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Carmarthenshire County Council - Mid and West Wales Health & Social Care Collaborative

Evaluation of Rapid Response Service

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1 EXECUTIVE SUMMARY

1.1 Introduction

In July 2015 PACEC was commissioned by the Mid and West Wales Health & Social Care Collaborative (HSCC) to undertake an evaluation of the Intermediate Care Fund (ICF or the Fund). The work involved evaluating six of the 86 projects funded through the ICF. This report evaluates the Rapid Response project. There are five other evaluation reports and an overall programme report completed as part of the evaluation.

1.2 Background

The ICF was introduced by the Welsh Government in April 2014 to assist in the development of new models of delivering sustainable integrated services that maintain and increase people's wellbeing and independence, and promote improved care coordination across social services, health, housing and other sectors. A one off allocation of £50 million within the devolved Welsh Government budget was made available in 2014/15 across Wales via ICF, comprising £35 million revenue funding and £15 million capital.

The Carmarthenshire Rapid Response service was awarded funding of £311,550 which aimed to:

- reduce the number of people admitted into hospital and deliver more timely discharges of patients back in to the community;
- further help people in their goal to remain healthy and independent;
- enhance the quality of life for people with care and support needs;
- delay and reduce the need for care and support; and
- ensure that people have a positive experience of care and support.

The Carmarthenshire Rapid Response service is delivered throughout Carmarthenshire from 7am to 10pm and is targeted towards patients who otherwise would have been admitted to hospital or would not have been discharged. The service is focused on the rehabilitation of patients and provides intensive support for short periods (e.g. up to 6 weeks), however in some cases the service facilitates discharge from hospital until a long term care package can be put in place.

The core Rapid Response Team consists of 24 Domiciliary Care workers (including supervisors and managers) and a Support and Development Manager who are responsible for providing personal care to patients referred to them.

1.3 Methodology

Methodological Element	Summary
Project Initiation and Initial Evidence Review	• Review of Project Initiation Document (PID) and Policy Context to outline what the project had set out to achieve / rationale for the project • A desk-based review of policy and literature regarding health and social care provision in Wales, including the integrated care context • Review of relevant literature (to outline the existing and new service user pathways and to develop an evaluation / logic model for the project in relation to outputs[1] and outcomes[2]) • A review and analysis of internal Rapid Response monitoring data, including financial data and progress reports • A desk based benchmarking exercise to identify and compare (to the extent possible) inputs, outputs and outcomes delivered by Rapid Response and other similar interventions
Primary Research	• A workshop and internal consultation with project managers across all six ICF projects involved in the evaluation, including group exercises to define pre and post service user pathways and service level logic models • An on-line survey of 12 staff members (50% of 24 staff)
Economic Assessment	Assessment of: • Value for Money (economy, efficiency and effectiveness) • Consideration of additionality, displacement and spillover effects • Estimation of cost savings and return on investment
Analysis & Synthesis	• Synthesis of qualitative and quantitative data • Identification of key lessons • Development of recommendations • Analysis of desk based and survey data.

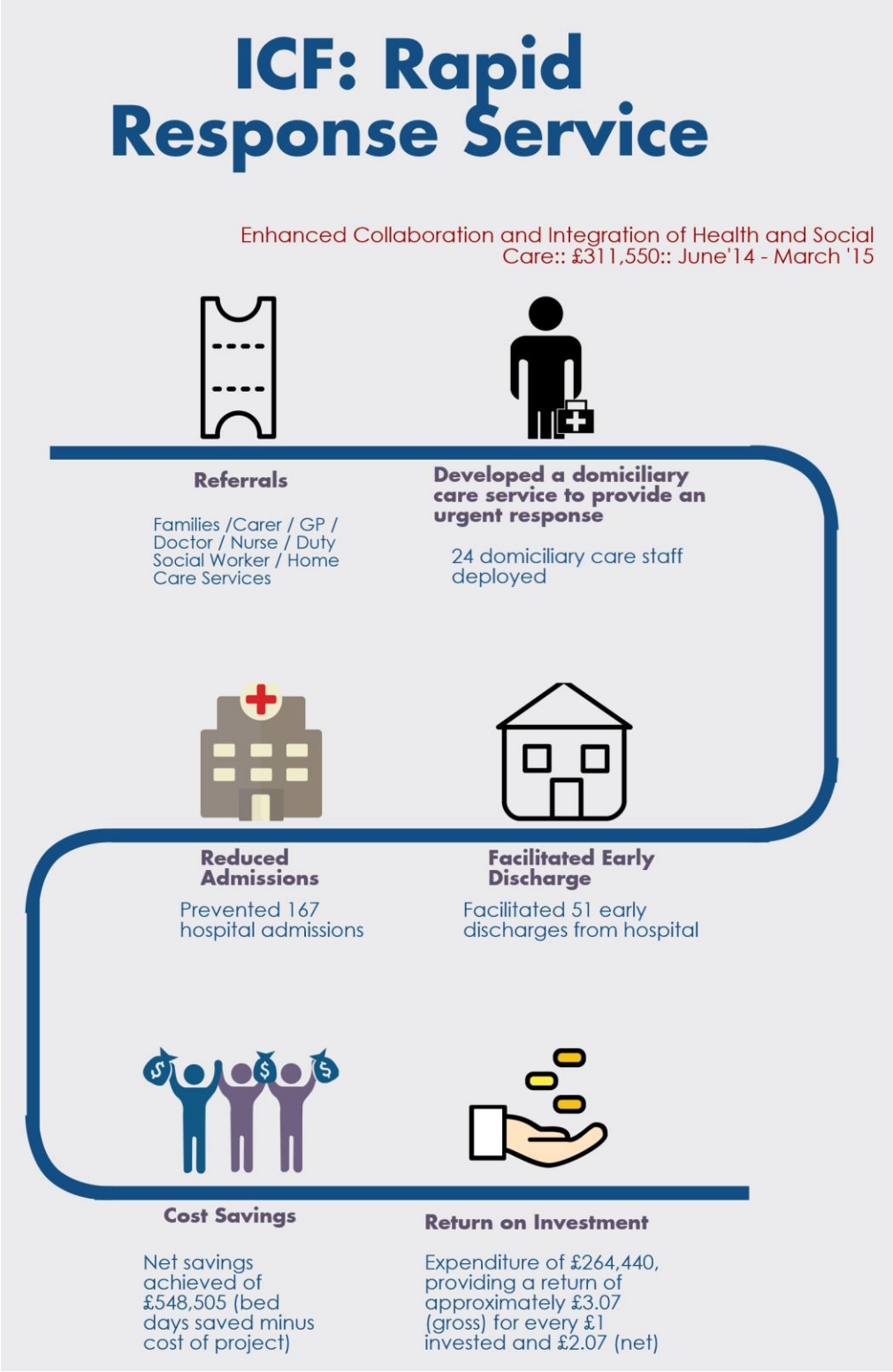
This report reflects an evaluation of the Rapid Response Service that was part of the ICF pilot schemes. The PACEC remit has been to evaluate progress within a set timeframe of six pilot projects representative of 86 projects that received ICFs. The TOR recommended the use of the Integrated Care Evaluation Framework (ICE-F)[3] which will give structure to the following evaluations. The evaluations all need to establish the difference between the outcomes of delivering integrated care services compared to the pre-existing services within a limited time frame.

[1] Outputs are the measureable components of service delivery that can be quantified (e.g. number of patients supported per week) (http://info.wirral.nhs.uk/document_uploads/evidence-factsheets/12%20Logic%20Modelling%20factsheet%20Feb%202014.pdf)

[2] Outcomes are the effects of activities and resulting outputs. These can be divided into short, medium and long term (e.g. short – increased knowledge and skills; medium – improved patient independence; long – reduced health inequalities)

1.4 Evaluation Summary

The following infographic sets out the background, ambitions, and a number of evaluation findings from the Rapid Response Service.



1.5 Key Findings

The key findings from the evaluation are listed below. These refer to the economic assessment of the project, what worked well, and what could be improved in the future via means of recommendations.

Cost Savings:

Total ICF expenditure for the Rapid Response Service was £264,440 and it is estimated that the project has generated net savings of £548,505 over the seven months that it was operational (October 2014 - March 2015). As such, for every £1 invested the Rapid Response service has provided a net return of £2.07. However, the cost savings noted above do not take into account other potential savings associated with the service, such as a potential reduction in the number of patients entering long term domiciliary care, avoided admissions to nursing or care homes, or avoided ambulance journeys. Furthermore, the analysis does not take into account the benefits to patients such as increased or re-gained functional ability. Due to a lack of data these savings cannot be measured at this point.

What worked well:

- Feedback from staff indicates that the project integrated well with other services and agencies. Staff in supervisory or managerial roles reported having more contact with staff from other agencies and professions as a result of the service.
- Project monitoring data indicates that the service prevented 167 admissions and supported 51 early discharges during its seven months of service delivery.
- Feedback from staff also indicates that without the service patients would have remained in hospital for longer and patient case studies demonstrate the positive impacts of the service on the health and well-being of patients.
- Staff survey feedback (100% of 12 responses) indicates that they felt the project had increased communication between social services and hospital staff, and that this in turn had helped to improve the patient handover process.

What could be improved:

- Staff reported limited awareness of the service by GPs, suggesting there is a need to raise the profile of the service (and the benefits it can bring to the Health Service and the patients), possibly through a handbook for GPs of the local care services they can directly refer to.
- While the Rapid Response project had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected.
- The service focused on measuring benefits at service level however the outcomes for service users should be also measured, including patient's experience and the extent to which their quality of life has improved, alongside those measuring gains to health / social care services in order to provide a holistic view of the benefits being achieved.

1.6 Recommendations

This report sets out four thematic sets of recommendations regarding integration, outputs and outcomes, economic assessment and future prospects / sustainability. The points below reflect the headline recommendations; a full depiction is set out in Section 8 of the main report.

1.6.1 Integration

The project adopted an integrated approach at a strategic level as it was overseen by an integrated project board. Qualitative feedback from the staff survey[4] indicated the project had **increased communication between social services and hospital staff** and that this in turn had helped to improve the patient handover process. It was also noted that the **referral process from integrated Community Resource Teams (CRTs) worked well** and that the **project had helped improve communications and relationships** between the staff involved. However, while the Rapid Response service had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected.

Recommendations:

- **Objectives and targets should be set with regard to what effective integration and collaboration looks like for the service**. Research[5] by the Nuffield Trust states that this should include impact on health outcomes, but also improved quality of care, service user satisfaction, and effective relationships and systems.
- **Referral data should be examined to consider the specific numbers being referred by GPs and Primary Care Teams and whether there are opportunities to increase these**. The project should consider ways in which the profile of the service (and the benefits it can bring to the Health Service and the patients) can be raised with other health care teams such as GPs and OTs (e.g. through community nurses) in order to maximise referrals. In addition, in any future service it would be useful to pilot work with a number of GP practices in order to project the potential numbers or % of GP case load that could be referred.
- We recommend that an **up to date handbook of care service**s is available to all care agencies to sustain integration, to allow for direct communication between professionals, and to build confidence in care provision.
- **Research is needed to confirm that all of the target audience are being reached**. Further work is required to assess whether there are a number of patients that could be utilising this service, but who are not and the reasons for this. This could be done through reviewing the records in a number of wards for a period of time. This would

[4] An on-line survey of 12 staff members (50% of 24 staff)
[5] Nuffield Trust (2011) *What is Integrated Care?*

provide information on whether the service is being referred to appropriately, and the projected numbers to come through should there be more numbers identified**.**

- **The capacity of the Rapid Response service should be sufficient** to ensure that a tight turn around target of all those being referred are supported within two days.

1.6.2 Outputs / Outcomes

Outcome Measures

Project monitoring reports provided information on service level 'outcomes', specifically the prevention of hospital admissions and facilitating early discharge. These were key to ensuring that service was demonstrating a contribution to reducing the pressure for beds within hospitals. However, it should also measure the patient experience and how quality of life is improved for those who use its services. In addition, a number of areas that were detailed in the PID were not monitored. Specifically, there was no data collected against the following aims / service user outcomes:

- People will be further helped in their goal to remain healthy and independent;
- To delay and reduce the need for care and support;
- Enhance the quality of life for people with care and support needs; and
- Ensure that people have a positive experience of care and support.

Evidence on all of the above can be collected through surveys or interviews with service users. There is a strong body of evidence noting that the collection of feedback from service users is best practice in the evaluation of intermediate care services,[6] including patient satisfaction, health and well-being improvements (reablement)[7] and patient quality of life.[8]

Performance

The key areas of strength within the existing service were the:

- Development of domiciliary care capacity and systems within the council in a short period of time;
- Achievement of 167 people avoiding hospital and 51 people discharged sooner as a result of this service; and
- Delivery of the service on time and within budget, and ability to respond to short turnaround times for helping clients.

Areas for development include:

- SMART targets should have been established for the Rapid Response service at the outset (based on performance against a baseline / linked to an evidence based logic model) and in line with ICE-F guidance, which states outputs and outcomes should be

[6] For example see Kings Fund (2002) Developing Intermediate Care. A Guide For Health and Social Services Professionals.
[7] Kings Fund (2002) Developing Intermediate Care: A Guide For Health And Social Services Professionals
[8] Kings Fund (2014) Community services How they can transform care

defined at national, local and individual / personal level. In the absence of SMART targets, it has not been possible to effectively conclude on the success or effectiveness of the Carmarthenshire Rapid Response service.

- Only 10% of referrals came from the Primary Care teams. Targets are needed for referrals from those working in primary care. These should be set after a review of the numbers of people being referred to hospital by them that could be helped at home. Targets are also needed for the number of in-hospital referrals.

Recommendations:

- **Include measures relating to individual and personal objectives**. For example, this would include patients' quality of life, improvements in health and well-being and levels of satisfaction with the services provided. The data collected should be in line with national standards for reablement services[9] and ICE-F guidance.
- **Baseline and distance travelled data is required** to provide evidence of how the service has contributed to individual outcomes (for example, rating wellbeing at beginning of service, middle and at discharge or referral).
- **SMART targets should be developed for each objective**; and
- **Future reporting templates should detail quarterly and cumulative progress** against all the objectives and targets details in the PID.

1.6.3 Economic Assessment

The Rapid Response service was under budget by £47,109 which was mainly due to the lead in time required to establish the project, attract and appoint staff, and acquire the equipment necessary to run the service. However, the service prevented admissions for 167 patients (43% of all referrals) and facilitated the early discharge of 51 patients. This resulted in a gross cost saving of £812,945 / net cost saving of £548,505. Therefore, every £1 invest in the Carmarthenshire Rapid Response service provided a return of £3.07 (gross) and £2.07 (net). However, this approach only captures cost saving due to hospital bed days saved, as data on the number of days saved in relation to residential care were not collected in the monitoring reports and therefore this does not reflect the full cost savings to the health and social care system.

