The Rapid Response Service

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The Rapid Response Service is one of a range of intermediate care facilities offered by certain hospitals and nursing and social service teams throughout the country. The general aim of the service is to ensure that patients have access to an alternative to hospital admission where this is appropriate and to prevent unnecessary hospital admissions by offering skilled nursing care and social support to patients in their own home. The service has responded to a rising number of emergency admissions and is designed to tackle the growing pressures on hospital beds.

Research carried out at the Royal Victoria Hospital in Folkestone who operate the Rapid Response Service for Shepway has provided the opportunity for a detail costing to be carried out. The cost estimates are presented in Schema 7.6 (page 100). Here we describe the service and basis for the cost estimates.

Service description and objectives

The objective of the Rapid Response Service is to provide rapid assessment and immediate treatment for patients in their own homes. Response is made within two hours of the referral being made by the patient's GP, the Social Services Department or from the Hospital. The team is then responsible for ensuring that effective communication is maintained with the General Practitioner, patients, relatives and other agencies involved. Programmes of care are designed to fit individual patients' needs enabling patients to return to their maximum functional independence. If appropriate, a Community Assessment and Rehabilitation Team (CART) also provide a rehabilitation programme. This has not been included in the cost estimates as it would require a separate detailed costing exercise.

The Rapid Response team comprises of a part time G grade staff nurse, two whole time E grade qualified nurses, five whole time B grade unqualified nursing staff and a G grade Care Manager. Supervision is provided by an I grade manager and administrative duties carried out by a full time administrative worker. The Service is available seven days a week from 8.00 am until 9.00 pm, but can provide an intensive package of care if required over a 24 hour period. This would mean that a Health Care Assistant would remain in the patient's home and, if he/she considered that the patient required qualified nursing care during the night, a community nurse could be called out between 10 pm and 8 am. At the time of writing the community nursing team had not been called out to a Rapid Response patient so this was not included in the cost estimates.

Service process

The process begins when a referral is made either by telephone or fax and this is responded to within two hours. A completed proforma, with the General Practitioner's signature accepting medical responsibility must be available the same day. Exceptions to this rule are made if there is a carer crisis or a situation where no medical support is required. However, the care package cannot be implemented unless the GP has accepted medical responsibility.

The referral is then assessed against service criteria before a face to face assessment is made of the patient. Patients have to be 60 years or over to qualify, although flexibility may be exercised

following discussion with the team. The patient must live in a designated area and the patient's family/carer must consent to treatment.

The referral can be made if the patient is unable to cope at home following injury or illness, or if there is a sudden reduction in mobility or exacerbation of any chronic condition requiring short-term nursing care and additional social support, such as a short-term carer crisis. However, the service is not for patients who require acute hospital admission who cannot be safely cared for in the community or who require administration of intravenous medication. Patients are not eligible if their needs can be met by existing community services or if they have symptoms of a stroke or a history of resistance to intervention.

When the eligibility criteria have been checked the patient will then be assessed by a Rapid Response Nurse and a care plan agreed with the patient and/or his or her carer. Written information is sent to the patient or carer and the referrer and is reviewed daily. All referrals for continuation of treatment by other agencies are completed pre-patient discharge to facilitate continuity of care and the team completes and sends a discharge summary report within two working days of discharge to the GP and other relevant agencies. Discharge planning forms an integral part of the patient's programme from the Rapid Response team and the team liaises with community services as soon as possible to ensure continuity of care.

Estimated costs

Detailed information was provided about expenditure and resource use, but information about the number of patients treated was not available. We have assumed that the service is working to capacity (seven patients per week), based on the types of programmes of treatment described below. Plans to expand the service suggest that it is working to capacity. A variety of unit costs have been estimated to reflect hours of care, types of activity (such as assessment) and episodes of care.

The amount of care required varies enormously from patient to patient so the basic cost of a delivered hour has been calculated for situations in which there is detailed information about the nature of the service received. This includes all costs related to those who provide the direct care and excludes other costs such as carrying out an assessment, discharging the patient and travel costs. These can be added on separately to reflect the service received by the individual patient. The cost per delivered hour is estimated to be £18 excluding, and £19 including the investment costs of the nurses' qualifications.

Approximately three quarters of assessments are carried out by an E grade nurse and the remainder by a G grade staff nurse. On this basis, the average weighted cost of an assessment was estimated as £39 (including travel). When a patient requires continuing care from the community nursing team, a Care Manager discharges the patients and makes the necessary preparations. This is estimated to cost £43 (including travel).

The costs of two typical types of episode have been identified. The first is an episode that typically consists of three visits during normal working hours at 30 minutes each for three days. This type of patient would undergo the obligatory assessment (including travel costs) but would not require any night care or incur discharge costs. The Rapid Response team may be called in simply to provide carer relief. This is estimated to cost £159.

A typical high cost episode includes the cost of assessing and discharging the patient and enhanced payments for unsocial hours. It consists of 10 visits, an average of 43 patient contact hours, of which 11 are paid at an enhanced rate. We estimate the cost of this episode to be £874.

Conclusion

There is a burgeoning of intermediate care services throughout the country but a dearth of information about the resource implications of these services. This limited study of one service provides us with some insight into the costs of provision. From these data it would seem that intensive episodes cost rather more than hospital stays for a similar period. However, this type of service is intended to be preventative. Any judgement about cost-effectiveness must be based on evidence about comprehensive costs and both short and longer-term outcomes.

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