Pilot of Rapid Access to Assessment and Care (RAAC)

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21st August 2013

Version 2

Version History

Version	Date Issued	Brief Summary of Change	Author/Contributors
D0.01	July 2013	Document Created	ATS/DM/LK/JR/AG/PR
D0.02	21/08/13	Updated finance following input from LN	ATS

Document Location

Document Location	File Name

Document sign off

Name	Role	Signature

Document Distribution List

Name	Purpose	Department/Organisation
AG/PR/LN	For review and comment	CSU and CCG
	For review/comment	
	For review/comment	
	For review/comment	
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Contents

1. Business Case Framework for Service Developments and New Investments

Please complete this form for new funding and/or service developments, to demonstrate how outcomes and value for money will be achieved.

Title of service development:	Pilot of Rapid Access to Assessment and Care
Provider Organisation and Department:	HCCG – COST team Herefordshire Council – Adult Social Care Wye Valley NHS Trust – Urgent Care
Submitted by:	Dr A Talbot-Smith
Date:	21st August 2013

2. Description of service development/investment proposal:

2.1.1. A full description is given in Appendix 1.

2.1.2. Aims of the Pilot Scheme

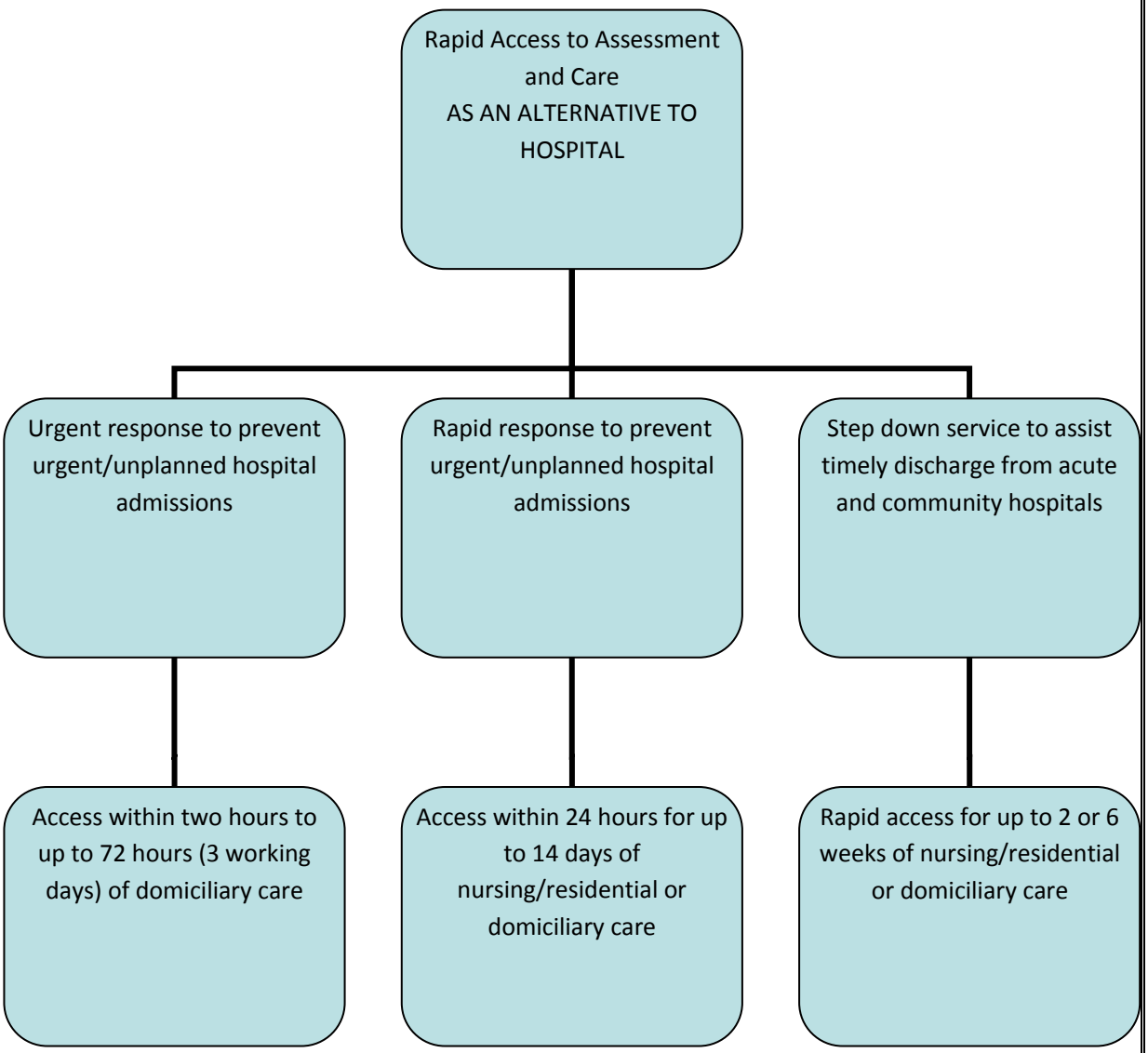
1. The pilot will evaluate the effectiveness of a "rapid access to assessment and care" scheme in Herefordshire.
2. The aims of the scheme are to:
    - reduce avoidable admissions to hospital and subsequent placements in long term nursing home, long term residential care or domiciliary care packages
    - maximise the independence of patients and residents and return to "usual place of residence"