Recommendations:

- **We recommend that any future project collects detailed quantitative data relating to early discharge**, for example the number of days saved through each early discharge (not just the number of patients who have been discharged early), which would enable the project to make a more accurate assessment of its impact.
- **We recommend that data is collected that shows the reduced cost to residential and nursing home care services**.

[9] Reablement Gold Standards & Toolkit. Developed in partnership between WSP and the Social Services Improvement Agency during 2009/10 through the development of an action learning set involving Welsh LAs.

1.6.4 Sustainability and Future Prospects

Further research should be undertaken on the need and capacity in other council areas before the service is rolled out across Mid and West Wales. Specifically, an assessment of need should be completed to determine if there is a need to provide an urgent response to referrals for domiciliary care to prevent delayed discharges and help to avoid unnecessary admissions.

There is a need to determine if there is existing capacity within domiciliary care/reablement services in other Councils within Mid and West to continue to provide this urgent response service or is there a need for additional resources. Any research or review in this area should take a whole systems approach and therefore consider the level of potential referrals from hospitals and other relevant staff in the community (e.g. GPs / community organisations), as well as the capacity to deliver the service.

It is noted that the Carmarthenshire Reablement Service Structures are currently review under and it is understood that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care).

2 TERMS OF REFERENCE AND METHODOLOGY

2.1 Terms of Reference

The table below details the terms of reference for the overall evaluation.

Table 2:1: Terms of Reference

Terms of Reference
To examine the process and benefits of integrating health and social care services within the region with a view to assessing (as set out in analysis and reporting): • Whether the process of integration has worked as expected and what aspects have worked well or less well; • If and how processes of integration have contributed to or retarded progress towards outcomes; and • What practical lessons can be learned for the continuing integration of services within the region and more widely.
Assess, to the extent possible, the outcomes of a selection of the region's ICF projects (through evidence review and primary research): • Characterise and categorise the range of outcomes expected from the region's projects, distinguishing service-related outcomes from service user outcomes and intermediate from final outcomes; • Gather evidence from a sub-set of the region's projects to explore if, how and to what extent these outcomes have been realised; and • Comment, as far as possible, on future prospects for realising outcomes, given the progress made to date
Conduct, to the extent possible, an economic assessment (see section 7), focusing on: • The cost-effectiveness of the region's integrated service models, vis-à-vis non-integrated ways of delivering services; • The extent to which integrated care is more efficient than non-integrated care; and • The potential for cost avoidance/negated costs contributed by preventative approaches
Provide commentary on the future prospects for care integration within the region by (as set out in conclusions and recommendations): • Identifying approaches with potential for replication or scaling up (within the context of the Social Services and Wellbeing (Wales) Act); • Discussing options for sustaining approaches following the cessation of WG funding; • Recommending components of an outcomes-based performance framework for the future • Discussing the likelihood of outcomes being realised in future; and • Discussing the trade-offs between investing further in integrating care and continuing to invest in other forms of care.

2.2 Methodology

To achieve the requirements within the Terms of Reference the following methodological approach was used:

Table 2:2: Methodology

Methodological Element	Summary
Project Initiation and Initial Evidence Review	• Review of Project Initiation Document (PID) and Policy Context to outline what the project had set out to achieve / rationale for the project • A desk-based review of policy and literature regarding health and social care provision in Wales, including the integrated care context • Review of relevant literature (to outline the existing and new service user pathways and to develop an evaluation / logic model for the project in relation to outputs[10] and outcomes[11]) • A review and analysis of internal Rapid Response monitoring data, including financial data and progress reports • A desk based benchmarking exercise to identify and compare (to the extent possible) inputs, outputs and outcomes delivered by Rapid Response and other similar interventions
Primary Research	• A workshop and internal consultation with project managers across all six ICF projects involved in the evaluation, including group exercises to define pre and post service user pathways and service level logic models • An on-line survey of 12 staff members (50% of 24 staff)
Economic Assessment	Assessment of: • Value for Money (economy, efficiency and effectiveness) • Consideration of additionality, displacement and spillover effects • Estimation of cost savings and return on investment
Analysis & Synthesis	• Synthesis of qualitative and quantitative data • Identification of key lessons • Development of recommendations • Analysis of desk based and survey data.

This report reflects an evaluation of the Rapid Response Service that was part of the ICF pilot schemes. The PACEC remit has been to evaluate progress within a set timeframe of six pilot projects representative of 86 projects that received ICFs.

[10] Outputs are the measureable components of service delivery that can be quantified (e.g. number of patients supported per week) (http://info.wirral.nhs.uk/document_uploads/evidence-factsheets/12%20Logic%20Modelling%20factsheet%20Feb%202014.pdf)

[11] Outcomes are the effects of activities and resulting outputs. These can be divided into short, medium and long term (e.g. short – increased knowledge and skills; medium – improved patient independence; long – reduced health inequalities)

2.3 Evaluation Challenges

In conducting this evaluation there were a number of main challenges:

Availability of data: data had not been collected / reported on in project monitoring reports against each of the activities / objectives stated in the project PID, meaning it was not possible to conclude on performance.

Limitations of the methodology: while the Integrated Care Evaluation Framework (ICE-F) states that in order to evaluate and understand an integrated service it is necessary to measure performance indicators, service outputs and personal outcomes achieved by the individual using the service, the evaluation team were not permitted to gather feedback from service users which meant there is limited evidence on the individual outcomes being achieved.

Cost savings: This evaluation was requested to identify potential cost savings to the Health and Social Care sector in Wales and to therefore provide an initial indication of potential savings which could be obtained from rolling out comparable schemes on a wider basis. This evaluation has identified the reduction in use of hospital (NHS) bed days as a proxy indicator for cost savings i.e. the unit cost of an NHS bed day is estimated at £426[12]; any identification of number of days saved per beneficiary due to intermediate care allows for a calculation of gross cost savings. The evaluation challenge is that this only reflects the use of one indicator, and for a number of projects dealing with preventative care services, there will be other 'non-captured' cost savings, for example, the cost of a handrail installation (c. £100-200) may serve to actually prevent a serious fall in the home, and these benefits may not be captured in the short-term. This means that there is a challenge in identifying cost savings in their entirety, due to the use of one indicator in the context of other service benefits over time. This does not allow for a full reflection of the actual cost saving potential of some intermediate care schemes.

[12] Welsh Government | *Health statistics Wales. Finance. 2012/13*. Available at: http://gov.wales/statistics-and-research/health-statistics-wales/?lang=en.

3 BACKGROUND

In July 2015 PACEC was commissioned by the Mid and West Wales Health & Social Care Collaborative (HSCC) to undertake an evaluation of the Intermediate Care Fund (ICF or the Fund). The evaluation involves a review of the overall programme and six of the ICF funded projects. This report evaluates the Rapid Response project.

3.1 Intermediate Care Fund (ICF)

The ICF was introduced by the Welsh Government in April 2014 to assist in the development of new models of delivering sustainable integrated services that maintain and increase people's wellbeing and independence, and promote improved care coordination across social services, health, housing and other sectors. A one off allocation of £50 million within the devolved Welsh Government budget was made available in 2014/15 across Wales via ICF, comprising £35 million revenue funding and £15 million capital.

The purpose of the Fund was to:

- Encourage integrated working between local authorities, health and housing; and
- Support older people, particularly the frail elderly, to maintain their independence and remain in their own home.

The total Fund is £8.4 million[13] which was shared between the four local authority areas as follows:

Table 3:1: Breakdown of ICF Funding 2014 / 15

Area	Revenue		Capital		Total	
Powys	£1,500,000	26.7%	£749,000	26.6%	£2,249,000	26.7%
Ceredigion	£801,000	14.2%	£400,000	14.2%	£1,201,000	14.2%
Pembrokeshire	£1,268,000	22.5%	£634,000	22.5%	£1,902,000	22.5%
Carmarthenshire	£2,058,000	36.6%	£1,029,000	36.6%	£3,087,000	36.6%
Total	**£5,627,000**	**100.0%**	**£2,812,000**	**100.0%**	**£8,439,000**	**100.0%**

Source: Intermediate Care Fund Mid and West Wales – Half Yearly Report – November 2014

[13]Intermediate Care Fund Mid and West Wales (November 2014) Half Yearly Report

ICF was intended to build on existing service arrangements and test out new approaches to intermediate care that would:

- Ensure a citizen focused approach to service planning and delivery;
- Promote independence among elderly individuals;
- Encourage further integration across health, social care and the wider sector;
- Foster direct engagement with key partners within local government (for example housing and the third sector in developing and delivering an ambitious programme of change in the region); and
- Make a key contribution to the delivery of commitments within the Hywel Dda and Powys area.

Over 70 individual projects were funded[14] delivering against two themes: "Investing to Go Further" and "Investing to Join Up". Investing to Go Further aims to increase integrated intermediate care capacity in order to prevent hospital admissions and maximise people's independence following a crisis. Investing to Join Up has the aim of building community resilience, creating environments receptive to intermediate care and contributing to its sustained success.

3.2 Rationale for the Rapid Response Project

The rationale for the Carmarthenshire Rapid Response service was set out in the Project Initiation Document (PID)[15] and is based on research from the National Institute of Health Research (NIHR) into the effectiveness of prevention services in adult social care[16]. This found that reablement services improved outcomes for 50–90% of the older people who used them, as demonstrated through their need for less or no support than when they initially contacted the service. Moreover, a report from the Centre for Workforce and Intelligence[17] identified a number of key benefits from Rapid Response services operating across England, as summarised in table 3.2.

[14] Intermediate Care Fund Mid and West Wales – Half Yearly Report – November 2014
[15] Domiciliary Rapid Response – Project Initiation Document (June 2014)
[16] http://blogs.lse.ac.uk/socialcareevidenceinpractice/2013/02/21/prevention-services-in-adult-social-care-reablement/
[17] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/864/updated_integrated-care-for-older-people%5B1%5D.pdf

Table 3:2: Identified benefits of a Rapid Response Service

Benefit identified	Explanation
Quality of care	Rapid Response services have high patient satisfaction because patients have the ability to choose whether they want their care to be delivered at home. Patients are also typically assessed within a few hours of referral.
Productivity and efficiency benefits	Data from the Salford Rapid Response team showed that the model avoided 3% of total A&E admissions which resulted in estimated net savings of £137million/year in Salford.
Workforce	A literature review conducted by the CfBT Education Trust[18] found that multi-agency working had a number of positive impacts on professionals such as increased knowledge and understanding of other agencies, as well as improved relationships and communication between agencies.

Source: Centre for Workforce Intelligence

3.3 Rapid Response Service – Funding, Aims and Objectives

The Carmarthenshire Rapid Response service was awarded £311,550 from the ICF via the Mid and West Wales Health and Social Care Collaborative from June 2014 to March 2015. The service was established with the main aim of further enhancing collaboration and integration of Carmarthenshire health and social care services and delivering 'Care Closer to Home'.[19] Other key aims for the Carmarthenshire Rapid Response service as set out in the PID[20] were:

- To strengthen the domiciliary team to be able to provide a model of anticipatory care to the frail elderly as well as to those with chronic conditions and palliative care needs whose needs can ebb and flow (rise and fall) overtime;
- To successfully reduce the number of people admitted into hospital and deliver more timely discharges of patients back in to the community;
- To further help people in their goal to remain healthy and independent;
- To enhance the quality of life for people with care and support needs;
- To delay and reduce the need for care and support; and

[18] http://www.nfer.ac.uk/publications/MAD01/MAD01.pdf
[19] This is part of a multi-million pound investment by the Welsh Government in local health services across Wales to help the NHS deliver more care closer to people's homes and reduce pressure on hospital services. This is part of the Welsh NHS Primary Care Fund aimed to improve primary care in Wales. For more information see: http://gov.wales/newsroom/healthandsocialcare/2014/141106primary-care/?lang=en
[20] Source: Domiciliary Rapid Response – Project Initiation Document (June 2014)

- To ensure that people have a positive experience of care and support.

The PID notes that in meeting these objectives the service was to:

- Respond to GPs and District Nurses who would identify service users in the community that would benefit from hospital avoidance and be able to remain safely at home;
- In-reach to referrals from the acute hospital departments of Accident and Emergency and CDU to remove people who are medically fit and ready for discharge out of the hospital setting, and return them safely to the community;
- Enhance access for service users requiring domiciliary rapid response support in order to prevent hospital admissions;
- Develop a domiciliary care service to provide an urgent response to the needs of people who are experiencing a crisis due to an acute or chronic condition; and
- Provide a rapid response to the telecare community alarm system when activated for assistance.

3.4 How the Rapid Response Service Operates

The Carmarthenshire Rapid Response service is delivered throughout Carmarthenshire from three bases which are co-terminous with the other Health and Social Care structures in the area (they are Llanelli, Amman Gwendraeth and 3 Ts). Each of these three localities also has Community Resource Teams (CRTs) and GP lead Multidisciplinary Teams (MDTs).

The service operates from 7am to 10pm and is targeted towards patients who otherwise would have been admitted to hospital or would not have been discharged. The service is focused on the rehabilitation of patients and provides intensive support for short periods (e.g. up to 6 weeks), however in some cases the service facilitates discharge from hospital until a long term care package can be put in place.

The core Rapid Response Team consists of 24 Domiciliary Care workers (including supervisors and managers) and a Support and Development Manager who are responsible for providing personal care to patients referred to them. The team works alongside other health and social services staff who are also responsible for providing care in the home, including Social Workers, District Nurses and Occupational Therapists (OTs). The service accepts referrals from a wide range of sources and aims to get domiciliary care packages in place within 2 days (where appropriate), as detailed in table 3.3.

Table 3:3: Source of Referrals to the Rapid Response Service (June 2014 - March 2015)

Source of Referrals	Number	%
Careline (telecare)	214	54.3%
Staff within Community Resource Teams	79	20.1%
Staff within Primary Care Teams	40	10.2%
Llanelli Central MDT	16	4.1%
Llanelli West MDT	14	3.6%
Llanelli East MDT	12	3.0%
Convalescence	3	0.8%
Meals On Wheels	1	0.3%
Other	15	3.8%

Source: Rapid Response Patient Data provided to PACEC – October 2015

Table 3.3 shows that the majority of referrals (up to October 2015) came from the telecare service, Careline (54.3%). The other most common sources of referral were from staff from within the CRTs (20.1%) and staff within the primary care teams. The referrals from CRTs may also include those who are also in Primary Care Teams, such as District Nurses and other professionals linked to GPs. The Support and Development Manager noted that the team (such as Domiciliary Team Managers and Supervisors) were in regular contact with Primary Care Teams through the CRTs. The table below sets out the response times for the service.

