reduce reliance on health and social care services.

Secondary aims are 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 from the formal health and social care system as possible.

Community Flow caseworkers work with patients, focussing on the things that are important to that person, and building a team around that person rather than professionals undertaking multiple isolated interventions. It ensures a holistic approach is taken to how the individual manages their life encompassing:

Physical Health	Finance and Income
Emotional Health	Community Access
Housing/accommodation	Employment, Education and Training
Family, Friends and Relationships	Self Care, Diet and Nutrition

The expected outcomes of the service are as follows:

System outcomes:

- Reduce likelihood of unnecessary re-admissions to hospital
- Enable faster and safer discharges for people medically fit
- Contribute to more efficient hospital flow by freeing up capacity
- Support community teams to be able to efficiently focus on clinical needs
- Support sustainability of clinical health interventions
- Join up and improve efficiency of multiple healthcare interventions
- Reduce the cost burden of health inequalities
- Reduces likelihood of ongoing care costs

Patient outcomes:

- Improve health and wellbeing
- Reduce the disadvantage of health inequalities
- Reduce loneliness and enables the individual to feel connected to their community
- Increase control over everyday life
- Maximize income opportunities
- Maximise independence
- Address poor housing/accommodation issues

Key aspects of the provision are as follows:

- 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

2.2 Alignment with the ICB's strategic objectives and outcomes

Community Flow provides a combination of responding directly to current system pressure around discharge and admission avoidance, whilst also undertaking the preventative work which improves the health and wellbeing of individuals, reducing their impact on health and social care.

The NHS Devon Recovery Plan and the NHS Priorities and Planning Objectives 2023/2024

Community Flow supports the priority on exiting segment 4 of the NHS Oversight Framework and contributes to the 2024/2025 NHS priorities and planning objectives around urgent and community care and health inequalities by:

- **Supporting earlier discharge** and admission avoidance contributing to the required reduction in bed occupancy to 92% or below.
- Working in the community to **avoid admissions and attendance to ED** which reduces the need for an ambulance response, allowing for more efficient response times to other emergency callouts
- **Reducing attendances to ED departments** which contributes towards enabling improved waiting times and patient experience within ED.
- **Enables UCR teams to focus on patient flow** by providing a place for these teams to direct complex and difficult scenarios where patients require in depth time and support.

> *"They [community flow] 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"*
> UCR Worker Feedback 2023

- Reduce the impact of health inequalities on patients within the within the Core20PLUS5 cohort.

One Devon ICS strategic priorities:

1. Improve population health and healthcare

JFP goal: People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care.

Community Flow works in a person-centred way to support individuals to improve their overall health and wellbeing and the wider determinants which can negatively affect this.

In 23/24, Community Flow worked with 377 patients and enabled a total of 1012 positive outcomes for the patient across all areas (table 1).

2. Tackle unequal access, experience and outcomes

JFP Goal: People in Devon will have access to info and services they need, in a way that works for them, so everyone can be equally healthy and well.

Community Flow directly addresses health inequalities. The majority of patients worked with are at risk of, or are experiencing, health inequalities. The service provides tailored support based on their needs and the things that are important to them, including support around access and information. With the exception of maternity, Community Flow worked with patients across all areas of Core 20+Plus5.

JFP Goal: Most vulnerable in Devon will have accessible, suitable, warm and dry housing: In 2023/24 Community Flow improved the housing/accommodation situation for 149 patients (table 1).

3. Enhance productivity and value for money.

JFP Goal: People in Devon will know how to access the right service first time and navigate the services they need across H&C improving personal experience, productivity and efficiency

Community Flow supported 472 admission avoidance and expediated discharge. Community Flow facilitates the co-ordination of services and, most crucially, put any clinical input in the context of the wider goals in that patient's life – this provides for more integrated and effective clinical interventions.

This frees up physical, human and financial resources within the acute and community teams meaning they can focus fully on their core tasks i.e. organising formal care or support medical recovery.

4. Helping the NHS support broader social and economic development

JFP Goal: Local communities and community groups in Devon will be empowered and supported to be more resilient, recognising them as equal partners in supporting the health and wellbeing of local people. Community Flow utilises an assets-based approach, working with individuals and their communities to find solutions, often working with the Community Developers to develop and source opportunities.

In 2023/24 Flow improved the economic situation, including employment for 183 patients as well as enabling partnerships with the VCSE and providers.