2.1.3. Objectives of the Pilot Scheme

3. The objective of the scheme is to provide temporary safe environments where targeted interventions can be provided and ongoing health and care needs assessed and met.
4. It will create a managed health and social care pathway in the community, for those who would otherwise have to be admitted to/or remain in, hospital. This pathway will enable:
    - Inter-agency, multidisciplinary assessment of ongoing health and social care needs
    - Targeted therapist input where appropriate, to maximise function and independence
    - Identification and provision of other available services to assist return to home, or alternative arrangement if that is required
    - Optimal onward placement based upon the principal of maximal independence

2.1.4. Overview of the Scheme

1. The Scheme will consist of three key components, all of which aim to prevent avoidable hospital admissions, restore maximal independence, and enable return to the usual place of residence where possible:
    - Urgent domiciliary care – within 2 hours for up to 72 hours
    - Rapid access to residential or nursing home care – within 24 hours for up to 14 days
    - Step down access to residential or nursing home care – for up to 2 weeks, or 6 weeks in non-weight bearing patients



2.1.5. Description of the Urgent Response Scheme

1. The urgent response scheme will provide access, within 2 hours, to up to 72 hours of domiciliary care.
2. The scheme will operate 24/7.
3. It is a targeted intervention intended to prevent avoidable hospital admissions, by providing emergency domiciliary care for those:
    - With anticipated short term care needs (< 72 hours)
    - With longer term care needs – providing an alternative to hospital admission whist longer term solutions are put in place. This might include waiting for an assessment or a rapid response placement.

2.1.6. Description of the Rapid Response (Assessment and Care) Scheme

1. The scheme will provide access within 24 hours to up to 7days of nursing, residential or domiciliary care, that can be extended for an additional 7 days (maximum 14 days of care).
2. It is a targeted intervention to prevent urgent/unplanned hospital admissions in those where:
    - It is unsafe for the service user remain in their normal place of residence BUT
    - Hospital admission is **not** required - any required medical intervention can be safely provided in a community setting.
3. Its function is to provide a temporary safe environment where:
    - Multi-agency assessment, care planning and onward placement can occur
    - Appropriate rehabilitation, reablement or enablement can be continued or commenced.

2.1.7. Description of the Step Down (Assessment and Care) Scheme

1. The scheme will provide access within 24 hours to nursing, residential or domiciliary care, for patients currently in the acute or community hospitals who are suitable for medical discharge but are temporarily unable to return home.
2. This will be provided for different time periods according to the purpose:
    - To enable assessment, care planning and onward placement outside of a hospital bed – up to 7 days that can be extended for an additional 7 days (maximum 14 days of care)
    - To enable longer term convalescence, enablement or reablement in non-weight bearing patients - up to 6 weeks.
3. It is a targeted intervention to facilitate discharge from acute and community hospital settings in service users where:
    - It is unsafe for the service user to return to their normal place of residence BUT
    - Ongoing inpatient stay is **not** required - any required medical intervention can be safely provided in a community setting.
4. Its function is to provide a temporary safe environment where:
    - Multi-agency assessment, care planning & onward placement can occur, enabling long term placement decisions to be made outside of a hospital bed
    - Appropriate rehabilitation, reablement or enablement can be continued or commenced.

Community MDT

To ensure optimal assessment, monitoring and care co-ordination, all people accessing the scheme will be tracked through a Community MDT led by a dedicated elderly care CNS. The MDT will oversee patients' progress, as well as providing Multi-Disciplinary Assessment and care Planning. It will link into Neighborhood Team MDTs, Virtual Wards, Social Care and Mental Health services as appropriate, to ensure integration and care co-ordination across the spectrum of provision.

Integration with other initiatives

People accessing these services will by definition not require acute hospital care – and as such will not be eligible if they are receiving the WVT Admission Avoidance/Early Supported discharge Hospital at Home service.

They may have inter-current healthcare needs, but of the form that can be managed in the community by a GP – this includes virtual ward patients and for the Urgent response service End of Life patients.