Table 3:4: Rapid Response Service Response times (June 2014 – March 2015)

Response time from referral	%
Same day	75.6
1 day	8.9
2 days	2.8
3 days	1.8
4 days	1.3
5+	6.9
Unknown	2.8
Total	100

A high proportion of patients referred were seen within the target time of 2 days (87%) while a small proportion (6.9%) took 5 days or more. Feedback provided by the Project Manager indicates that almost half of those that took more than 5 days relate to patients were Rapid Response was used as an interim arrangement until a long term care package could be established. Therefore, these referrals may not have been entirely appropriate and may make the service appear less effective.

3.4.1 User Pathways

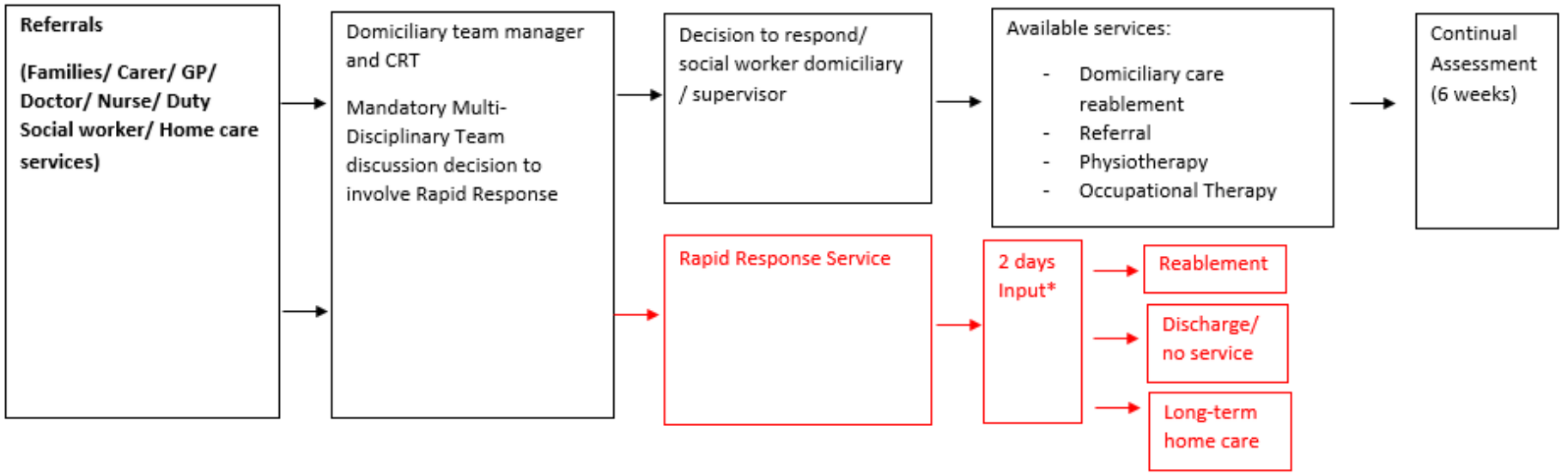
The evaluation team met with the Support and Development Manager to understand how the service developed as result of the ICF funding and how it differed from the service that was provided before.

The before and after ICF funding patient pathways were drafted by the evaluation team and agreed with the project manager. The figure overleaf shows the new Carmarthenshire Rapid Response service within the wider Domiciliary Care service as the red pathway.

As illustrated the process for the Rapid Response service is: patients are assessed by the Multi-disciplinary team (MDT) within Social Services. If the needs of the patient are deemed to be urgent or, the patient is in crisis, the MDT will refer the case to Carmarthenshire Rapid Response and there is a target these will be responded to within 2 days.

It should be noted that there are no specific referral criteria for the service, however referrers are asked to use their professional judgement and their assessment of patient's needs. Prior to the implementation of Carmarthenshire Rapid Response social workers would have made an assessment and if domiciliary care was required the patient would then go onto a waiting list which could be up to 6 weeks. Furthermore, the care packages provided under the Carmarthenshire Rapid Response service were likely to be more intensive (i.e. more hours provided each day and be more focused on regaining functionality), and provided for a much shorter period of time (up to six weeks).

Figure 3:1: Care Pathways before and after the ICF funding for Rapid Response (2014/15)



The following case study provides an example of the activities provided by the Carmarthenshire Rapid Response service under this process.

Table 3:5: Case study illustrating how Rapid Response operates in Carmarthenshire

Case Study- Mrs P Enhanced Hospital Discharge	
Background	Mrs P's recent hospital admission was due to a fall which caused a fractured hip. Mrs P's medical history is of a previous CVA, dementia and she is partially sighted. Whilst in hospital Mrs P continued to fall when trying to get in and out of bed and was regularly muddled, confused with poor orientation to time and place, and had been verbally and physically aggressive to the staff on the ward. Mrs P prior to admission lived at home with her daughter and family. To plan for a safe return home the Carmarthenshire Rapid Response service was commissioned until capacity was available within Reablement in two weeks' time.
Rapid Response Intervention	Initial Care package - 4 calls per day x 2 Domiciliary Support Workers to work towards gaining skills and independence with personal care, dressing, undressing and toileting.
Outcome	Within the first few days it was evident that Mrs P could weight bear and was able to mobilise slowly with minimal assistance. Mrs P, in her home environment, was calm, content and happy to be back with her family. On transfer to Reablement two weeks later the care package was for one worker three times per day. Without the initial input of the Carmarthenshire Rapid Response Team this return home would have been delayed for another 2 weeks.

Source: ICF RR 14-15 Year End project report

Summary

The Carmarthenshire Rapid Response service was provided with £311,550 funding from ICF over the period June 2014 to March 2015. It was designed under a reablement model to address an identified need for additional capacity within domiciliary care in order to respond urgently to referrals from a wide range of agencies including hospitals, GPs and telecare providers. It was recognised that the provision of this type of service can facilitate early discharge and prevent unnecessary hospital admissions for older patients, with research noting that benefits of a Rapid Response service include improved quality of care, reduced hospital admissions and increased knowledge and understanding within multidisciplinary teams.

4 CONTEXT, LITERATURE REVIEW & LOGIC MODEL

4.1 Introduction

This section sets out the context in which the Rapid Response service operated in Carmarthenshire as well a brief summary of the literature relating to benefits and the outcomes that can be expected from such services.

4.2 Socio-economic context

4.2.1 Carmarthenshire Population

People over 65 in Carmarthenshire account for 22% of the total population.[21] As shown in table 4.1, these numbers are expected to grow by 11% (n=4,433) by 2020.

Table 4:1 Carmarthenshire Population Projections for People Aged 65 and Over[22]

Year	Males Aged 65 and Over	Females Aged 65 and Over	Total Population Aged 65 and Over
2014	19,307	22,368	41,676
2015	19,729	22,684	42,413
2016	20,100	23,015	43,115
2017	20,486	23,364	43,850
2018	20,859	23,758	44,616
2019	21,259	24,097	45,356
2020	21,641	24,468	46,109

Source: Stats Wales https://statswales.wales.gov.uk/Catalogue/Population-and-Migration/Population/Projections/Local-Authority/2011-Based/PopulationProjections-by-LocalAuthority-Year

This highlights a growing level of demand for health and social services as well as the need for innovative solutions / models of delivery that can provide the supports needed more cost efficiently and effectively to the public purse.

[21] Carmarthenshire County Council: http://www.carmarthenshire.gov.wales/media/824482/county_profile.pdf.

[22] This change relates to the increase of older persons in Wales under the definition solely that these people are over 65. It is anticipated that in future years healthy life expectancy years will improve; and hence service demand for this age bracket will not necessarily increase in line with the growth in size of the number of people over the age of 65. Sourced via: Kings Fund (2014) *Making our health and care systems fit for an ageing population*

4.2.2 Rural Areas and Need for Health and Social Care Support

The Carmarthenshire Rapid Response service covers a geographically large area and many parts of the county are very remote and sparsely populated. Research suggests that the costs of rural services are higher because of the geography of rural areas and the smaller dispersed populations within them. Specifically, a comprehensive review[23] of evidence on the additional costs of service provision in rural areas concluded that there was a clear cost premium in order to achieve a similar standard of service to that in urban areas.

Furthermore, people who live at exceptionally rural parts of the county may experience particular difficulties accessing domiciliary support should they require it urgently to prevent hospital admissions, convalescence bed or residential care. The Carmarthenshire Rapid Response service covers the whole county, responds to urgent referrals and supports clients until the crisis is resolved or, another agency is able to accommodate, although this can often be for some time.

4.3 Evidence Review - Rapid Response

There is a wide range of evidence demonstrating that community based, intermediate care services are effective in reducing hospital admissions, supporting early discharge and delivering a higher quality patient experience.[24] The literature suggests that effective Rapid Response services include the following measures:

Service Outputs / Outcomes:

- Reduction in unscheduled admissions - the reduction of inappropriate admissions to acute or residential care has been identified as part of the role of intermediate care[25].[26].[27]. Small-scale studies of rapid response teams suggest that their provision of health and social care services in the community has an important role in supporting people to remain in their own homes. In the Brooks' study referenced of a new intermediate care rapid assessment support service, just four (5%) of all the older people using the service were admitted to an acute hospital.
- Reduced hospital admissions - an analysis of community based intermediate care showed that care provided at home and effective discharge planning can reduce hospital admissions by 15%[28];

[23] Hindle, T., Spollen, M., and Dixon, P. (2004) Review of the evidence on additional costs of delivering services to rural communities

[24] Imison, C, Thompson, J, Poteliakhoff, E (2012). *Older people and emergency bed use.* London: The King's Fund

[25] Beech, R. et al. (2004) 'An evaluation of a multidisciplinary team for intermediate care at home', *International Journal of Integrated Care*, no 4 (October−December).

[26] Brooks, N. (2002) 'Intermediate care rapid assessment support service: an evaluation', *British Journal of Community Nursing*, vol 7, no 12, pp 623−633.

[27] Kaambwa, B. et al. (2008) 'Costs and health outcomes intermediare care: results from five UK cases sites', *Health & Social Care inthe Community*, vol 16, no 6, pp 573−581.

[28] Shepperd, S. et al. (2009) 'Avoiding hospital admission through provision of hospital care at home: a systematic review and

- Reduced delayed discharges - a Health Foundation study found that hospitals can reduce delayed discharges if they have access to services that can react to patients needs quickly[29]; and
- Reduced dependency on services - a study by the RCN on a Scottish Rapid Response service found that a reablement focused, Rapid Response service is likely to be more efficient than other forms of care in the community as they are focused on regaining independence and therefore reduce dependency on other services[30].

Service user / patient outcomes include:

- Increased independence - the Kings Fund notes that intermediate care is effective with regard to helping users regain independence[31];
- Improved access to other health and social care services[32]; a Centre for workforce intelligence report noted that due to the range of professionals that are involved in intermediate care, patients' access to a wider range of services is increased[33]; and
- Improved experience / quality of life - for example a review of Bristol Rapid Response service found significant improvements in patients' experience. Furthermore, other studies have found that patients who accessed reablement services demonstrated a significant short-term improvement in perceived health and quality of life.[34]

4.4 Logic Model

Logic models set out, based on evidence, the inputs and outputs needed to deliver on the expected outputs. The following logic model has been developed using the evidence noted in section 4.3 regarding other Rapid Response Services. It provides evidence of the KPIs used to measure performance of other Rapid Response programmes and allows a comparison with the measures used in the Carmarthenshire Rapid Response service.

meta-analysis of individual patient data'. Canadian Medical Association Journal, vol 180, no 2 pp 175-82.

[29] Health Foundation (2013). Improving patient flow: how two trusts focused on flow to improve the quality of care and use available capacity effectively. London: Health Foundation.

[30] Http://www.rcn.org.uk/__data/assets/pdf_file/0005/592601/Gail_Meier_Short_term_augmented_response_service_STARS.pdf

[31] Kings Fund (2002) Developing Intermediate Care. A Guide for Health and Social Care Professionals.

[32] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/864/updated_integrated-care-for-older-people%5B1%5D.pdf

[33] Kings Fund (2002) Developing Intermediate Care. A Guide for Health and Social Care Professionals.

[34] Kings Fund (2014) Community services How they can transform care. Nigel Edwards

Table 4:2: Illustrative Rapid Response Logic Model

Inputs	Activities	Outputs	Outcomes
Salaries Admin and Equipment Travel costs.	Appointment of team Awareness raising across primary, acute and community sector stakeholders Assessments Development of Processes Response to referrals within time lines Signposting to other services (as appropriate to patients' needs) Personal care provision.	Number of Referrals / by source Number of users seen / supported in line with target waiting times / response times Number diverted from hospital admission/Number of people discharged early/Improved patient flow in hospital and community services[35]	**Service Related Outcomes** • Reduction in the number of unscheduled hospital admissions of over 65 yr. olds [36] • Reduction in the length of hospital stay for patients over 65 / Reduction in delayed discharge[37] • Community and hospital resources used more efficiently[38] • Reduce pressure on other parts of community & hospital services[39] **Service user Outcomes[40]** • Quality of life of service users is improved [41] • Service users regain or maintain independence / functionality[42]; • Improved access to services for patients[43]/ Speedier and more appropriate referral of the patient[44]

[35] Health Foundation (2013) Improving patient flow
[36] Health Foundation (2013) Improving patient flow
[37] Kings Fund (2014) Community services: How they can transform care. Nigel Edwards.
[38] http://www.rcn.org.uk/__data/assets/pdf_file/0005/592601/Gail_Meier_Short_term_augmented_response_service_STARS.pdf
[39] Health Foundation (2013) Improving patient flow.
[40] The service user outcomes should be monitored by user profile to ensure equality and build understanding of the service i.e. gender, age, source of referral, user needs etc.
[41] Kings Fund (2014) Community Services: How they can transform care. Nigel Edwards.
[42] Kings Fund (2002) Developing Intermediate Care A Guide For Health and Social Services Professionals
[43] Centre for Workforce Intelligence Older People Care Pathway Team June 2011
[44] Centre for Workforce Intelligence Older People Care Pathway Team June 2011

Key Findings

Research shows that older people may be admitted to hospital or kept in hospital longer than required due to a lack of support / help at home, resulting in a significant cost to the health and social care system and a poorer experience for patients. ICF monies for the Carmarthenshire Rapid Response service were used to address this need by providing a domiciliary care service that provides an urgent response to prevent unnecessary hospital admissions and to facilitate early discharge from acute hospitals.

5 INTEGRATION

5.1 Introduction

The following section details integration[45] of stakeholders at strategic and operational levels.

