Unscheduled Care: Resetting the System Business Case

Section 1 (This section is mandatory)

1. Proposal description

1.1. Proposal title

Increase Occupational Therapy and Physiotherapy workforce within Rapid Assessment for Discharge (RAD) and frailty team to become a 52 week/ 7 day service 7am – 6pm.

1.2. Name of the person leading the Workstream

Lorna Darrie (Physiotherapy Service Lead)

Joanna Stewart (Occupational Therapy Service Lead)

2. What is the proposal intended to do?

2.1. Proposal description

The RAD AHP serviced is based with the Medical Assessment Unit (MAU) and Emergency Department (ED) with the BGH. Currently the RAD team work core hours Monday to Friday 8.30 am – 4.30 pm. Patients presenting to ED after the hours of 3.30pm are therefore not assessed by physiotherapy/ occupational therapy until the following day. Weekend rotas are covered on a voluntary basis and paid as additional hours. The leaves continuity of the weekend service at risk and vulnerable in terms of sickness absence and at peak times of annual leave. Winter funding 21/22 has enabled test of change/pilot of an Advanced Physiotherapy Practitioner (APP) frailty in the Emergency Department. The data presented in 2.3 and financial calculations in 2.4.4 are based on this test of change.

Nationally, this proposal will deliver a positive impact within the unscheduled care workstream; optimising flow and 'Discharge without Delay'

- Increase in Prevention of Admission of people presenting to the Emergency Department
- Reduction in Length of Stay of people admitted to Medical Admissions Unit (MAU) and ward inpatients.

Locally, it is anticipated that this proposal will deliver a positive impact on the Acute Recovery Programme Board Priorities:

- 1) Increase Frailty Provision in ED and MAU
- 2) Impacting 'Productive Ward' by improving ward communication
- 4) Impacting Elective Bed Model by facilitating patient flow.
- 5) Development of Pathways from ED Direct to Speciality

It is proposed that an increase in registered Occupational Therapy, Physiotherapy and HCSW workforce within the RAD and Frailty team would facilitate new working patterns as follows:

- working 52 weeks a year
- working across 7 days
- working different daily shift patterns (Early 7am – 3pm, Late 10am – 6pm)

- Workforce establishment uplift of 21% to ensure annual leave and absence cover.

RAD rota and staffing calculations.d

In order to deliver a service as described above the team will require the workforce skill–mix described in ***fig. 1***.

Staff Grade	Current Staffing	Current Cost to Employ (22/23)	Proposed staff requirement	Proposed Cost to Employ (22/23) incl 21% headroom	Increase Required (WTE)	Funding Requirement
Band 7	1	59,959.00	3	£217,650	2	£157,691.00
Band 6	1.6	£79,393.60	1	£60,041	-0.6	-£36,024.60
Band 5	0	£0.00	1	£48,398	1	£48,398.00
Band 4	0	£0.00	2	£80,211	2	£80,211.00
Band 3	0	£0.00	1	£36,870	-1	£36,870.00
Temp 7	*1*	*59,959.00*	*0*	*0*	*-1*	*-£59,959.00*
Temp 3	*2*	*£60,942.00*	*0*	*0*	*-2*	*-£60.942.00*
TOTAL	**4.6**	**£260,253.60**	**8**	**£443,170**	**3.4**	**£166,245**

Fig. 1

Note – See embedded doc for details of workforce skill-mix

Proposed RAD Workforce Skillmix.dc

2.2. Proposal category

Prevent admission

2.3. Baseline and impact

2.3.1. Current baseline

Data for the period 10/01/2022 – 04/02/2022	
Number of ED POA (prevention of admission)	**34**
Number of RAD Assessments in ED	68
Known unmet Need ED (based on Out of Hours/weekend presentations) *	16
Total Number of RAD Assessments in MAU	190
Number of RAD led D/Cs from MAU	49
Unmet need MAU (data collected 16/03/22 – 13/04/2022)	134 (not Ax within 24 hours)

* Unmet need numbers anticipated to be significantly higher than currently identified.

Fig.2

Type of Clinical Presentations	
Fall/Frailty (national data average LOS 35 Days)	**42**
Medical	15
Neuro	3
Palliative	1
MSK	5

Fig.3

2.3.2. Expected impact

Enhanced workforce 7am – 6pm across 7 days will greatly impact on number of patients assessed, treated and discharged which will reduce their length of stay and prevent admission to hospital. A 7-day service will provide continuity and efficiencies to service delivery with reduction in handover time.

