RAD Business Case proposal for MDT funds

Written by: Paul Williams (Associate Director AHPs)

Bhav Joshi (GM Unscheduled Care)

Situation

This paper outlines an alternative workforce proposal at significantly reduced cost from an original frailty / RAD business case submitted to HCSP leadership team in April 2022. (See embedded document)

SBHSCP RAD-Frailty Business Case2 (003)

The RAD team is comprised of Occupational Therapists, Physiotherapists, HCSW and form part of the wider multi-disciplinary team across ED and MAU. The team's primary function is to facilitate assessment, treatment and discharge across front door services through complex physical, social and medical assessment. The value and necessity of this team has been supported by clinicians, ward staff and Acute Hospital Management.

The AHP skills, knowledge and experience required to deliver this service is outwith core physiotherapy and occupational therapy competency due to the specialist and cross-professional boundary skills that are required. This requires specialist staff and senior clinical decision makers to be based within the service, and also necessitates training and development across wider Physiotherapy and Occupational Therapy staffing groups across Acute services.

A Winter bid for additional staffing from Dec 21- present has allowed an increase in RAD staffing resource from 2.6wte to 4.6wte incorporating an APP based in ED.

Activity/ KPIs

The most significant KPI within RAD is the number of discharges from MAU/ED. Secondary KPIs include: assessment to discharge ratio, onward referral to community services, and re-admission rates. When core RAD staff are delivering this service, the ratio or assessment to discharge is approximately 50%. When staffed by non-core RAD staff, the conversion rate is approx. 20%.

Demand

Activity data is captured and reported through EMIS-web.

Average activity Jan-Nov 22 (with enhanced staffing in place)

- Average weekly ED assessments – 21
- Average weekly MAU assessments – 64
- Average weekly discharges from ED – 13
- Average weekly discharges from MAU – 29

Average Demand Jan- Nov 22

Average weekly ED referrals – 26
Average weekly MAU referrals - 75

Capacity

RAD funded establishment currents sits at 2.6wte which includes provision of a volunteer weekend rota from wider AHP staffing. This model does not support uplift for predicted absence and therefore service provision drops significantly during periods of leave such as sickness absence and vacancy cover. During these periods RAG status for RAD often reduces from amber to red. It is not uncommon to have only 1 therapist on MAU, with unmet demand greater than 40%.

This core staffing provides the following clinical capacity (when accounting AL/ sickness absence/ vacancy):

- Average total assessment time to facilitate discharge: 65mins
- Daily Capacity per therapist: 4-6 assessments
- 'Core' service capacity: 44 assessments per week

Current enhanced staffing due to winter funding has increased capacity to (when accounting AL/ sickness absence/ vacancy):

- Current 'enhanced' service capacity: 72 assessments per week

Unmet need

The above demand and capacity mismatch is confirmed through unmet need (those patients who could have achieved same day discharge if assessed) captured during the Kaizen project and during reduced 'core' staffing levels.

- Weekly unmet need (core staffing) – 32 **
- Weekly unmet need (enhanced staffing) – 8 *

* Data from MAU Kaizen project
** snapshot from 7/11/22 when staffing equated core staffing due to sickness absence

Proposal

The following skill mix is required to meet current service demand and KPIs.

Core establishment

- 1 wte B7 Team Lead (in post)
- 0.6 wte B6 Physiotherapist (in post)
- 1.0 wte B6 OT (in post)

Additional staffing required

- 1 wte B7 APP in ED (to prevent admission to MAU)

- 1 wte B5 OT (to enable 7 day cover)
- 0.4 wte B6 Physio (to enable 7 day cover)
- 1 wte B4 HCSW (increase capacity throughout week, release specialist staff time)

Benefits

The above staffing proposal will bring the following benefits:

- Ability to meet current demand across ED and MAU in order to facilitate the maximum number of discharges across 7 days
- Weekend service to be staffed predominantly from RAD core staff thus providing consistency and maximising assessment: discharge ratio. Wider AHP staff to supplement rota as required.
- Core staff working 5 over 7 pattern to negate the necessity to rely on volunteer rota
- Increased resilience to mitigate risk of service entering red RAG status
- Increased service capacity to ensure 'RAD principles' are promoted across BGH downstream wards and community teams.

Finance required

Additional Staffing	Annual Cost	Overall cost
1.0 WTE Band 7 Advanced Practitioner - ED	£59,959.00	£152,979
0.4 WTE Band 6 Physiotherapist	£19,848	
1 WTE Band 5 Occupational Therapist	£39,996	
1 x WTE Band 4 Therapy Support Worker	£33,144.00	

Risks/ Contingencies

RAD input to ED/MAU remains an area of clinical importance regarding hospital flow. The risks and mitigations for the service moving forward include:

Risk	**Impact**	**Grade**	**Mitigation**
Staffing returns to established 2.6wte	Unable to guarantee weekend cover and poor resilience without predicted absence allowance. Risk of 40%+ unmet need with MAU equating to 30+ missed discharges per week	High	Unable to mitigate within service
Direct RAD input to ED stopped	Significant reduction in admission prevention (In sept	High	Unable to mitigate within service

	2022, 101 assessments and 70 discharges direct from ED avoiding admission)		
Hospital flow impacted by reduction/ lack of resilience within RAD team	Increased pressure across MAU/ ED and emergency access standards. Increased pressure across downstream wards and Home First regarding discharge profile.	High	Other services flexing to accommodate flow pressures but limited due to bed/ service capacity.
RAD establishment increased to 5wte as per proposal but without 22% predicted absence allowance	Intermittent unplanned short term absence to move service from green to amber. Intermittent necessity to utilise volunteers to fill weekend rota in this instance.	Medium	5 over 7 working pattern to ensure core RAD staff populate weekend rota, with enhanced training to support wider AHP services to fill any weekend gaps. In order to fully mitigate, staffing would need to significantly increase in line with original business case.
RAD service does not currently provide extended hours coverage (8am- 8pm)	Some discharges may be delayed by RAD staff working core 8:30-4:30pm hours	Low	Month long pilot demonstrated minimal benefit of extended hours due to the limitations of other core services beyond 4:30pm (Home First/ START/ pharmacy/ transport)
Workforce recruitment to support additional roles	Ongoing national recruitment challenges across AHP services, and risk of not recruiting to these roles.	Low	RAD clinical roles seen as desirable within AHP services and therefore recruitment not seen as a high risk. If internal staff move into these roles, it is easier to cover downstream roles through agency/ bank staff.