5.2 Pre ICF Integration Levels

The Whole Systems Partnership Report issued in March 2014 set out the current situation at that time with regard to integration between health, social care and housing. It stated that:

- *'There is no **common language** for intermediate care in the Mid and West Wales area;*
- *Whilst there had been some progress there were **variable levels of integration** between health and social care and there had been little integration with the third sector or housing services.*
- *No consistent or robust **information base** on levels of need or housing services*
- *No consistent or robust basis for **constructing proposals or evaluating costs and benefits** for further development of intermediate care services'.*

A mixed methods approach was used to measure the distance travelled with regard to the integration between these services (e.g. using surveys and interviews to ask staff and stakeholders regarding change in integration, use of language and systems and use of consistent processes throughout the funding period).

This section reviews the extent to which ICF has progressed in each of these areas based on the feedback provided.

5.3 Strategic Level Integration

5.3.1 Project Board

The project is overseen by an Integrated Project Board, which includes Carmarthenshire County Council Social Services Directors, Hywel Dda University Health Board Heads of Service and a third sector representative (Pembrokeshire Association for Voluntary Action (PAVS)). Therefore relevant organisations are represented on the Project Board and at a sufficiently senior level to make decisions and to influence the structure and delivery of the project. The project board met monthly from June 2014 to March 2015 and reviewed progress against the Projection Initiation Document (PID).

Therefore, the Project Board brought together representatives from different sectors, however there is insufficient evidence to conclude on the effectiveness of this structure.

[45] By integration this refers to in principal "a single system of needs assessment, service commissioning and/or service provision" to deliver health outcomes (Health and Well-being Best Practice and Innovation Board (2013) *The Determinants of Effective Integration of Health and Social Care*)

5.4 Operational level integration

5.4.1 Project Management, Structure and Resources

There is a dedicated Support and Development Manager (SDM) for service provision who is employed by Carmarthenshire County Council and reports to the Senior Service Manager. The SDM represents the Senior Manager at Regional Project Board meetings. This structure allows the Support and Development manager access to all the organisations who are key to the delivery of the project.

Table 5:1: Staff Structure for the Rapid Response Service

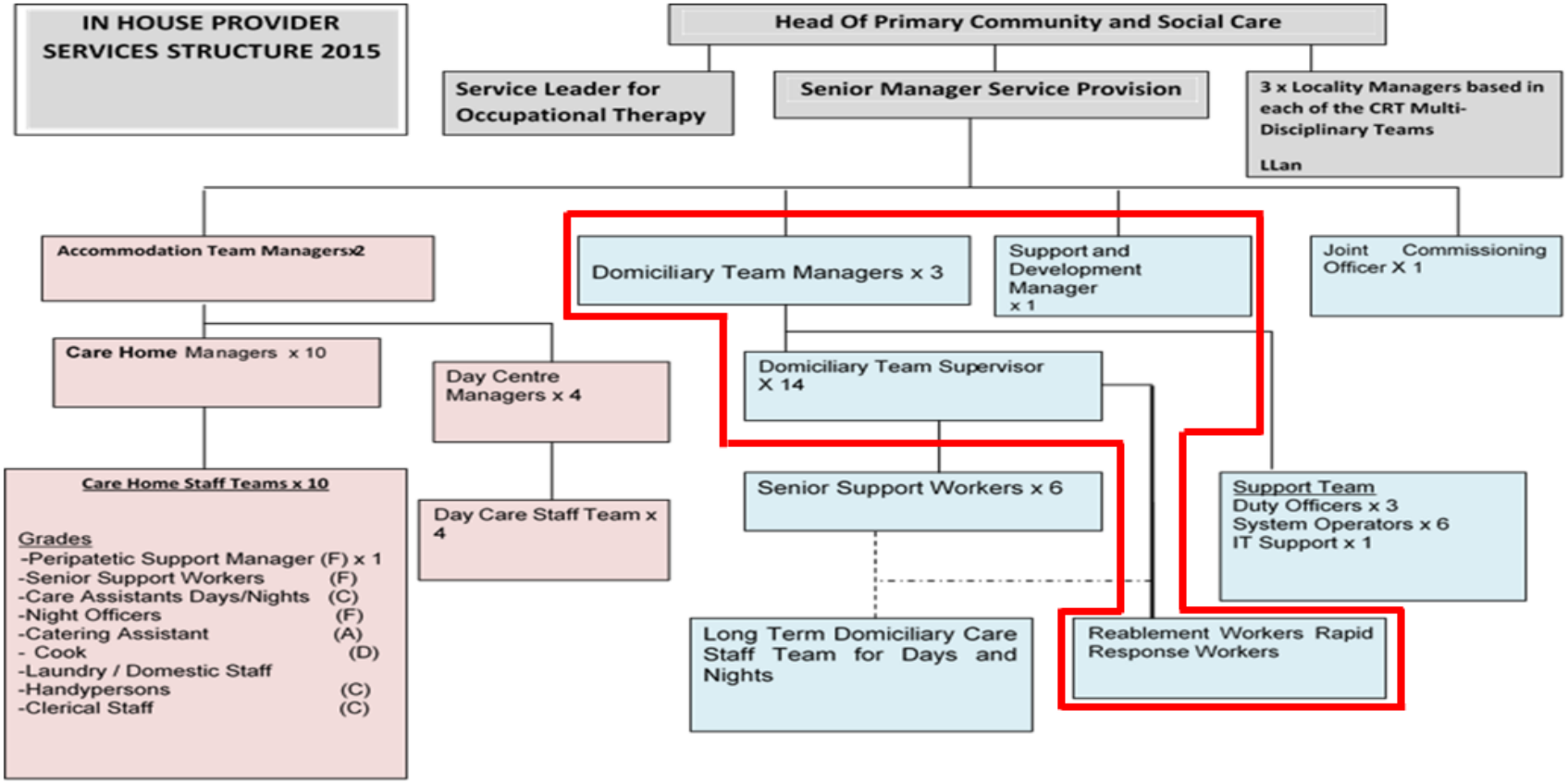
Role	Details / Purpose
Support and Development Manager (x1)	Oversees implementation of the Rapid Response Service
Domiciliary Support Workers (x24)	Provision of care and support to service users 24 @ 261/4 hours per week- 2 shifts: Early Shift 7am-3pm Late Shift 2pm – 10pm

Source: Project Initiation Document – June 2014

The Support and Development Manager is based within the Provider Service Team and works from a centralised location in Carmarthenshire to manage the service. This post supports service development and Team Managers.

The following figure shows the current connections between Rapid Response, domiciliary care and other social services teams including the multi-disciplinary CRTs and long term domiciliary care services.

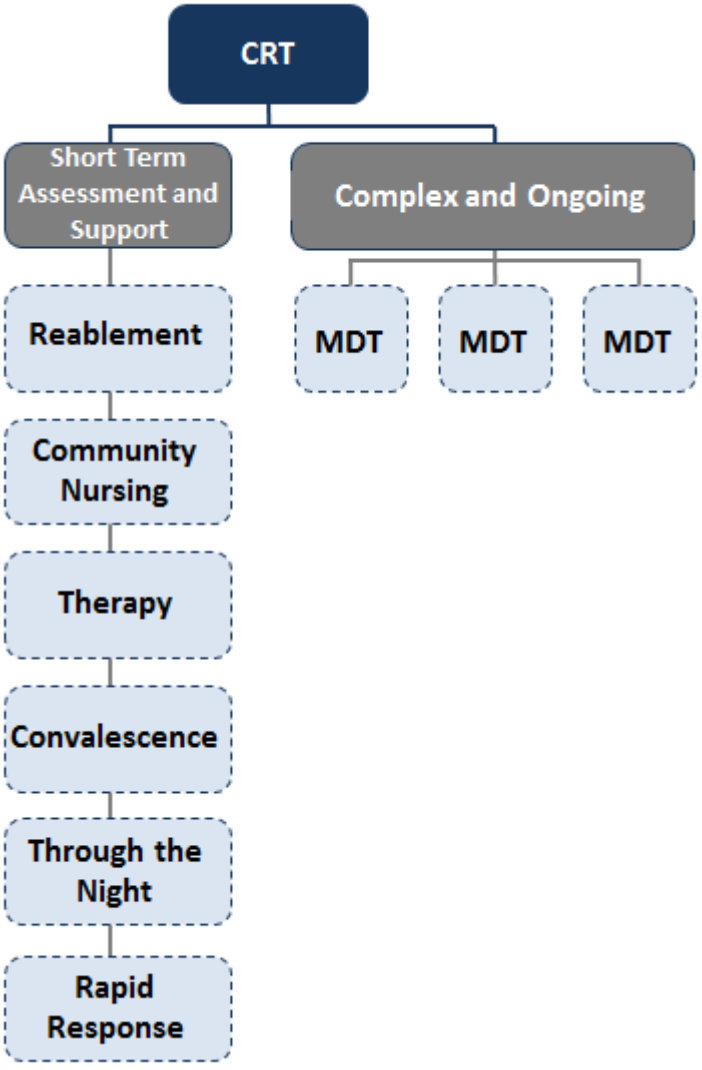
Figure 5:1: Overview of how Rapid Response currently sits within the overall Domiciliary Care Service



Source: Rapid Response- Reablement - Staffing June14

It is noted that there is currently a review underway of all short term intervention services, it is envisaged that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care). An outline of the proposed new structure is in figure 5.2.

Figure 5:2: Proposed New Structure



Source: Support and Development Manager

5.4.2 Staff Feedback on Integration

As part of the evaluation staff were surveyed (see appendix B) about their views on the Carmarthenshire Rapid Response service and their experiences of working as part of an integrated team. Twelve members of 24 staff (50% response rate) provided feedback and a summary of this is provided below.

Staff in supervisory or managerial roles reported having more contact with staff from other agencies and professions as a result of the service. For example, they noted that hospital staff were now more likely to contact them and ask for advice on who to refer and / or make referrals to the service. 100% of staff who responded to the survey agreed or strongly agreed that that there was effective multi-disciplinary team working in the service and two respondents specifically noted that the service had improved patient handover procedures. However, a small number of staff also **suggested areas for improvement**:

- **Communication**: one respondent felt that communication between the service and hospital staff could be improved. Two respondents also noted that there should be increased levels of communication with OTs and another two felt communication with the Primary Care teams could be improved. These respondents believed that there was a low level of awareness of the service amongst GPs, particularly with the Out Of Hours (OOH) service.
- **Standards**: one interviewee noted different competencies and standards for staff from different agencies, which made working as part of a multi-disciplinary, multi-agency team more difficult. For example, District Nurses work to Health Standards[46] while Care Workers work to standards set out by the Care Council Wales (CCW).[47] This interviewee believed that the service would be more effective and streamlined if the same standards/competencies could be used. Whilst these reflect different lines of work, there may be scope to explore the use of common standards and associated competencies.

5.5 Risk Management

An initial risk assessment[48] was undertaken at the project planning stage. The risk plan developed as a result of this assessment highlighted risks regarding: getting staff recruited on time; ensuring that there was sufficient capacity within Domiciliary Care to meet demand; inappropriate referrals to the service; and funding not being available to deliver the service in the future.

The lack of integrated working was not noted as a risk, however it was partially mitigated through the appointment of experienced domiciliary care staff, who already had relationships

[46] http://www.qni.org.uk/docs/DN_Standards_Web.pdf
[47] http://www.ccwales.org.uk/national-occupational-standards/

[48] Domiciliary Rapid Response – Project Initiation Document (June 2014)

developed with hospital staff, and therefore able to get referrals. However, there was a need to develop closer working relationships with more GPs.

Key Findings

The project adopted an integrated approach at a strategic level as it was overseen by an integrated project board. Qualitative feedback from staff indicated the project had increased communication between social services and hospital staff and that this in turn had helped to improve the patient handover process. It was also noted that the referral process from integrated CRTs worked well and that the project had helped improve communications and relationships between staff from the various agencies.

Whilst the services are delivered solely by Carmarthenshire County Council Social Services staff, the project has provided the opportunity for them to work more closely with staff from other organisations including Hywel Dda Health Board and the integrated CRTs.

Staff survey feedback indicates that they felt the project had increased communication between social services and hospital staff and that this in turn had helped to improve the patient handover process. It was also noted that the referral process from integrated CRTs worked well and that the project had helped improve communications and relationships between staff from the various agencies.

Areas for Development

While the Rapid Response project had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected. Research[49] by the Nuffield Trust states that this should include impact on health outcomes, but also improved quality of care, service user satisfaction, and effective relationships and systems.

Going forward, the project should consider ways in which the profile of the service (and the benefits it can bring to the Health Service and the patients) can be raised with other health care teams such as GPs and OTs, possibly through e.g. community nurses, in order to maximise referrals.

[49] Nuffield Trust (2011) *What is Integrated Care?*

6 PROJECT MONITORING AND OUTCOMES

6.1 Introduction

The following section provides an assessment of the extent to which any service related and service user outcomes[50] have been realised from June 2014 to March 2015 and how outcomes have been monitored.

6.2 Monitoring and Reporting

6.2.1 Data Collection and Reporting

The Support and Development Manager collates data from Service Managers and Supervisors. Quarterly reports were submitted to the Project Board. These reported on:

- Total funding allocation / spend for each quarter / total spend to date and any underspend;
- Number of referrals / people who accessed the service;
- Number of potential hospital admissions diverted / avoided;
- Number of patients that have been discharged early; and
- Qualitative examples of the services in the form of short case studies.

An end of year report followed the same format and provided information on achievements from June 2014 to March 2015.

The quarterly and end of year reports primarily provide information on the following three objectives:

- Increased integrated Rapid Response capacity will reduce unscheduled admissions to hospital;
- To achieve increased Rapid Response Capacity, working towards the achievement of an optimised function in which 15% of potential unscheduled over 65 medical admissions are to be avoided through provision of alternative support; and
- Provide a rapid response to the telecare community alarm system when activated for assistance.

[50] Outcomes for integrated care are centred on the impact services have on a person's life. The Social Policy Research Unit split outcomes into four separate categories Quality of life outcomes/personal outcomes – daily living and acceptable quality of life; Process outcomes – individual experience of support; Change outcomes – improvements to physical, mental or emotional functioning; and Maintenance outcomes – no change in condition (Glendinning, C., Clarke, S., Hare, P., Kotchetkova, I., Maddison, J. and Newbronner, L. (2006) Outcomes-focused Services for Older People, SCIE Knowledge Review, 13)

Monitoring and Reporting – Areas for Development

There are areas included in the PID which are not monitoring or reported on. These are:

- To further help people in their goal to remain healthy and independent;
- To enhance the quality of life for people with care and support needs; and
- To ensure that people have a positive experience of care and support.

Given that there are set as objectives for Rapid Response, it is important that there is evidence that the service is delivering on these.