The RAD team are experts in complex discharge planning and will provide education to staff working across acute services in turn, promoting discharge to assess model. The team will also provide an out-reach model by supporting patients to return home and providing community follow up and rehabilitation, thus supporting the Home First 'Discharge to Assess' approach.

2.3.3. How will the impact be measured and evaluated against the baseline?

Robust data collection of time to first assessment, onward referral and discharge data will be measured and evaluated. This will provide accurate data which will be measured against current baseline data which will highlight financial impact, patient flow, increased discharges and reduction of admission.

2.4. Benefits

2.4.1. Benefits to service users

Prevention of Admission (PoA) = improved person-centred outcomes and self-management closer to home or homely setting

Reduction in Length of Stay - earlier identification of frailty, earlier identification of Planned Discharge Date (PDD) = reduction in LoS and Hospital Acquired Deconditioning (HAD) and Hospital Acquired Infection (HAI), reduction in falls and harm.

2.4.2. Benefits to staff

Continuity of service over 7 days will provide return on investment by reducing the weekend build up of referrals and assessments on Monday. This has potential to enhance staff wellbeing, reduce stress and work related anxiety, increase job satisfaction, team working and staff recruitment and retention.

2.4.3. Benefits to the system (non-financial)

- Potential to support BUCC/ ambulatory care through PT input for soft tissue injury, walking aid/equipment prescription, assessment of acute on chronic pain presentations
- Move from volunteer weekend service to rostered service provides potential to develop community based weekend model therefore increasing community capacity. This is currently limited by the number of available 'volunteers'.
- Improved more rapid multidisciplinary decision making

- Enhanced ability to meet DWD priorities; 'Home First' Principles, PDD and Pathways model approach to discharge planning
- Improved profile and understanding of role and contribution of OT/PT and HCSWs
- Improved communication across the whole system into Primary & Community Services Teams and Social care

2.4.4. Benefits to the system (financial)

Based on the data detailed in 2.3.1 the following assessment can be made on costs associated with Prevention of Admission directly linked to our service.

APP Test of Change 10/01/22 – 04/02/22					
Acute Bed - cost per day	Average LOS (Fall / Frailty)	TOTAL	ED POA x 1 WTE APP (Current 5 Day Week)	Predicted Cost Saving POA	Annualised
£450.00	35	£15,750.00	34	£535,500.00	£6,426,000.00

Fig.4

Expected Impact of proposal					
Acute Bed - cost per day	Average LOS (Fall / Frailty)	TOTAL	ED POA x 2 WTE APP (Proposed 7 Day Week)	Predicted Cost Saving POA	Annualised
£450.00	35	£15,750.00	47.6	£749,700.00	£8,996,400.00

Fig.5

Based on the above test of change, increasing ED staffing resource as per our proposal detailed in 2.1 a further annual prevention of admission cost saving of £2,570,400.00 could be achieved.

Net of increased staff costs at £166,245.00 **= £2,298,151 cost saving based on inpatient bed days saved**

Further predications can be calculated as follows:

- Unmet need within MAU for period 16/03/2022 – 13/04/2022 = 134 not assessed within 24 hours
- No unmet need recorded when the team are staffed with 3 registered staff and 1 HCSW = optimal staffing levels – reflected in example RAD rota embedded within section 2.1
- Unmet need within ED for period 10/01/22 – 04/02/22 = 15 (estimated as unmet need data collection at weekend is variable). Annualised = 180 referrals for RAD Ax unmet.
- Based on Test of Change (see ***Fig. 2***) approx 50% of RAD assessments in ED result in Prevention of Admission = 90
- Based on proposed workforce and average length of stay this has potential to save 3150 inpatient bed days.
- 3150 x £450 (average acute cost bed per day) = **a further £1,417,500 potential cost saving based on inpatient bed days saved**

2.5. Proposed Measures (KPIs/QPIs)

Emergency Access Standard

Length of time to 1st Assessment

Delayed Discharges

Patient Experience

Staff Experience

Earlier identification of frailty (implementation of frailty score/competencies)

2.6. Alignment to national / local strategies or workstreams / IJB directions

Discharge without Delay

2.7. Alignment to National Health and Wellbeing outcomes

Please note all national health and wellbeing outcomes that this proposal would impact upon