Table 1: Community Flow Outputs and Outcomes 2023/2024

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**
PERSON CENTRED SUPPORT PROVIDED – OUTPUTS	
What Matters to Me conversations taken place with lead professional and client	**292**
Team Around the Person meeting conducted	**27**
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**
SYSTEM 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**
Employment, education, and volunteering	**42**
Money & Finance including employment an	**141**
Community Connection	**44**
Total Patient Outcomes	**1012**

Alignment to Devon JFP and commissioner expectations – a summary. The Joint Forward Plan identifies 12 challenges facing health and social care services in Devon - with a clear commitment to directly tackle these challenges. The data above also shows how Community Flow works with individual patients directly to address 7 of these 12 challenges:

- Access to services, including socio-economic and cultural barriers
- Poor mental health and wellbeing, social isolation and loneliness
- Economic Resilience
- Housing Quality and affordability
- Poor health outcomes caused by modifiable behaviours and earlier onset of health problems in more deprived areas
- Pressure on health and care services (especially unplanned care)

The NHS Devon Joint Forward Plan Themes: Healthy People, Healthy Safe Communities, Healthy, sustainable system:

Community Flow contributes to all three themes as it supports people using the resources available in their community and supports the system to be able to concentrate on providing health and social care and releasing them from being involved in a person's wider needs or needing to continue care for people who no longer need it.

2.4. Advice and guidance from external bodies on the "best way" to deliver the service or statutory requirement for the service.

The Community Flow approach and methodology is based on the proven methodology of High-Flow and applied to a community discharge setting.

It ensures focus on the things that are important to the person and building a team around that person. It ensures a holistic approach is taken to how the individual manages their life.

3. OPTIONS APPRAISAL

3.1 MAIN OPTIONS SUMMARY

Option 1 – ICB's population health budget funds Community Flow until March 2025
Ensure the continuation of Community Flow enabling the development of a full business case for 2025/2026 recurrent funding.

Option 2 – Do Nothing. The service will run until September 2024 after which the contract will end and the service will cease.

3.2 HOW EACH OPTION MEETS THE OBJECTIVES AND CRITICAL SUCCESS FACTORS

Option 1: Funding Community Flow
The service is currently operating successfully, providing a very cost effective means (£60k) of supporting 100s of effective discharges and wider needs to reduce impact on statutory services. This is demonstrated by the data shown above in section 2.2.

Community Flow delivers aspects of the Devon Joint Forward Plan, contributes to NOF4 exit criteria in terms of supporting patient flow and enables aspects of the ICS strategic priorities.

Option 2: Allow the Community Flow service to end
No objectives would be met and all benefits of the existing service would be lost.

3.3 BENEFIT, RISK AND MITIGATIONS COMPARISON AND CONCLUSION

Option 1: Continued funding for Community Flow – March 2025		
Benefits	**Risk**	**Mitigation**
• The service is already set up and functioning well, with all processes, pathways and data capture mechanisms built, staff in place, and a commitment by the provider to continue to deliver. • The model is based on the learning and successes gained in the previous High Flow pilot and therefore it benefits from insight and experience. • Partners within the system have expressed commitment to continue to be engaged and are in support of this model. • The model is in line with lo al, regional and national NHS strategies and operational priorities • Community Flow would be in place to support the Northern system over winter	The evaluation may not be sufficient to demonstrate an impact and the evidence-base to enable Community Flow to be embedded into provider Operational Plans / operational team core business. **Operational Risks:** There are a number of potential operational risks as follows: • Over-reliance by an individual on a single caseworker due to level of complexity and need that may exists. • Risk that demand could exceed capacity as referral numbers continue to rise. • Caseworker burnout/reduced wellbeing due to complexity of cases. • Patients not wishing to engage with the process or that interventions prove ineffective.	Initial and early results show signs that this is an effective service. However, the additional time frame enabled by this funding will allow the team to demonstrate this. The extended funding enables a commitment to retention of the current workforce and a focus on staff support via a complete supervision process. Further effective monitoring of patient engagement, training, supervision and sharing of best practice works towards ensuring effective interventions. Communication will be needed with referrers and a patient prioritisation policy will be needs if demand starts to consistently exceed capacity.

Option 2: Do nothing and allow service to cease - Sept 24		
Benefits	**Risk**	**Mitigation**
The funding to support Community Flow would be available to meet other ICB priorities.	**Losing of a highly skilled provider:** The current VCSE Community Flow provider is	Whilst relations are strong between OND and the VCSE, and the VCSE is unfortunately used to

	highly-skilled, well regarded and effective. Such providers are not common and non-renewal of their contract will mean they divert their resources elsewhere or make the Community Flow caseworkers redundant. A similar service will inevitably be required and commissioned for winter 2024.	insecure funding streams, there is no mitigation for the loss of the skilful input of this VCSE partner in Community Flow. Funding the Community Flow service is the only mitigation of the wasted work and potential loss of skilled VCSE caseworkers.