Furthermore, data is collected on response times for referrals, however this data is not reported to the project board. This is a key indicator as the Carmarthenshire Rapid Response service was established to provide a faster service than the service that had existed previously. Reports should therefore measure performance in these areas.

There is currently no process in place to collect satisfaction data, quality of life or feedback on their experience of the service. It is suggested that KPIs are set for these areas such in line with those suggested in the logic model (see section 3; i.e. service user satisfaction and quality of life) and evidence should be collected against these using robust tools such as the Older Peoples Quality of Life Questionnaire (OPQOL).[51]

ICE-F guidance[52] states that the assessment of the impact of delivering integrated care needs to be considered at three levels; national, local and individual:

- National Objectives: For example, the number of over 65s length of stays in hospital will be reduced; a reduction in A&E call outs and emergency admissions for over 65s
- Local, service or organisational objectives: For example, output measures concerned with service efficiency and performance could monitor avoidable admissions, unnecessary length of stays, number of planned care admissions against emergency admissions for over 65s. Costs can be calculated according to service use; and
- Individual or personal objectives for the individual for the service users: Social Cost benefit / outcomes measures: For example, individuals and their carers can maintain contact with a key health or social care professional with whom they can discuss their care needs and can plan and refer care as necessary. The individual's wellbeing, independence and capability can be measured against their desired outcomes from receiving the service delivered.

The Carmarthenshire Rapid Response service has KPIs at national and local level, however KPIs should be developed at individual level. In addition, baseline or distance travelled data is required to provide evidence of how the service has contributed to individual outcomes (for example, rating wellbeing at beginning of service, middle and at discharge or referral).

[51] Bowling, A. an Stenner, P. Journal of Epidemiology and Community Health 2011;**65**:273-280

[52] Dr Carnes-Chichlowska, Susan; Professor Burholt, Vanessa & Dr Rea, David (2015) The Integrated Care Evaluation Framework (ICE-F): *A Realistic Evaluation of Integrated Health and Social Care Services in Wales*

6.3 Performance over the Evaluation Period

The Rapid Response PID sets out a number of activities that were required to take place in order to meet the objectives. These were reported on quarterly, as summarised in the table below:

Table 6:1: Performance against Objectives (June 2014[53] – March 2015)

Activities [54]	Performance
Respond to GPs and District Nurses who identify service users in the community that would benefit from hospital avoidance and be able to remain safely at home	**Activity Completed:** Consultations with key stakeholders and staff suggested there was a low level of awareness of the service amongst GPs and in particular the GP OoH service. This point of view is further validated by the low level of referrals to the service from Primary Care teams (10%). However, GPs were not consulted as part of this evaluation and therefore their reasons for low referrals is not known. **No specific targets were developed for this activity / objective. In any future service, it would be useful to pilot work with a number of GP practices in order to project the potential numbers or % of GP case load that could be referred. These %s could then be applied to other GP practices.**
In-reach to referrals from the acute hospital departments of Accident and Emergency and CDU to remove people who are medically fit and ready for discharge out of the hospital setting and return them safely to the community	**Activity Completed:** The project monitoring reports state that the service has been able to reach 51 people who were medically fit but in hospital and to facilitate their discharge. This will have contributed to service level outcomes including improved patient flow, freeing up of vital hospital resources and produced costs savings. It is not possible to calculate the cost savings (due to those who are medically fit but in hospital) as the number of days saved for each patient is not collected. **No specific targets were developed it is unclear as to whether all the potential patients that could have been referred where referred. Further work is required again to assess whether there are a number of patients that could be utilising this service, but who are not and the reasons for this.**

[53] Recruitment of existing internal staff for the Rapid Response Service commenced in June 2014, staffing resource was in place to introduce the service from September 2014
[54] Rapid Response Project Initiation Document

Activities [54]	Performance
Enhance access for service users requiring domiciliary rapid response support in order to prevent hospital admissions	**Activity Completed:** 75% of referrals were responded to within the same day (based on project monitoring data). **No specific targets were developed for this activity / objective.**
Develop a domiciliary care service to provide an urgent response to the needs of people who are experiencing a crisis due to an acute or chronic condition	**Activity Completed:** 24 domiciliary care support staff were deployed in provide an urgent response service (since October 2014). **No specific targets were developed for this activity / objective.**
Provide a rapid response to the telecare community alarm system when activated for assistance	**Activity Completed:** 113 people who used telecare alarms were referred to the Rapid Response service (based on project monitoring data). **No specific targets were developed for this activity / objective.**
To increase the use of rapid response by primary care	Only 10% of the referrals (as detailed in section 2) came from Primary Care Teams. As no baseline data or specific targets were set, it is not possible to say if this objective has been achieved. **No specific targets were developed for this activity / objective.**

Data sourced on performance and detailed in the table above has been sourced from Project Monitoring reports.

Overall, it is not possible to determine the extent to which the project met all of its stated objectives as while there is evidence of activities, there were no associated targets set.

6.4 Outcomes

The Carmarthenshire Rapid Response service set the following 'key outcomes' at service level (as defined in the project end of year report).

Table 6:2: Patient outcomes

Project Outcomes	Patient Numbers	%
Potential hospital admissions diverted to RR	167	43%
Early Hospital Discharge	51	13%
Total number of responses to Telecare Alarms during the day	113	30%
Service User numbers held by RR awaiting Reablement/ Long Term Domiciliary	39	10%
Other	15	4%
Total	385	100%

Source: Project End of Year Report March 2015

Table 6.2 shows that of the 385 patients who accessed the service 43% of them avoided hospital admission. This contributes towards the objective of providing 'an optimised function in which 15% of potential unscheduled over 65 medical admissions are to be avoided through provision of alternative support'. However, as the total number of hospital admissions for those aged 65 has not been specified, it is not clear if the objective has been fully achieved.[55] Cost savings are considered in the economic assessment section (section 6).

Additionality is a key concept when assessing the impact of any intervention as it assesses the extent to which the outcomes delivered would have happened anyway. Patient feedback is generally used to get this information; however, it was not possible to complete such a survey in this evaluation. Staff survey feedback indicated they felt that patients would definitely not have achieved the same benefits and would have had to spend a longer time in hospital.

Patient Case studies

Whilst it was not possible through this evaluation to collect primary data from service users to understand the impact of the Carmarthenshire Rapid Response service for service users, the following case studies were included in the Project End of Year report dated March 2015.

[55] Data from Hywel Dda University Health Board shows that in 2014/15 there were 36,526 emergency admissions to Glangwili and Prince Philips Hospitals, however, the proportion of these who were aged over 65 years has not as yet been provided.

Case Study 1 – Mrs A Enhanced Hospital Discharge

Mrs A was admitted into hospital via A& E on the 20th of November, 2014 due to a general deterioration in health and confusion. Whilst on the ward staff and the service users' husband raised concerns that Mrs A's health and mobility had deteriorated in the months prior to admission resulting in oedema and ulcers on both legs. District Nurses had been visiting daily. Being unable to undertake personal care resulted in tissue viability issues which was exacerbated by Mrs A sleeping on a reclining chair for the last 12 months. On admission Mrs A was non weight bearing and was therefore hoisted for all transfers.

Rapid Response Intervention

Whilst considerable therapeutic and nursing support was input by the hospital staff the care package to go home was for 2 Domiciliary Support Workers four times per day to support with personal care, dressing, undressing, toileting and all transfers

Outcome

Mrs A's husband was supported by ensuring that his wife's nutritional needs were met by providing meals, snacks and drinks. In the first few week RR staff worked closely with Mr and Mrs A. Progress was made and the care package was reduced from four visits a day to two visits per day. Following the transfer to Reablement continual progress was made to Mrs A's mobility and only one carer was required twice per day to assist with personal care.

Case Study 2 – Mrs Y Avoiding Hospital Admission

Mrs Y was taken to A&E after falling on a shop escalator and suffering a sprained ankle, broken knuckles, and bruising to her ribs and left side of her face. Mrs Y lives with her husband who has chronic heart failure and hearing problems. Mrs Y is her husband's main carer. After assessment in A&E, Mrs Y was discharged to the Rapid Response Team via the Out of Hours Domiciliary Care Manager, thus avoiding hospital admission. Prior to this accident Mrs Y was independent and no social service input had ever been in place. When discussing what was important to Mrs Y she explained that she would like to regain her independence as soon as possible.

Rapid Response Intervention

It was identified that three calls per day by a single staff member was required for assistance with personal care tasks and meal preparation. The Rapid Response Team supported Mrs Y for four days, after which the care package was transferred to the Reablement Team.

Outcome

During this time, Mrs Y improved and within three to four weeks visits were decreased and eventually ceased due to full independence being achieved. Mrs Y was so grateful for the input of the service that she sent a letter to compliment and thank the staff teams.

Key Findings

The Carmarthenshire Rapid Response Project has prevented 167 admissions and supported 51 early discharges over the evaluation period, which related to 7 months of service delivery, given the time needed to get the service up and running Feedback from staff also indicates that without the service patients would have remained in hospital for longer and patient case studies demonstrate the positive impacts of the service on the health and well-being of patients.

Areas for Development

Carmarthenshire Rapid Response has focused on benefits at service level, as shown by the information reported on to the Project Board monthly. Further information is required in order to fully evidence the total impact of the service. In particular, the outcomes for service users should be measured, including patient's experience and the extent to which their quality of life has improved alongside those measuring gains to health / social care services in order to provide a holistic view of the benefits being achieved. Specifically, data should be collected in relation to the following:

- **Reduction in the length of hospital stay for patients over 65 / Reduction in delayed discharge**: data should be collected on the number of days saved through early discharge which would facilitate a more accurate analysis of hospital bed days saved.
- **Improved patient flow**: as noted in the logic model (section 3) Rapid Response services should have a positive impact on patient flow. This could be measured using data such as length of stay in hospital, length of engagement with Rapid Response and information on where patients are discharged to following Rapid Response.
- **Patient satisfaction/patient experience:** whilst it is recognised that qualitative case studies have been collected to describe the patient journey, there has been no systematic approach to collecting data on patients' experience with the service. Staff should issue brief surveys to all those who have been supported through the service and the results should be reported on a quarterly basis.
- **Increased independence/functionality/quality of life:** the improvement in health and well-being of patients is core to the delivery of intermediate care services. The National Audit of Intermediate Care[56] recommends the use of the Barthel Index[57] on admission to and discharge from intermediate care services to assess the extent to which patients have regained their day-to-day functioning.

[56] NHS (2015) National Audit of Intermediate Care
[57] Ordinal scale used to measure performance in activities of daily living (ADL) – measures function & quality of life

7 ECONOMIC ASSESSMENT

7.1 Introduction

This section sets out the economy, efficiency and effectiveness of the Rapid Response service, as well as the saving it has generated within health or social services.

7.2 Economy[58]

The funding received for this project was £311,550 for over the period June 2014[59] to March 2015.

Table 7:1: Budget vs. Expenditure for the Rapid Response Project (June 2014 – March 2015)

	Budget	Expenditure	Variance[60]
Quarter 1 (June 2014)	£77,887.50	£0.00	£77,887.50
Quarter 2 (July – Sept 2014)	£77,887.50	£9,627.55	£68,259.95
Quarter 3 (Oct – Dec 2014)	£77,887.50	£112,665.43	-£34,777.93
Quarter 4 (Jan – Mar 2015)	£77,887.50	£142,147.52	-£64,260.02
Total	**£311,550**	**£264,440.50**	**-£47,109.5**

Source: Rapid Response Project Manager (October 2015) – ICF Claim Form

Overall the programme recorded an underspend of almost £50,000. This was largely due to the lead in time required to establish the service, attract and appoint staff, and acquire the necessary equipment. The service became operational on the 15 September 2014 and while spend in the next quarter increased significantly, there was insufficient time left to meet the overall spend targets for the year.

[58] Economy considers the extent to which activities were delivered at minimum cost
[59] Recruitment of existing internal staff for the Rapid Response Service commenced in June 2014, staffing resource was in place to introduce the service from September 2014
[60] Refers to how much an actual expense deviates from the budgeted or forecast amount

Table 7:2: Analysis of Spend (June 2014 – March 2015)

Area of Spend	Budget[61]		Actual[62]		Variance	
	£	% of total budget	£	% of spend	£	% of spend vs. budget
Staffing						
Salaries and Staff Costs	£265,976	85.4%	£248,196	93.9%	-£17,780	93.3%
Staff Travel Expenses	£43,590	14.0%	£14,493	5.5%	-£29,097	33.2%
Administration and Equipment						
Admin, Operational & Office Equipment	£1,984	0.6%	£146	0.1%	-£1,838	7.4%
Computer Hardware	-	--	£1,600	0.6%	+£1,600	-
Subsistence						
Subsistence	-	-	£6.80	0.003%	+£6.80	
Grand Total	**£311,550**	**100%**	**£264,441**	**100%**	**£47,109**	**84.9%**

As set out in the above table the majority of spend was on staff salaries, which accounted for 93.9% (£248,196) of the total spend. Other staffing related costs including travel expenses accounted for 5.5% of the total spend (and accounted for over half of the under spend). Less than 1% was spent on administration and equipment.

It should also be noted that the project received in-kind support from Carmarthenshire County Council. In-kind contributions included support from a Social Services Manager (20% of her time which equates to approximately £11,718 over the 10-month period) and other indirect costs such as HR, IT and accommodation, the value of which would be in the region of £39,667 based on 15% of the project costs.[63] Therefore the total value of the Council's in-

[61] Carmarthenshire County Council Finance
[62] Carmarthenshire County Council Finance
[63] Indirect costs usually include resources such as Human Resources, Finance and IT services and are also allocated to projects based on estimates. We have used an estimated overhead figure of 15% that is normally applied to project work as this is sighted as best practice by the Wales European Funding Office.

kind contribution is in the region of £51,385.

The Carmarthenshire Rapid Response service has been delivered economically as it was able to use Council services to establish and manage the project. The ICF funding was therefore mainly used for additional domiciliary care staff delivering front line services.

7.3 Efficiency[64]

Efficiency is measured through comparing the average cost per patient for the Carmarthenshire Rapid Response service with two other schemes which were also focused on reducing hospital admissions. Note, it was not possible to access robust evaluation data on other Rapid Response services based on a social care model and this information would have been preferred. Ideally, social care model comparators will be found for any future evaluation. The two comparators (Advanced Prevention and Facilitated Discharge and Lincoln Rapid Response Teams) are health led and are mainly delivered by clinical staff (including GPs and nurse clinicians), they are focused on getting packages of care into patient's homes to facilitate early discharge and reduce hospital admissions. Therefore, it is important to consider the differences in how the schemes are delivered when comparing outputs. Details on the benchmarks are included in Appendix C.