N	Description	Mark X for all that apply
1	People are able to look after and improve their own health and wellbeing and live in good health for longer.	x
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3	People who use health and social care services have positive experiences of those services, and have their dignity respected.	x
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	x
5	Health and social care services contribute to reducing health inequalities.	x
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	
7	People who use health and social care services are safe from harm.	x
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	x
9	Resources are used effectively and efficiently in the provision of health and social care services.	x

3. Proposal feasibility/impact assessment

3.1. Expected feasibility

High

3.2. Expected impact

High

3.3. Expected effort

Medium

3.4. Expected delivery timescales

Long-term

3.5. Is an Equalities / Human Rights Impact Assessment required?

No - if not, explain why RAD team already exists, this is to enhance the existing structure.

3.6. Is any project management support required?

No.

3.7. Key risks to delivery

Risk description	Likelihood (1-5)	Impact (1-5)	Mitigation	Residual likelihood (1-5)	Residual impact (1-5)
Inability to recruit to new posts if these are fixed term temporary	5	5	Permanent appointments	1	2
Lack of community capacity (Home First, social care, third sector) limiting the impact of POA and therefore reducing benefit	3	3	Ongoing work to develop Home First in tandem with RAD in order to maximise capacity across the system	2	2

4. Financial requirements

Please complete all parts of section 4 following discussion with your finance business partner

4.1. Does this align to an existing financial workstream/source?

Yes - Discharge without Delay

4.2. Expected costs

Proposed Establishment					
	Indicative*			Indicative*	Indicative*
	1 x WTE	2 x WTE		Total	Cost
	21/22	22/24		22/23	Incl. 21%
	Cost	Cost^		Cost^	Headroom
Grade	£	£	WTE	£	£
B7	58,783	59,959	3.0	179,876	217,650
B6	48,648	49,621	1.0	49,621	60,041
B5	39,214	39,998	1.0	39,998	48,398
B4	32,495	33,145	2.0	66,290	80,211
B3	29,874	30,471	1.0	30,471	36,870

	366,257	**443,170**

Current Substantive Establishment					
		Indicative*		**Indicative***	
	1 x WTE	**2 x WTE**		**Total**	
	21/22	**22/24**		**22/23**	
	Cost	**Cost^**		**Cost^**	
Grade	**£**	**£**	**WTE**	**£**	
B7	**58,783**	**59,959**	**1.0**	**59,959**	
B6	**48,648**	**49,621**	**1.6**	**79,394**	
				139,352	**139,352**

Additional Funding Requirement	**226,904**	**303,818**

4.3. Recurrent or Non-recurrent funding required

Recurrent

5. Support for business case

5.1. Please provide the list of stakeholders who support this bid

Paul Williams (Associate Director AHPs, NHS Borders)

Lynne McCallum (Medical Director, NHS Borders)

Janet Bennison (Associate Medical Director, NHS Borders)

Rachel Stewart (Consultant Geriatrician, NHS Borders)

Eva Palik (Consultant Acute Medicine, NHS Borders)

Colm McCArthy (Consultant Emergency Medicine, NHS Borders)

Louise McIntosh (Senior Charge Nurse, MAU, NHS Borders)

Lesley Anderson (Senior Charge Nurse, ED, NHS Borders)

James Taylor (Locum General Medicine Consultant)

5.2. Finance business partner sign-off

Paul McMenamin (PCS Finance Business Partner)

5.3. Director sign-off

Insert name here

5.4. Contact details for person submitting the case

Lorna.darrie@borders.scot.nhs.uk

Joanna.stewart@borders.scot.nhs.uk

Section 2 (Complete this section if/once the proposal is approved by the panel)

6. How will the Integration delivery principles be carried out?

This section only needs to be completed if the proposal is shortlisted.

The integration delivery principles are:	
The main purpose of services is to improve the wellbeing of service-users, and services should be provided in a way that:	Describe how you will achieve this in the rows below
• is integrated from the point of view of service-users,	
• takes account of the particular needs of different service-users,	
• takes account of the particular needs of service-users in different parts of the area in which the service is being provided,	
• takes account of the particular characteristics and circumstances of different service-users,	
• respects the rights of service-users,	
• takes account of the dignity of service-users,	
• takes account of the participation by service-users in the community in which service-users live,	
• protects and improves the safety of service-users,	
• improves the quality of the service,	
• is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),	
• best anticipates needs and prevents them arising,	
• makes the best use of the available facilities, people and other resources.	