3. Local and National Context

1. The proposal meets the following strategic objectives:
    - It forms a key component of the local Urgent Care Recovery Plan, acting to:
        - Reduce "avoidable" emergency hospital admissions
        - Facilitate discharge from acute and community hospitals and improve patient flow through the urgent care system
    - It provides targeted reablement
    - It promotes return to independence and "usual place of residence"
    - It provides targeted prevention, a core component of the Next Stage Integration Project

2. It sits alongside other initiatives being developed, such as the Virtual Ward and Hospital at Home Schemes.

3. It should be noted that patents may be in the risk stratification component of the Virtual Ward and access this scheme. However it cannot be accessed at the same time as the Admission Avoidance/Early supported discharge component of Virtual Wards.

4. Evidence of Clinical and Cost-Effectiveness

1. The "Urgent Response" component was piloted in Chichester in 2010 – at 2010 prices this component cost £370 per patient compared to an average emergency admission cost of £2,500 per patient.

2. The "Rapid Response" and "Step Down" service were piloted and evaluated in NHS Wirrall, which has a population of 330,000. With all components being new investment (as opposed to renegotiation of existing provision) the scheme:
    - Cost the NHS £1.5 million
    - Saved the NHS £1.75 million – a net saving of £250k
    - Was considered likely to have made savings for social care services – although these weren't evaluated.

3. Similar schemes are being implemented in many other areas, including Worcestershire – but no formal evaluations are available yet.

5. What are the intended clinical outcomes:

The scheme should deliver immediate benefits for patients in terms of:

- Prevented hospital admissions
- Earlier hospital discharges and improved flow through the urgent care system
- Maximisation of independence and self-care
- Reduced long term health and social care needs
- Increased return to usual place of residence

6. Have Inequalities been considered

The scheme will be available county wide. Adults of any age can enter the scheme, although it is probable that it will be used mainly in older patients.

By focusing on people who are admitted to hospital due to a lack of a suitable alternative, the pilot will improve inequalities and meet an unmet need.

7. Costs and Savings – Return on Investment

Preliminary discussions with WVT clinicians and managers, and with local providers suggest demand will outstrip available capacity – at least until the pilot demonstrates this as a successful model of working to local providers. This will be focused in two localities until more providers enter the pilot.

Anticipated Activity

For the purpose of the pilot we propose commissioning:

- Urgent response: 1 package per week
- Rapid response: 4 placements at any one time
- Step down service: 4 placements at any one time

Using "worst case" scenario's this would give the following throughput - see Appendix 2 for more detail:

- The urgent response service manages an average of one patient per week – so that there is a throughput of 22 patients
- The patients utilising the rapid response placements stay for the full available 14 days – so that the available beds have a throughput of 44 people
- Half of the patients utilising the step down service stay for 14 days and half stay for the full 42 days – so that the available beds have a throughout of 30 people
- This gives a total anticipated throughput of 96 people

Costings of the scheme:

To ensure we provide "worst case" costing scenarios we have:

- Used "top end" costings
- For the rapid response and step down services costed the more expensive options of residential and nursing home placements rather than domiciliary care.

Costs used:

- Domiciliary care - £16 per hour 8am till 8pm. £24 per hour out of hours
- Residential care £650 per week
- Nursing care £750 per week

Summary costs are provided here in Table 1 – see Appendix 1 for detail.

Realisation of lower costs per case through the pilot would enable us to increase capacity as momentum builds. In addition there are opportunities to renegotiate existing block contracts to re-align unused capacity with this proposal – this is likely to be beyond the timescales of the pilot, but may provide additional capacity from April 2014 onwards.

For the purpose of the pilot we propose to realign existing therapist support – we will evaluate whether and what additional support would be required for larger scale provision as part of the evaluation.

Summary costs are provided here – please see Appendix 3 for more detail.

Table 1. Summary costs of the scheme, from November 2013 to end of March 2014

	Renegotiation of existing contracts	New investment	Total investment
Elderly care CNS	N/A	£44,000	£44,000
Domiciliary care	Opportunities from April 2014 onwards	£16 per hour 8 till 8 £24 per hour unsocial	£31,680
Residential care	Opportunities from April 2014 onwards	£650 per week	£57,200
Nursing home	Opportunities from April 2014 onwards	£750 per week	£66,000
Therapists	Realignment of existing staff for the pilot duration	N/A	0
Admin support	N/A	£22,000	£22,000
Other	N/A	£10,000	£10,000
Total			£230,880

Anticipated NHS "system" savings from the scheme

Calculating NHS savings from the scheme is difficult, since costs of an unscheduled admission are dependent upon:

- The specific medical diagnosis
- The presence of complications
- The length of stay, and whether this is above the point when an additional daily charge (long stay adjustment) becomes eligible

Reviewing the data for 2012/13 unscheduled admissions to WVT confirmed that the ability to identify the relevant cohort of eligible patients from routine data is limited. Evaluation of the pilot will be the mechanism by which we gather that information.