Table 7:3: Comparison of Services

	Carmarthenshire Rapid Response	APFD	Lincoln RRT
Cost	£264,440.50 (ten months from June 2014 to March 2015[65])	£93,658.49 (Feb 2011-January 2012[66])	£989,218[67] (November 2013 to March 2014)
Cost per patient	£687[68]	£306[69]	£1,910
Average number of referrals per month	39[70]	28[71]	124[72]

[64] Efficiency: considers the benefits (the net outputs or outcomes) compared to the intervention costs
[65] Service delivery was September 2014 – March 2015
[66] Proposal for the future commissioning of the admissions prevention service (29th November 2011)
[67] This figure does not include the staff salaries of operational workers who were already in post. If these salaries are included, the set-up and operational costs of the RRT rise to £1,185,940. This figure is also for four RRTs.
[68] Cost to deliver the service over a 10 month period £264,440.50 / 385 patients who accessed the service over the period = £686.86 per patient
[69] Cost of the service over a 12 month period £102,172.90 (Cost for 11 months (February 2011 – January 2012) £93,658.49 / 11 = £8,514.41 (costs per month) * 12 (months) = £102,172.90) / /334 =£305.91
[70] Based on 385 patients accessing the service over the 10-month period / 10 = 39 per month
[71] Based on 334 referrals in the first full year / 12 months = 28 per month
[72] Based on 621 referrals to four teams from November 2013 to March 2014.

Table 7.3 shows that the Rapid Response service compares very favorably with Lincoln RRT in terms of cost per patient and overall cost (and this could be due to the involvement of GPs and nurses not involved in Carmarthenshire Rapid Response). The Lincoln service is similar to the Carmarthenshire Rapid Response service as it accepts referrals from a range of stakeholders and delivers care in the home following a multi-disciplinary assessment. The Carmarthenshire Rapid Response service cost per patient is significantly less than the Lincolnshire service at £687 compared to £1,091.

The other service that was identified as a benchmark (APFD) appears less expensive per patient than the Carmarthenshire Rapid Response service (at £306 per patient). However, the APFD service primarily accepts referrals, undertakes assessments and then refers the patient on to other appropriate services. Unlike the Carmarthenshire Rapid Response service and the Lincolnshire RRT it does not provide the care (while the Carmarthenshire Rapid Response service may intervene to support people at crisis, it also maintains domiciliary support until another agency can provide support if longer term needs are identified). APDF was included as a benchmark as the structures and processes that were established to respond quickly and make patient assessments are similar.

It should also be recognised that the Carmarthenshire Rapid Response service was a pilot and there have been costs involved in set up (i.e. developing new processes; training staff in new processes and building new relationships with referral bodies etc.) which have impacted on the costs; therefore further efficiencies may be possible in the future.

7.4 Effectiveness[73]

Effectiveness considers how well the project delivered against the objectives that were set for it. No specific targets were set for the number of patients to be treated by the service, the rate of hospital admissions prevented or bed days saved.

7.5 Cost Savings

The service prevented admissions for 167 patients (43% of all referrals).[74] Data from local hospitals[75] indicates that the average length of stay in hospital for patients over 75 years in Carmarthenshire is 10.7 days. Therefore, if it was assumed that each of the 167 patients were saved from staying in hospital for this period it results in an estimated saving of 1,786.9 days. However further information is needed on the nature of the conditions in order to more accurately predict the number of bed days saved.

Furthermore, the project facilitated the early discharge of 51 patients, however it is not known how many hospital bed days were saved as a result of the service, nor is it known how long patients stayed in hospital prior to their discharge. However, if it is assumed that the

[73] Effectiveness: involves considering whether an intervention's objectives have been met.
[74] Data source from project reports
[75] Hospital patient data provided via the project manager

Carmarthenshire Rapid Response service saved at least 1 hospital bed day per patient that would equate to an additional 51 bed days saved. If it is assumed that the facilitation of early discharge would save half of the average hospital stay of 10.7 days this would equate to a total saving of 272.8 bed days. Therefore, it is estimated that the Rapid Response service delivered a saving of between 51 and 272.8 bed days through the facilitation of early discharge

Data from NHS Wales[76] indicates that the cost of an acute hospital bed day is £426. The following table provides an overview of the estimated savings in hospital bed days generated by the Carmarthenshire Rapid Response service, based on the assumptions detailed above.

Table 7:4: Estimated Savings from Hospital bed days saved

	No. of patients	Estimated bed days saved	Estimated Costs Saved
Prevented Hospital Admission	167	1,786.9	£791,219
Early Discharge from Hospital (1 day) – 51 patients	51	51	£21,726
Early Discharge from Hospital (5.35 days) –51 patients	51	272.8	£115,148

As set out in the above table, the estimated gross savings in hospital bed costs is £812,945 (£791,219 + £21,726), based on a saving of 1 day per patient early discharge. If it is assumed that the service could generate up to 5.3 days hospital beds days for early discharge patients, the total estimated gross savings could increase to £906,367 (based on 51 patients).[77]

Total ICF expenditure was £264,440, therefore the project has generated net savings of £548,505 over the seven months that it was operational (October 2014 - March 2015). If it is assumed that patients who were discharged early saved on average 5.3 days the net saving would increase to £641,927. However, these figures should be treated with caution based on the assumptions made. The cost savings noted above do not take into account other potential savings associated with the service, such as a potential reduction in the number of patients entering long term domiciliary care, avoided admissions to nursing or care homes, or avoided ambulance journeys. Furthermore, the analysis does not take into account the benefits to patients such as increased or re-gained functional ability or quality of life. Due to a lack of data these additional savings cannot be measured at this point in time.

[76] NHS Wales
[77] 51 patients x 5.3 bed days x £426 (cost of a bed day) = £115,148 + £791,219 (avoided admissions) = £906,367.

7.6 Sustainability and Future Prospects

Further research should be undertaken on the need and capacity in other council areas before the service is rolled out across Mid and West Wales. Specifically, an assessment of need should be completed to determine if there is a need to provide an urgent response to referrals for domiciliary care to prevent delayed discharges and help to avoid unnecessary admissions. There is a need to determine if there is existing capacity within domiciliary care/reablement services in other Councils within Mid and West to continue to provide this urgent response service or is there a need for additional resources. Any research or review in this area should take a whole systems approach and therefore consider the level of potential referrals from hospitals and other relevant staff in the community (e.g. GPs / community organisations), as well as the capacity to deliver the service. It is noted that the Carmarthenshire Reablement Service Structures are currently review under and it is understood that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, a higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care).

Key Findings

The project can be considered to be economic as it was delivered within budget and also 93% of expenditure was on front line services. Overall the Rapid Response service was under budget by £47,109 which was mainly due to the lead in time required to establish the project, attract and appoint staff, and acquire the equipment necessary to run the service. However the service effectively prevented admissions for 167 patients (43% of all referrals) and facilitated the early discharge of 51 patients. This resulted in a gross cost saving of £812,945 / net cost saving of £548,505. Therefore, every £1 invest in the Carmarthenshire Rapid Response service provided a return of £3.07 (gross) and £2.07 (net).

Areas for Development

Targets were not set for the Carmarthenshire Rapid Response service and therefore it is not possible to definitely conclude on whether it effectively delivered on expectations.

However, cost saving calculations only reflect those due to hospital bed days saved and there is potential for further outcomes and cost savings to be evidenced through more robust monitoring and data collection of service user outcomes and data on the discharge location of service users (e.g. to another secondary care setting).

8 CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

The Carmarthenshire Rapid Response service was designed to enhance collaboration and integration through a multi-disciplinary, coordinated care approach. It was devised to support the provision of increased care closer to home as part of the integrated community locality model. The key aims for the Carmarthenshire Rapid Response service as set out in the PID[78] were:

- To strengthen the domiciliary team to be able to provide a model of anticipatory care to the frail elderly as well as to those with chronic conditions and palliative care needs whose needs can ebb and flow (rise and fall) overtime;
- To successfully reduce the number of people admitted into hospital and deliver more timely discharges of patients back into the community;
- To further help people in their goal to remain healthy and independent;
- To enhance the quality of life for people with care and support needs;
- To delay and reduce the need for care and support; and
- To ensure that people have a positive experience of care and support.

8.2 Integration

The project adopted an integrated approach at a strategic level as it was overseen by an integrated project board. Qualitative feedback from the staff survey[79] indicated the project had **increased communication between social services and hospital staff** and that this in turn had helped to improve the patient handover process. It was also noted that the **referral process from integrated Community Resource Teams (CRTs) worked well** and that the **project had helped improve communications and relationships** between the staff involved. However, while the Rapid Response service had a clear focus on early discharge and reducing the number of people admitted to hospital, no targets were set regarding integration / collaboration, meaning it is not possible to conclude on whether the process worked as expected.

Recommendations:

- **Objectives and targets should be set with regard to what effective integration and collaboration looks like for the service**. Research[80] by the Nuffield Trust states that this should include impact on health outcomes, but also improved quality of care, service user satisfaction, and effective relationships and systems.
- **Referral data should be examined to consider the specific numbers being referred by GPs and Primary Care Teams and whether there are opportunities to**

[78] Source: Domiciliary Rapid Response – Project Initiation Document (June 2014)
[79] An on-line survey of 12 staff members (50% of 24 staff)
[80] Nuffield Trust (2011) *What is Integrated Care?*

increase these. The project should consider ways in which the profile of the service (and the benefits it can bring to the Health Service and the patients) can be raised with other health care teams such as GPs and OTs (e.g. through community nurses) in order to maximise referrals. In addition, in any future service it would be useful to pilot work with a number of GP practices in order to project the potential numbers or % of GP case load that could be referred. These %s could then be applied to other GP practices.

- We recommend that an **up to date handbook of care service**s is available to all care agencies to sustain integration, to allow for direct communication between professionals, and to build confidence in care provision.
- **Research is needed to confirm that all of the target audience are being reached**. Further work is required to assess whether there are a number of patients that could be utilising this service, but who are not and the reasons for this. This could be done through reviewing the records in a number of wards for a period of time. This would provide information on whether the service is being referred to appropriately, and the projected numbers to come through should there be more numbers identified**.**
- **The capacity of the Rapid Response service should be sufficient** to ensure that a tight turn around target of all those being referred are supported within two days.

8.3 Outputs / Outcomes

8.3.1 Outcome Measures

Project monitoring reports provided information on service level 'outcomes', specifically the prevention of hospital admissions and facilitating early discharge. These were key to ensuring that service was demonstrating a contribution to reducing the pressure for beds within hospitals. However, it should also measure the patient experience and how quality of life is improved for those who use its services. In addition, a number of areas that were detailed in the PID were not monitored. Specifically, there was no data collected against the following aims / service user outcomes:

- People will be further helped in their goal to remain healthy and independent;
- To delay and reduce the need for care and support;
- Enhance the quality of life for people with care and support needs; and
- Ensure that people have a positive experience of care and support.

Evidence on all of the above can be collected through surveys or interviews with service users. There is a strong body of evidence noting that the collection of feedback from service users is best practice in the evaluation of intermediate care services,[81] including patient satisfaction, health and well-being improvements (reablement)[82] and patient quality of life.[83]

[81] For example see Kings Fund (2002) Developing Intermediate Care. A Guide For Health And Social Services Professionals.
[82] Kings Fund (2002) Developing Intermediate Care A Guide For Health And Social Services Professionals
[83] Kings Fund (2014) Community services How they can transform care. Nigel Edwards

8.3.2 Performance

The key areas of strength within the existing service were the:

- Development of domiciliary care capacity and systems within the council in a short period of time;
- Achievement of 167 people avoiding hospital and 51 people discharged sooner as a result of this service; and
- Delivery of the service on time and within budget, and ability to respond to short turnaround times for helping clients.

Areas for development include:

- SMART targets should have been established for the Rapid Response service at the outset (based on performance against a baseline / linked to an evidence based logic model) and in line with ICE-F guidance, which states outputs and outcomes should be defined at national, local and individual / personal level. In the absence of SMART targets, it has not been possible to effectively conclude on the success or effectiveness of the Carmarthenshire Rapid Response service.
- Only 10% of referrals came from the Primary Care teams. Targets are needed for referrals from those working in primary care. These should be set after a review of the numbers of people being referred to hospital by them that could be helped at home. Targets are also needed for the number of in-hospital referrals.

Recommendations:

- **Include measures relating to individual and personal objectives**. For example, this would include patients' quality of life, improvements in health and well-being and levels of satisfaction with the services provided. The data collected should be in line with national standards for reablement services[84] and ICE-F guidance.
- **Baseline and distance travelled data is required** to provide evidence of how the service has contributed to individual outcomes (for example, rating wellbeing at beginning of service, middle and at discharge or referral).
- **SMART targets should be developed for each objective**; and
- **Future reporting templates should detail quarterly and cumulative progress** against all the objectives and targets details in the PID.

8.4 Economic Assessment

The project was assessed with regard to its economy, efficiency, effectiveness and cost effectiveness and it demonstrated that:

[84] Reablement Gold Standards & Toolkit. Developed in partnership between WSP and the Social Services Improvement Agency during 2009/10 through the development of an action learning set involving 9 of the 22 Welsh Local Authorities.

- **Economy**: Overall expenditure for the project was under budget by £47,109. This was mainly due to the lead in time required to establish the project, attract and appoint staff, and acquire the equipment necessary to run the service. It was delivered economically as it was supported through existing Council structures and resources (i.e. HR, Finance and IT). The ICF monies were therefore focused on front line delivery.
- **Efficiency:** It is difficult to get benchmarks that are exactly the same to the Carmarthenshire Rapid Response service in terms of the support being provided and how it is delivered. However based on available information, the Lincolnshire RRT appears similar in that it accepts referrals from a range of stakeholders and delivers care in the home following a multi-disciplinary assessment. The Carmarthenshire service compares very favorably with the Lincoln RRT benchmark in terms of cost per patient and overall cost. The Rapid Response service cost per patient is significantly less than the Lincolnshire service at £687 compared to £1,910.
- **Effectiveness**: The service prevented admissions for 167 patients (43% of all referrals)[85] and facilitated the early discharge of 51 patients. This resulted in a gross cost saving of £812,945 / net cost saving of £548,505. Therefore, every £1 invest in the Carmarthenshire Rapid Response service provided a return of £3.07 (gross) and £2.07 (net). However, to calculate total savings to the health sector required data on the number of hospital bed days that were saved as a result of the early discharge, however this had not been collected.

Recommendations:

- **We recommend that any future project collects detailed quantitative data relating to early discharge**, for example the number of days saved through each early discharge (not just the number of patients who have been discharged early), which would enable the project to make a more accurate assessment of its impact; and
- **We recommend that data is collected that shows the reduced cost to residential and nursing home care services**.