Conclusion and preferred option

The preferred option is Option 1: to continue funding the Community Flow case workers until March 2025.

3.4 DELIVERABILITY COMPARISON AND CONCLUSION

Option 1 is extremely easy to achieve as the service is already set up and performing, with staff in post who have been fully trained and capable of delivering the required outcomes. All pathways and processes have been built and are operating effectively.

Option 2 would require notice being given to the provider and a cut-off and transition process implemented whereby plans are made to close the service and withdraw from all those patient's being supported as the contract end approaches. A clear communication strategy to inform stakeholders that the service had ceased operations would also be required.

3.5 COST AND BENEFIT ANALYSIS AND CONCLUSION

Table 2: Financial summary for each of the Options (see detail under Appendix 1)

	Option 1 Do nothing	Option 2	Option 3	Option 4	Option 4
	£000	£000	£000	£000	£000
Lifecycle Capital Investments					
Total lifecycle Revenue (+)	66.9				
Total Lifecyle Cost (-)	-126.3				
Total Cashable Savings (+)					
Total Revenue Impact	-59.4	0.0	0.0	0.0	0.0
Total Non- Cashable Savings (+)					
NPV					
Pay back					
IRR					

Option 1 offers the most benefit to the system – see section 4.2.2 for details of the potential returns on investment.

3.6 EQUALITY AND ENVIRONMENTAL IMPACT

3.6.1 Does the preferred option support to eliminate unlawful discrimination or other conduct prohibited by the Equality Act 2010

Yes. The entire guiding principle of the Community Flow service is to reduce inequality and ensure equity of outcome irrespective of socio-economic context.
The service is not open to or suitable for people under the age of 18 or those with dementia (in line with the national service specification) although people in these categories can be secondary beneficiaries (in the team around the family approach).

3.6.2 Does the preferred option address health inequalities?

Yes. Option 1 clearly addresses health inequalities as described in section 2. The service works with individuals who are at risk of health inequalities and the service is specifically designed to address these risks.

Option 2 would withdraw this service and lead to increased inequality and inequity.

3.6.3 Does the preferred option encourage equality and create opportunities for people from different diverse groups and meeting heir diverse needs?

Yes. The Flow model is designed around what matters to that individual and is person centred working with whatever diverse needs an individual may have. The model seeks to encourage equality and create opportunities, when needed, for people from diverse groups with diverse needs.

3.6.4 Does the preferred option address an area with known inequalities (deprivation/unemployed/homeless/people with protective characteristics)?

Yes. There are significant pockets of deprivation in Northern Devon. ICS health needs analyses outline the characteristics of Northern Devon which include very low car ownership, lower life expectancy, higher prevalence of Core20+5 indicators, poor housing quality and availability and lower earnings that the national average. Torridge has been identified as requiring a Levelling Up place partnership and there is a Taskforce on Housing in Ilfracombe.
Experience developed through the One Northern Devon flow programme has enabled effective working practices with these cohorts of patients.

3.6.5 Will the preferred option result in positive environmental impact (reduce carbon emissions / reduce wastage / reduce harmful materials)?>

Whilst not specifically designed to achieve a positive environmental impact, option 1 indirectly does so. Due to the rurality and size of Northern Devon the model is designed so that each worker is allocated to each of the 3 geographical Adult Community Health and Social care Teams. This reduces the environmental impact of excessive travel by staff.
Further, by reducing the patient ambulance conveyances and travel associated with physically attending hospital, an environmental benefit will be achieved.

3.7 PREFERRED OPTION

The decision to submit Community Flow as a priority within the Devon population health was made through the governance process of the OND Local Care Partnership:

- OND Health Inequalities Group (Clinical Lead Dr Oliver Hassall) agreed recommendations on 13th February 2024
- The Northern LCP Programme Group (Chair Becky Harty) agreed the recommendations for approval on 21st February
- The OND LCP Board (Chair Lou Higgins) agreed the recommendations on 27th February 2024

4 IMPLICATIONS OF PREFERRED OPTION

4.1 SERVICE IMPLICATIONS

How does the preferred option specifically address our clinical and operational priorities?

- Working in the community to avoid admissions and attendance to ED reduces the need for an category 2 ambulance response, allowing for more efficient response times to other emergency callouts
- Reducing attendances to ED departments which contributes towards enabling improved waiting times and patient experience within ED.
- Supporting earlier discharge and admission avoidance contributing to the required reduction in bed occupancy to 92% or below.
- Working with UCR to support them to provide a more efficient response to alleviate the distraction of unregulated care requirements and non-medical issues
- Working directly to reduce the health inequalities of patients within the within the Core20PLUS5 cohort.