However for the purpose of this business case we have no other data available, so have used the 2012/13 emergency admissions data to identify the HRG codes considered to represent eligible patients, and the associated activity and excess bed days. For the step down component we made assumptions that we would be targeting a different cohort of patients and that there would be full realization of benefits. We also modeled two scenarios to evaluate the effects on the savings profile of bed days reductions falling in the acute and community hospitals (Appendix 4).

It should be noted that we not know where reductions in length of stay will fall, and so cannot determine until we evaluate the pilot whether savings fall within the acute (PbR) or community (block) components of the contract with WVT. However the scheme is a key component of the Urgent Care recovery plan, and as well as improving outcomes for patients it should provide "system wide" NHS savings that benefit both WVT and so ultimately Herefordshire CCG.

In addition it is anticipated that there will be savings to social care commissioners, although these were not evaluated in the NHS Wirrall evaluation.

Summary savings to the NHS – see Appendix 4 for detail.

	Admissions Avoided	Excess bed days	Total
Scenario one - all savings from reduced LOS in community hospitals. Assume savings of £100 per day to the system	£90,820	£84,200	£175,020
Scenario two - savings from reduced LOS split between acute and community hospitals. Assume savings of £150 per day to the system	£90,820	£126,300	£217,120
Scenario three - savings from reduced LOS fall in the acute hospital, apart from the 6 week component of the step down service. Assume savings of £205 in the acute and £100 in the community hospitals, to the NHS system.	£90,820	£126,440	£217,260

When considered against costs of the pilot this gives the following NHS net savings predictions.

Anticipated Net Savings – NHS "System Wide"

	Cost	Potential NHS Savings	Net Savings
Scenario one - all savings from reduced LOS in community hospitals. Assume savings of £100 per day to the system	£230,880	£175,020	(£55,860) (COST)
Scenario two - savings from reduced LOS split between acute and community hospitals. Assume savings of £150 per day to the system	£230,880	£217,120	(£13,760) (COST)
Scenario three - savings from reduced LOS fall in the acute hospital, apart from the 6 week component of the step down service. Assume savings of £205 in the acute and £100 in the community hospitals, to the NHS system.	£230,880	£217,260	(£13,620) (COST)

It should be noted that this does not take into account social care savings, which are anticipated to result from:

- Increased return to independence
- Increased return to usual place of residence

8. Stakeholders views

This is a joint proposal developed between Herefordshire CCG, Herefordshire Council and Wye Valley NHS Trust – both managerial and clinical staff. Additional stakeholders views have been included from domiciliary care, residential and nursing home providers, and from Herefordshire Carer's Support.

9. Delivery Plan

Investment is required for 12 months, 1st November 2013 to 1st November 2014.

Key milestones are:

- Provider interview to gain market overview – end July 2013
- STIG discussion - August 2013
- Complete business case – submit to HCCG Board/HWWB/Urgent Care Delivery Board early September 2013
- Commence renegotiation existing contracts – September 2013
- Provider event – mid September 2013
- Recruit elderly care CNS – September 2013
- New contracts with providers (new investment) – October 2013
- Commence November 2013
- Existing contracts fully realigned end of March 2014
- Evaluation, February, May, August and December 2014

10. Risk Assessment

This proposal forms a key component of the Herefordshire Urgent Care Recovery Plan, as a robust mechanism to reduce avoidable admissions to hospital and facilitate speedier discharge. Not implementing the proposal will have a significant negative effect on the local Urgent Care system and recovery plan.

It should be noted that it is an explicit preventative approach, focused on reablement and return to independent living – and so also represents an important enabler for Herefordshire Council's Next Stage Integration Project.

11. Performance Management/Evaluation

The evaluation is detailed more fully in Appendix 1.

HCCG will monitor expenditure and report in year and at year end. The pilot will be evaluated at 3, 6 and 9 months against its core aims and objectives. We will determine:

- The number of hospital admissions prevented
- The case-mix and needs of patients entering the scheme
- How successful the scheme was at returning patients to their usual place of residence
- Whether there is need for additional therapist input
- Opportunities to broaden out the scheme – in terms of capacity or admission routes (e.g. ambulance ECPs)

Each component of the scheme will be valuated separately, namely:

- The urgent response scheme
- The rapid access scheme
- The "maximum 14 days" step down service
- The "maximum 6 weeks" step down service

Outcomes

- Type of hospital admission avoided with nominal HRG
- (For Step down service) – type of preceding admission
- (For step down service) – number of bed days avoided and where these fall in relation to trim point
- Onward destination from scheme:
    - Return home to usual care
    - Return home with additional support
    - Residential placement
    - Nursing care placement
- Patients admitted to hospital during the scheme, with reasons
- Number of beds "de-commissioned" during scheme, by provider
- Staff satisfaction
- Stakeholder satisfaction
- Patient experience
- Critical factors affecting scheme not captured above – e.g. the need for additional therapist or community equipment input.