8.5 Sustainability and Future Prospects

Further research should be undertaken on the need and capacity in other council areas before the service is rolled out across Mid and West Wales. Specifically, an assessment of need should be completed to determine if there is a need to provide an urgent response to referrals for domiciliary care to prevent delayed discharges and help to avoid unnecessary admissions.

There is a need to determine if there is existing capacity within domiciliary care/reablement services in other Councils within Mid and West to continue to provide this urgent response service or is there a need for additional resources. Any research or review in this area should take a whole systems approach and therefore consider the level of potential referrals from hospitals and other relevant staff in the community (e.g. GPs / community organisations), as

[85] Based on project reports

well as the capacity to deliver the service.

It is noted that the Carmarthenshire Reablement Service Structures are currently review under and it is understood that the Rapid Response service will be more closely aligned in order to facilitate closer links to hospital staff, a higher levels of referrals and a reduction in inappropriate referrals (for example fewer referrals for patients who require long term care).

APPENDIX A – REPORT TEMPLATE

Intermediate Care Fund

Project Report – Rapid Response Service

Work Stream: Rapid Response Service

Theme/ Category: Investing to do more

Lead Officer: Gail Jones

Project Detail:

It is proposed that the Rapid Response Service will support the provision of increased care closer to home as part of the integrated community locality model by meeting the needs of local communities. This service design will strengthen the domiciliary team to be able to provide a model of anticipatory care to the frail elderly as well as those with chronic conditions and palliative care needs whose needs ebb and flow (rise and fall) overtime.

Allocation of Revenue Funding - £311,550	**Claim for Q1 = £0** **Claim for Q2 = £** 9,627.55 **Claim for Q3 = £** 112,665.43	**Claim for Q4** - £142,758.62 **Total Spend** -£265,051.60 Under spend - £-46,498.40

Key Objectives:

1. Increased integrated Rapid Response capacity will reduce unscheduled admissions to hospital.
2. To achieve increased Rapid Response Capacity, working towards the achievement of an optimised function in which 15% of potential unscheduled over 65 medical admissions are to be avoided through provision of alternative support.
3. To increase use of Rapid Response by primary care.

Progress against Key Objectives as at March 2015:

- There are now 24 Rapid Response staff in post, induction training has been completed and service delivery commenced on the 15/09/2014.
- Service Managers are actively working with colleagues within the Community Resource Teams MDT's to discuss individual referrals for people that would benefit from the Rapid Response service.
- Service Users within Carmarthenshire have been receiving support and care via the RR service. Activity within the Rapid Response Service has been set out in key outcomes below.

Key Outcomes:

Outcome information- From the 20/1/15 to the 24/02/2015

			Rapid Response TTT	Llanelli	A&G	Total
A	RR interventions	Total People who have accessed the RR service between the above dates.	**17**	**20**	**30**	**67**
B	Potential hospital admissions diverted to RR	Input from the RR team to avoid potential hospital admission	**17**	**5**	**7**	**51**
C	Early Hospital Discharge		**2**	**2**	**0**	**4**
D	Total number of responses to Telecare Alarms during the day		**3**	**8**	**12**	**23**
	Service User numbers held by RR awaiting Reablement/ Long Term Domiciliary	Data information as of 24/02/2015	**20**	**1**	**6**	**27**
	Other Outcomes					

Case Study examples:

Case Study 1 – Mrs P Enhanced Hospital Discharge

Mrs P's recent hospital admission was due to a fall which caused a fractured hip. Mrs P's medical history is of a previous CVA, dementia and is partially sighted. Whilst in hospital Mrs P continued to fall when trying to get in and out of bed, was regularly muddled, confused with poor orientation to time and place and, had been verbally and physically aggressive to the staff on the ward. Mrs P prior to admission lived at home with her daughter and family. To plan for a safe return home RR was commissioned until capacity was available within Reablement in two weeks time.

By MDT agreement the following was implemented:-

Rapid Response Intervention

Initial Care package; - 4 calls per day x 2 Domiciliary Support Workers to work towards gaining skills and independence with personal care, dressing, undressing and toileting.

Outcome

Within the first few days it was evident that Mrs P could weight bear and was able to mobilise slowly with minimal assistance. Mrs P, in her home environment was calm, content and happy to be back with her family, On transfer to Reablement two weeks later the care package was for one worker three times per day. Without the initial input of the RR Team this return home would have been delayed for another 2 weeks

Case Study 2 – Mrs A Enhanced Hospital Discharge

Mrs A was admitted into hospital via A and E on the 20th of November, 2014 due to a general deterioration in health and confusion. Whilst on the ward staff and the service users husband raised concerns that Mrs A's health and mobility had deteriorated in the months prior to admission resulting in oedema and ulcers on both legs District Nurses had been visiting daily. Being unable to undertake personal care resulted in tissue viability issues which was exacerbated by Mrs A sleeping on a reclining chair for the last 12 months. On admission Mrs A was non weight bearing and was therefore hoisted for all transfers.

Rapid Response Intervention

Whilst considerable therapeutic and nursing support was input by the hospital staff the care package to go home was for 2 Domiciliary Support Workers four times per day to support with personal care, dressing, undressing, toileting and all transfers

Outcome

Mrs A's husband supported by ensuring that his wife's nutritional needs were met by providing meals, snacks and drinks. In the first few week RR staff worked closely with Mr and Mrs A. Progress was made and the care package was reduced from four visits a day to two visits per day. Following the transfer to Reablement continual progress has been made to Mrs A's mobility as only one carer is now required twice per day to assist with personal care.

Case Study 3 – Mrs Y Avoiding Hospital Admission

Mrs Y lives with her husband who has chronic heart failure and hearing problems. Mrs Y is her husband's main carer, therefore, he was unable to physically support her. They have a daughter, who lives in Cardiff, and fortunately friendly and supportive neighbours.

Mrs Y fell on a shop escalator, due to the fall she sustained a sprained ankle, broke to knuckles bruised her ribs and the left side of her face. Mrs Y was taken to A and E but after assessment was discharged into the care of the Rapid Response Team via the Out of Hours Domiciliary Care Manager thus avoiding hospital admission. Prior to this accident Mrs Y was independent and no social service input had ever been in place. When discussing what was important to Mrs Y she explained that she would like to regain her independence as soon as possible.

It was indentified that 3 calls per day single staffed were required for assistance with personal care tasks and meal preparations. Rapid Response supported for 4 days and then the care package was transferred to the Reablement Team. During this time Mr Y improved and within three to four weeks visits were decreased and then stopped due to full independence being achieved. Mrs Y was so grateful for the input of the service she sent in a letter to compliment and thank the staff teams. (Letter is available)

APPENDIX B – STAFF SURVEY

Introduction

This section sets out the findings from the survey and interviews with staff and other key stakeholders involved in the development and delivery of the Rapid Response project.

An online survey developed by the evaluation team was emailed to 24 service delivery staff by the project manager. Eight members of staff completed the survey. A further four members of staff completed one to one interviews. Three GPs who refer into the service were also invited to take part in short telephone interviews, one of whom agreed to do so. Therefore, in total feedback was received from thirteen key stakeholders.

The survey and the interviews covered a number of key issues relating to the evaluation, including

- The extent of health and social care integration within the project and how well integration has worked;
- The outcomes that have been achieved, service-related and service user outcomes;
- The cost-effectiveness of the project, compared to non-integrated ways of delivering services;
- The future prospects for Rapid Response services.

Outcomes achieved

The evaluation team could not access patient contact details and therefore, it was not possible to collect primary evidence from patients on their outcomes as a result of using the service. However, feedback from staff who are involved in service delivery noted that because the service is very patient focused it has achieved a number of positive outcomes and impacts for service users. Almost all staff noted that most clients would not have got out of hospital as quickly without the service or have been able to stay in their own home without the service. It was noted that this is an important factor in maximising the service users' independence and functional ability and also improves quality of life.

The funding for the Rapid Response service provided new and additional resources within the existing Domiciliary Care services and without the ICF monies the service would not have been implemented and the patients and service outcomes would not have been achieved.

A small number of those who were interviewed (circa 25%) also noted that there are no processes in place to routinely collect data on patient outcomes and that the evidence for the effectiveness of the service would be strengthened if baseline and exit data on the patients' health and well-being was collected.

Summary

A number of key themes have emerged from the analysis of the response to the online survey and consultations with staff and other key stakeholders as summarised below:

- All felt the service facilitated a reduction in hospital admissions and supported early discharge among patients over 65. Furthermore, all of those who provided feedback also noted a range of positive service users' outcomes. These included the ability of patients to regain or, maintain independence and have an improved quality of life than would have been the case without the service.
- A small number of interviewees also noted that the evidence of the effectiveness of the service could be strengthened if information from clients was collected regarding their quality of life/ independence / confidence etc. before and after the service.

APPENDIX C – BENCHMARKING

Benchmarking

Introduction

In order to assess the effectiveness of the Rapid Response service a benchmarking exercise was undertaken to compare the outcomes and impacts achieved by Rapid Response Carmarthenshire with those elsewhere. It is difficult to find directly comparable services to benchmark, but two have been agreed with the project team. These are:

- Rapid Response Teams, Lincoln; and
- Admissions Prevention and Facilitated Discharge Service (Wirrral).

Rapid Response Teams (Lincoln)[86]

Rationale for Selecting Admission Avoidance Programme – Rapid Response Teams

The Rapid Response Teams are one of the services operating under the Admission Avoidance Programme in Lincolnshire. The teams aim to enhance community capacity to treat and support patients in their own home in order to reduce emergency hospital admissions. The vast majority of patients who are assessed by the service are over 70 years of age. The Rapid Response team is jointly managed and funded by Lincolnshire Partnership NHS Foundation Trust (LPFT) and Lincolnshire Community Health Services (LCHS).

Therefore, this service possesses similar aims and objectives and targets a similar group as the Rapid Response service in Carmarthenshire.

Background to Admission Avoidance Programme – Rapid Response Teams

The Admission Avoidance Programme Board was set up in April 2013 with the aim of reducing emergency hospital admissions across the winter pressures period (October to March). Four projects were identified and planned of which Rapid Response Teams were one.

The Rapid Response Teams (RRT) in Lincoln, Grantham, Boston and Louth were initially planned to be operational from 18 November 2013. In the project initiation documents, it was identified that each RRT should operate 24 hours across seven days a week and would encompass a range and mix of skills: an Emergency Care or Advanced Nurse practitioner (Band 7); a Mental Health Nurse (Band 6), a Nurse (Band 5) and six generic health care support workers (Band 3). However, in some areas not all envisaged staff members were recruited and other teams were forced to operate more limited hours (e.g. 9am to 5pm) due to staff capacity issues. In comparison, the Rapid Response service in Carmarthenshire is comprised of one Project Manager and 24 Domiciliary Support Workers (Grade D and recruited from existing staff). The service is also supported by 24 part-time Domiciliary Support Workers (Grade D) who were recruited to backfill the positions vacated by the

[86] Windle et al. (2014). *Admission Avoidance Programme: Final Report.* University of Lincoln: Community and Health Research Unit.

internal recruitment process. The service in Carmarthenshire operates a flexible service which is delivered between the hours of 7am to 10pm.

The four RRTs receive referrals from the Contact Centre or Lincolnshire Out-of-Hours team. Following receipt of referral, the relevant RRT will visit and assess the patient within two hours, providing treatment, support at home and onward referral as necessary. Referrals come to the Rapid Response service in Carmarthenshire from a range of different sources such as Careline, the community resource teams, and staff within the primary care team.

Objectives and Targets

The remit of the Admission Avoidance Programme was to identify and implement a range of community-based resources that could reduce emergency admissions by 5,000 finished consultant episodes, (pro-rata), across the winter pressures period (October 2013 to March 2014).

Outcomes

Over the period of implementation (November 2013 – March 2014), the total number of referrals received was 621. The majority of referrals were received from GPs. The majority of patients were managed in the community with fewer than 15% of patients admitted to acute care. From data collated by the Lincoln RRT, the mean age of the patient assessed was 82 with almost the total population (89%) aged 70 and over. Over three-quarters of patients (77%) received one day's care, with only one in ten requiring three or more days support. Table 1 details the destination of patients referred to/assessed by Lincoln RRT during the implementation period.

Table 1: Destination of patients referred to/assessed by Lincoln RRT

Disposition	Aged < 74	Aged > 75
Referral to A&E (%)	0	5
Admission (acute, respite, rehabilitation) (%)	18	35
Community Support (%)	64	51
Referral to MEAU (%)	18	9
Totals	**100% (n=33)**	**100% (n=115)**

Source: Windle et al. (2014). Admission Avoidance Programme: Final Report. University of Lincoln: Community and Health Research Unit.

Costs and Funding

The total cost from November 2013 to March 2014 of the RRT including set-up and operational costs was £1,185,940 (see table 2 for a detailed breakdown of costs). Using

these figures, the likely per annum costs were calculated as £2,493,105.

Table 2: Costs of the Rapid Response Teams (November 2013 – March 2014)

Cost item over the planning and implementation period of the RRT	Cost to date (£)	Budget from which monies were drawn
Total Project Management Costs, LPFT & LCHS (x 8 months)	93,450	LCHS/LPFT
Total Staff Costs (5 months)	940,004	RRT/LCHS
Non-pay staff expenditure	66,328	RRT
Medical, surgical and clinical equipment	18,750	RRT
IT costs	14,000	RRT
Workforce Training	12,300	OD Workforce Development
Financial administration	33,908	Finance
Recruitment (Human Resources)	7,200	HR
Total spend over implementation period		**1,185,940**

Source: Windle et al. (2014). Admission Avoidance Programme: Final Report. University of Lincoln: Community and Health Research Unit.

The cost per patient referred and attended over the period of development and implementation was £1,910. As mentioned above, the mean age of patients referred to the Lincoln RRT was 82. A total of 5,889 patients aged 80 and over were admitted to Lincoln County Hospital (LCH) between October 2013 and February 2014. Of these, 2,569 (45%) had lengths of stay of seven or more bed-days. If 51 percent of these patients (1,310) were continued to be managed in the community by RRT, a saving of £3,209,966 could be generated.

Evaluation and Benefits Delivered

An evaluation was carried out to assess the effectiveness of the Admission Avoidance Programme projects over their short-term of operation. The evaluation addressed two questions:

1. Does the scheme contribute to discernible, (real and tangible) quantifiable reduction in acute emergency admissions?

2. Does the scheme represent value for money when benchmarked against the cost of an acute admission?

A combination of methods was used in the evaluation: rapid literature reviews (where

evidence was available); semi-structured interviews with strategic and operational staff; process mapping exercises; assessment of costs; non-participant observation; statistical process control and secondary quantitative analysis across a range of datasets.