Productivity Implications

The preferred option has the following productivity implications:

- It contributes towards expediated and safer discharges, freeing up capacity within the NHS
- It reduces unplanned admissions and works towards admission avoidance
- It reduces attendances to ED and contributes towards targets around reduced waiting times i
- Contribute to more efficient hospital flow by freeing up capacity
- Support community teams to be able to efficiently focus on clinical needs
- Support sustainability of clinical health interventions
- Join up and improves efficiency of multiple healthcare interventions
- Reduces likelihood of ongoing care costs

Workforce implications of the preferred option

There are no current workforce implications of the preferred option as the service is currently operating. All posts have been filled, staff trained, and relationships are developed. If funding is approved the service will continue to operate with the same workforce.

4.2 FINANCIAL IMPLICATIONS

4.2.1 Detailed life cycle financial implications and phasing of the preferred option

Business Case Register Reference Number:							
Scheme Name	Total lifecyc	Year 1	Year 2	Year 3	Year 4	Year 5	Source of Data
Total Cashable Savings / Reduction of Current Cost pressure (+)	0.0	0.0	0.0	0.0	0.0	0.0	
Net Revenue (cost) / savings - Cash Impact	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	
Total Non-Cashable Savings / Cost Avoidance (+)	0.0	0.0	0.0	0.0	0.0	0.0	
Deprecation Charges (-)	0.0	0.0	0.0	0.0	0.0	0.0	
Net Revenue (cost) / savings - Budgetary Impact	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	
Discount Rate	3.50%						
Cost of Capital	3.50%						
Financial Evaluation Measurement							
Cash Flow	0.0	0.0	0.0	0.0	0.0	0.0	
Cash Flow (Adjusted for Optimism Bias)	0.0	0.0	0.0	0.0	0.0	0.0	
NPV	0.0	LBF Adjusted	0.0				
Payback Period (Years)	Enter Here	LBF Adjusted	Enter Here				
IRR	Check Negative NPV	LBF Adjusted	Check Negative NPV				

4.2.2 Describe and demonstrator affordably and sensitivity to assumptions

It is proposed that option be funded from a combination of existing OND funding to September 2024 and then funding from the ICB Population Health Budget for the remainder of the financial year. With this funding the LCP will evaluate the full impact of Community Flow and propose a recurrent funding stream based on the system cost savings from avoided failed discharges, reduced statutory input into discharges and the improved health and wellbeing of patients.

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.

(NB for notes on methodology see Appendix 1)

Discharge expediated:

Over the past year, Community Flow has speeded up discharge in 54 instances. Using the data above, and working on a <u>minimum</u> assumption that it speeded up discharge by just <u>one day only</u> 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.

4.2.3 Describe the sources and assumptions for the evidence supporting the recommended option, and why approvers should have confidence in the information provided.

Devon BI team and locally collated evaluation data.

4.3 PROCUREMENT CONSIDERATIONS

As the funding for delivery runs out in September 2024, the RDUH procurement team has advised that restarting the service after the current service contract ends would require a procurement exercise.

Best practice procurement requires three formal quotes and a tender appraisal process. Avoiding a break in delivery can be avoided by Option 1 and extending the current contract with the existing provider.

5. MANAGEMENT AND DELIVERABILITY

5.1 Governance roles and responsibilities

The service is currently operating and governance, IG policies and SOPs are already in place with the provider for this service.

5.2 Detailed feasibility study where appropriate

N/a

5.3 Detailed resourcing and management requirement for delivery to planned budget and the delivery time scale

As the service is currently operational, resources and management requirement have already been identified and allocated. The budget can be immediately committed via a contract extension.

5.4 Project plan, delivery timeline, project assurance and project dependencies

A full project plan is in place. The service is being delivered in line with these plans, with assurance being overseen by the RDUH Partnership Team.

The funding would enable the next phase of the project plan: impact reporting, evaluation and analysis and the development of a full business case to be for funding beyond 2024/2025. Processes are already in place to support this via the design and implementation of sufficient data and evidence capture.

5.5 Any assistance required from other parts of government or the private sector

No assistance needed.

5.6 Risk and benefit schedule on the preferred option (from Annex 1)

Annex 1 – Business Case Finance, Risk and Benefits Template (See Excel Template)

Business Case
Finance, Risks and Ber

NOTE Macros in an embedded Excel file is automatically blocked, to enable Macro in this template please flow the following steps:

1 enable macros when opening the embedded file above
2 save the file in a trusted location
3 Run macros and save file again

APPENDIX 1 ; Notes on Methodology

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.