The results showed no overall demonstrable changes in the monthly emergency admissions for United Lincolnshire Hospitals NHS Trust (ULHT). However, the Rapid Response service did result in the majority of patients referred being managed in the community with fewer than 15% of patients admitted to acute care. Quantifiable reductions were also found across two other measures: numbers of bed-nights and zero lengths of stay. From November 2013 to February 2014, only 20 winter expansion beds were opened, compared to over 100 during October 2012 to February 2013.

The short-term nature of the evaluation did not enable a full cost-effectiveness analysis to be undertaken. However, each of the four services operating under the Admission Avoidance Programme, including the Rapid Response Teams, would seem to demonstrate value for money when benchmarked against the cost of an acute admission.

Conclusions

The Rapid Response Teams in Lincolnshire and the Rapid Response Teams in Carmarthenshire are similar services with similar objectives and outcomes. Both aim to reduce emergency hospital admissions and enhance community capacity for the patient to remain in their home; both utilise multi-disciplinary teams; both target mainly the older population; and both have resulted in avoided hospital admissions for the majority of patients referred to the service.

Admissions Prevention & Facilitated Discharge Service

Rationale for Selecting the Admissions Prevention & Facilitated Discharge Service

The Admissions Prevention and Facilitated Discharge (APFD) service was implemented in 2011 and is specific to Wirral. The service aims to reduce the incidence of hospital admissions and also aims to facilitate a timely supported discharge process for those that are admitted into hospital[87].

The APFD service provides interventions such as increased packages of care within a patients' home, rapid access to respite and 24 hour nursing beds, prompt access to therapies (e.g. physiotherapy, occupational therapy), the facilitation of early supported discharge from hospital into alternative community settings, and also when needed, long term care arrangements for patients. The typical user of the APFD service is an older patient over the age of 65[88].

Therefore, the service has similar aims and objectives and targets similar patients as the Rapid Response project however, the crucial difference between the two services is that the

[87] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013
[88] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013

Carmarthenshire Rapid Response service also delivers the care whereas the APFD projects refers on to other service providers.

Background to the Admissions Prevention & Facilitated Discharge Service[89]

The APFD service was hosted and delivered by two General Practices co-located at a medical centre in Wirral. A Senior Nurse Clinician was initially recruited to develop and deliver the project in February 2011 for 25 hours per week supported by full administrative support. The Senior Nurse Clinician worked closely with health and social care Multi-Disciplinary Teams to support case management approaches to patient care. In comparison, the Rapid Response service in Carmarthenshire is comprised of one Project Manager, 24 Domiciliary Support Workers and another 24 part-time Domiciliary Support Workers who were recruited in order to enable a flexible service operating from 7am to 10pm to be provided.

Patients are referred to the APFD service by health care professionals such as their GP, a District Nurse or a social worker. Within the first full year, the service had received 334 referrals. The most common cause of referral to the APFD service during the period of April 2011 to September 2011 was for fall, chronic obstructive pulmonary disease, and dementia, with the typical user of the APFD service being an older patient[90]. Referrals come to the Rapid Response service in Carmarthenshire from a range of different sources such as Careline, the community resource teams, and staff within the primary care team.

The APFD service provides interventions such as:

- Increased packages of care within the patient's home,
- Rapid access to respite and twenty four hour care nursing beds,
- Arranging prompt access to therapies (e.g. physiotherapy and providing necessary adaptations within an individual's home),
- Facilitating supported discharge, and
- The service also arranges long term care placements within nursing homes where necessary.

These interventions are provided with an aim to prevent acute crises from occurring that require a hospital admission; to support individuals to maintain themselves within their community for as long as they are able; and to facilitate a supported, timely discharge if individuals are admitted into hospital.

Objectives and Targets

Whilst there were no targets for the service, the objectives were:

- To increase and improve the packages of care provided to patients;
- To improve the access to therapies (e.g. physiotherapy);
- To increase the access to respite and 24 hour nursing beds;

[89] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013
[90] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013

- To facilitate a process of supported discharge; and
- To arrange long term care placements where required.

Outcomes

As mentioned above, in its' first full year of operation, the APFD service had received 334 referrals. In comparison, the Carmarthenshire Rapid Response service received 385 referrals across a 10 month period.

The table below presents the number and outcomes of referrals (i.e. what course of action was taken for the patient following referral to the APFD service) over a 6 month period between March and September 2011 only.

Table 3: APFD Outcomes of Referral over 6 months

Outcome	Number	%
Admission Prevented	76	46.9
Home Support/ Increased Care Package [91]	42	26.0
Hospital Admission	14	8.6
Facilitated/Supported Discharge	5	3.1
Referred to other services	2	1.2
Change from residential to nursing bed status	2	1.2
Community Equipment	2	1.2
Referred to Wirral Department of Adult Social Services (DASS)[92]	1	0.6
Inappropriate referral/ Patient declined support	18	11.1
Total	**162**	**100**

Source: Proposal for the future commissioning of the admissions prevention service (29th November 2011)

[91] Relates to 42 referrals that resulted in a patient being supported to remain in their own home rather than go into residential care / hospital, through commissioning home support services

[92] Provides access to a range of support services which will enable people to live safely and independently in either their own homes, or alternative accommodation if appropriate

Costs and Funding

The costs involved in providing the support from February 2011 to January 2012 are detailed below.

Table 4: APFD Costings

Cost Element	Cost	Detail
Staffing		
Nurse Practitioner	£37,295	25 hours per week
Admin support	£13,653	37.5 hours per week
Duty GP (rota)	£6,048	£161.89 per session (37.35 sessions)
Practice Manager	£9,505	10 hours per week
Sub total	£66,501	
On cost @ 24%	£15,960.24	
Back up Staffing		
Ad Hoc Nurse Clinician	£5,400	To cover Nurse Practitioner annual leave @ 5 session per week
Ad hoc GP Locum Costs	£4,047.25	To cover 2hr meeting based on 25 meetings per year
Sub-Total	£9,447.25	
Sundry		
Travel/Mileage Costs	£1,000	
Office / Promotional Costs	£750	
Sub-Total	£1,750	
Grand Total	**£93,658.49**	

Source: Proposal for the future commissioning of the admissions prevention service (29th November 2011)

The evaluation included a cost saving review by the NHS Wirral Performance and Intelligence Team[93] based on six months of data from April to September 2011. **The**

[93] : Proposal for the future commissioning of the admissions prevention service (29th November 2011)

estimated savings[94] from avoided hospital admissions were calculated at an average of £127,000 for the six-month period. However this does not take into consideration the potential saving from A&E attendance which could add a further £10,000 saving if patients were admitted via the A&E department[95].

Evaluation and Benefits Delivered[96]

The evaluation took into consideration the cost saving review that is detailed above, as well as collecting qualitative data via:

- Semi-structured telephone interviews with health care professionals; and
- Semi-structured case study interviews with families of patients.

The evaluation demonstrated the potential cost-effectiveness of the APFD service, as the cost to deliver the service was approximately £94'000 for the 11 month period from February 2011 to January 2012 therefore approximate costs for a six month period are £51,086.45[97] compared to potential savings from avoided hospital admissions of £127,000 that were calculated for the six month period from April to September 2011.

The main findings of the qualitative evaluation indicate a high level of user satisfaction with the APFD service. Family members of patients described experiencing strain and difficulty in accessing support services before the APFD service had intervened. The service had intervened at a critical point for many and provided a rapid response which often resulted in an avoided hospital admission for patients. Many family members described the service as crucial, and expressed dismay at the thought of not having the service.

Conclusions

Whilst the APFD service had similar aims and objectives as the Rapid Response and produced similar outcomes, it was structured differently, for example it was based within a primary care setting which is likely to increase awareness of the service amongst GPs. However, this did not appear to have an impact on the number of referrals to the service – Carmarthenshire had an average of 39 referrals per month, while APFD only had an average of 28 referrals). Furthermore, the service was focused around increasing access to existing services and creating care packages around existing services, whereas the Rapid Response project created additional care staff in the community to provide the care, therefore increasing capacity and level of provision.

[94] The potential cost savings from avoided hospital admissions as a result of the Admission Prevention team was estimated by multiplying the proportion of referrals with a known diagnosis by the lowest and highest cost of admission for that diagnosis
[95] Proposal for the future commissioning of the admissions prevention service (29th November 2011)
[96] Admissions Prevention and Facilitated Discharge Service Evaluation – Final Report, February 2013
[97] Cost for 11 months (February 2011 – January 2012) £93,658.49 / 11 = £8,514.41 (costs per month) * 6 (months) = £51,086.45

Summary

The two benchmarked examples, whilst delivered under different models, possess similar aims and outcomes. The points below compare some of the key metrics with the performance of Rapid Response:

Table 5: Comparison of services

	Carmarthenshire Rapid Response	APFD	Lincoln RRT
Cost	£264,440.50 (ten months from June 2014 to March 2015[98])	£93,658.49 (Feb 2011-January 2012[99])	£989,218[100] (November 2013 to March 2014)
Cost per patient	£686.86[101]	£305.91[102]	£1,910
Average number of referrals per month	39[103]	28[104]	124[105]

Therefore, the Rapid Response service provides similar services (such as enhancing community capacity to treat and support patients in their own home in order to reduce emergency hospital admissions) to those in Lincoln but at significantly less cost per patient (£686 compared to £1,910). It is difficult to say for certain as to why the Lincoln service costs so much more than that of the Carmarthenshire service. However, it is possible that it is due to the higher grade of staff that are recruited by the Rapid Response Teams in Lincoln (i.e. Band 7 Advanced Nurse Practitioner, Band 6 Mental Health Nurse and Band 5 nurse, compared to Grade 4 Domiciliary Support Workers in Carmarthenshire).

Whilst the Carmarthenshire service was more expensive than the APFD project, the AFPD did not actual deliver the services but referred patients on to other providers. On this basis the Carmarthenshire Rapid Response service compares well with the other services.

[98] Service delivery was September 2014 – March 2015
[99] Proposal for the future commissioning of the admissions prevention service (29th November 2011)
[100] This figure does not include the staff salaries of operational workers who were already in post. If these salaries are included, the set-up and operational costs of the RRT rise to £1,185,940. This figure is also for four RRTs.
[101] Cost to deliver the service over a 10 month period £264,440.50 / 385 patients who accessed the service over the period = £686.86 per patient
[102] Cost of the service over a 12 month period £102,172.90 (Cost for 11 months (February 2011 – January 2012) £93,658.49 / 11 = £8,514.41 (costs per month) * 12 (months) = £102,172.90) / /334 =£305.91
[103] Based on 385 patients accessing the service over the 10 month period / 10 = 39 per month
[104] Based on 334 referrals in the first full year / 12 months = 28 per month
[105] Based on 621 referrals to four teams from November 2013 to March 2014.

APPENDIX D – POLICY CONTEXT

Policy Context

There are a number of Welsh Government policies and strategies that are directly relevant to the implementation and delivery of the Rapid Response services as summarised in the following table.

Table 1 Relevant National Policies and Strategies

Policy	Relevance
The National Service Framework (NSF) for Older people in Wales[106] (2008)	This document sets out to improve health and social care services and equity of access for older people by setting national evidence-based standards for health and social care services. Specific aims of relevance include 'Challenging Dependency- methods should be put in place to help older people retain their independence'
Social Service Wellbeing Act (2014)[107]	This act provides a single statutory framework covering local authorities responsibilities in relation to all those who need care and support, of all ages, and including their carers. It specifically impacts the delivery of integrated care in Wales as it reforms and integrates social service law and makes provision for: • A duty to assess the needs of an adult for care and support, particularly through the provision of preventative measures put in place to meet individual needs • Co-ordination and partnership by public authorities with a view to improving the well-being of people
A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs (2014)[108]	The purpose of this Framework is to focus on older people with complex needs and ensure they have a strong voice and control over their care and support. It places a strong focus on preventative services and support to maintain well-being. It is about ensuring services, care and support are designed, co-ordinated and delivered effectively, to meet the outcomes that are important to people and their carers. The Statement of Intent in this framework sets out the need for an integrated approach to targeted preventative services e.g. reablement & intermediate care.
Setting the Direction	'Setting the Direction' recognises the commitment to delivering world-class integrated health care in Wales which requires a change in the

[106] http://www.wales.nhs.uk/sites3/Documents/439/NSFforOlderPeopleInWalesEnglish.pdf
[107] http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf
[108] http://gov.wales/docs/dhss/publications/140319integrationen.pdf

Policy	Relevance
(Feb 2010)	approach to developing both policy and service delivery models for primary and community care. The key underlying Principles for improvement include: • Universal population registration and open access to effectively organised services within the community • First contact with generalist physicians that deal with undifferentiated problems supported by an integrated community team • Localised primary care team-working serving discrete populations • Focus on prevention, early intervention and improving public health not just treatment • Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill-health, reduce dependency and effectively treat illness • A highly skilled and integrated workforce • Health and social care working together across the entire patient journey ensuring that services are accessible and easily navigated • Robust information and communication systems to support effective decision-making and public engagement • Active involvement of citizens and their carers in decisions about their care and well-being.
Sustainable Social Services (Feb 2011)	The documents sets out the commitment to reshaping social services on the basis of the following: • Prioritise integrated services esp. for families with complex needs, looked after children, transition to adulthood, frail older people • Need to build services around people • Integrated care one of the 8 priorities for action, led to reshaping services in reablement and family support through integration with health services
Delivering Local Healthcare (July 2013)	This document sets out; • Deliver more healthcare closer to home to reduce hospital use • Increase ability of local services to support people being healthier and facilitate easier access • Greater integration with single system of care planning and service delivery

Table 2 Relevant Local Policies and Strategies

Policy	Relevance
Carmarthenshire County Council Annual Report 2014/15 & Improvement Plan 2015/16[109]	The report sets out the aim to 'transform service delivery that reduces dependency and promotes independence. It aims to secure greater independence and choice for local people, with preventative strategies at the heart of service delivery in adult services.' A key area of focus is to reduce the delayed transfer of care through: • Improve the links between the community and acute sector • A Rapid Response domiciliary care service • Key models established to reduce the number of hospital admissions as well as put in place preventative measures.
Strategy for the care of older people in Carmarthenshire[110]	The areas within this theme are intermediate care, delayed transfers of care, aids and equipment and rehabilitation. Aims include: • Ensure that older people will have access to a range of high quality services, including rehabilitation and intermediate care services to enhance their ability to live as independently as possible in their own home or other care settings. • Resolve the problems of delayed transfers of care

[109] http://www.carmarthenshire.gov.wales/media/846036/Full_ARIP_Report_15-16.pdf
[110] http://online.carmarthenshire.gov.uk/agendas/eng/SHEW20040331/REP04_01.HTM