Resource Utilisation and Classification Study (RUCS) Residential Aged Care Preliminary Findings

Professor Kathy Eagar
Australian Health Services Research Institute (AHSRI)
June 2018
A reminder of the background
Background

- AHSRI completed a major report in early 2017 on alternate funding models for residential aged care
- Department of Health and AHSRI undertook national consultations during 2017
- RUCS is a major ($2m) research and design study on the recommended option
  - But results will be useful more generally
- Work in progress (results at end 2018), policy decisions need to be made after that
# ACFI daily rates 2017-18

(plus basic fee and capital)

<table>
<thead>
<tr>
<th>Level</th>
<th>Activities of daily living (ADL)</th>
<th>Behaviour (BEH)</th>
<th>Complex Health Care (CHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Low</td>
<td>$36.65</td>
<td>$8.37</td>
<td>$16.37</td>
</tr>
<tr>
<td>Medium</td>
<td>$79.80</td>
<td>$17.36</td>
<td>$46.62</td>
</tr>
<tr>
<td>High</td>
<td>$110.55</td>
<td>$36.19</td>
<td>$67.32</td>
</tr>
<tr>
<td>High, high, high</td>
<td></td>
<td></td>
<td>$214.06</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plus basic fee @ 85% pension</th>
<th>per fortnight</th>
<th>$814.00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$58.14</td>
</tr>
</tbody>
</table>

| Max per day (plus supplements) | $272.20 |
| Per year                      | $99,354.04 |
Major issues with ACFI

- Additive design – the sum of individual item scores ignores interactions
- Does not focus on what drives care costs
- Does not discriminate enough between residents
- Inequitable outcomes (geographic and socioeconomic)
- Creates perverse incentives for income maximisation resulting in funding uncertainty
- One third of residents are classified to just one payment class

**Conclusion:** ACFI is no longer fit for purpose
ACFI profile 2015-16

- **Major Cities**: High, high, high
- **Inner Regional**: One or two Highs
- **Outer Regional**: No Highs
- **Remote**: One or two Highs
- **Very Remote**: No Highs
RUCS represents a very clear policy alternative to the current ACFI model

For both government and the sector
Six core elements (1)

- Separate assessment for funding from assessment for care planning
- Assessment for care planning to be undertaken by the residential aged care facility
  - based on resident needs and underpinned by CDC principles
- Assessment for funding purposes to be undertaken by external assessors
  - capturing only the information necessary to assign a resident to a payment class
Six core elements (2)

- One-off adjustment payment for each new resident
  - Recognising additional, but time-limited, resource requirements when someone initially enters residential care

- Fixed per diem price for the costs of care that are shared equally by all residents
  - may vary by location (and size and specialisation?)

- Variable price per day for the costs of individualised care for each resident
  - based on each resident’s casemix funding class
  - price per class would be standardised across Australia
What else can this type of system deliver?

- Better data to understand resident profile and changing needs and costs
- If resource utilisation classes contain residents with similar needs, they can be used to measure quality and outcomes in meaningful ways
  - eg, hospital transfer rates adjusted for casemix
  - eg, rates of functional decline adjusted for class at entry
  - eg, rates of adverse events – falls, medication errors, injuries – adjusted for casemix
Key elements of a new ‘blended payment model’
Adjustment payment

◆ One–off initial payment

◆ Time-limited costs involved with residents transitioning into care, eg:
  – Time spent getting to know the resident and their family
  – Individualised care planning
  – Behaviour management
  – Health care assessments
  – Facilitating health care arising from assessments:
    ♦ Pain control, dental care, palliative care etc
  – Developing an advanced care directive in partnership with the resident and their family
Fixed payments for ‘shared’ costs

- Care costs that are not tailored to individual resident needs.

- Care costs that are not affected by changes in the needs of individual residents:
  - Direct – eg, night staffing, dining room supervision
  - Indirect – eg, clinical educators, care co-ordinators, quality managers, infection control, remote salary loadings, staff leave.

- May vary based on location, size, specialisation of facility

- Actual proportions of shared and individualised costs will come from RUCS study
Variable payments for ‘individualised’ costs

◆ Care costs driven by individual resident needs and that are affected by changes in the needs of individual residents

◆ Residents classified to a casemix payment class

◆ Requires rules for reassessment (and assignment to a new class) as needs change

◆ Hypothetical classes developed by RUCS expert panels to guide assessment system design
The Resource Utilisation and Classification Study (RUCS)

Design August 2017 – February 2018
Study went live March 2018
Results end 2018
Sector engagement and advice

- Sector Reference Group advising the Department of Health

- Overall design informed by four expert panels advising ASHRI:
  - Function, cognition and behaviour specialist advisory panel
  - Wound management specialist advisory panel
  - End of Life specialist advisory panel
  - Technical nursing specialist advisory panel
The RUCS outline

- 3 studies over 18 months
- Each study aligned with a particular set of project deliverables
- Studies One and Two have overlapping timeframes
- Study Three will be completed with information derived from the previous two studies
Study One
Service utilisation and classification development

◆ To identify service inputs and resident cost drivers
  - Three data collections in one study:
    ◆ Resident assessments
    ◆ Service utilisation by day and
    ◆ Cost data by day

◆ 30 facilities in 3 regions - Northern Queensland, Melbourne and Hunter NSW – representing the range of resident need groups
RUCS Study One

- Assess each resident in Study One using the variables agreed to by the expert panels
- Collect service utilisation (time in minutes) per resident per day & calculate actual cost for each resident day
- Test the hypothetical classification tree
- Develop a final classification tree based on the evidence collected in Study One
  - Use this in Study Three to develop a national resident classification profile
Study Two

Analysis to identify shared cost drivers

- Financial data to identify factors that drive shared costs based on facility characteristics by region, facility size and specialisation and to test seasonal effects

- Nationally representative sample of 110 care homes.
  - Oversampling remote and very remote services to ensure that their shared costs are adequately represented

- We currently (June 2018) have data in for 94 homes, 16 more to come
Study Three

The casemix profiling study

◆ To model the impact of introducing the classification in a blended payment model

◆ Classification variables from Study One in an additional 80 nationally representative facilities.
  – Purpose is to develop a national profile of residents allocated to each final casemix class and to model and test the impact of implementing the blended payment model nationally.

◆ Detailed planning in progress
Results of the expert panels
Four expert panels

- Function, cognition and behaviour specialist advisory panel
- Wound management specialist advisory panel
- End of Life specialist advisory panel
- Technical nursing specialist advisory panel

Key questions:
- What drives cost?
- What costs are standard (shared time) versus individual?
- What assessment tools best assess these cost drivers?
Criteria for selecting assessment tools

◆ Capture variables that best predict resource consumption
  – Not comprehensive, not for care planning

◆ Initial external assessment for classification purposes
  – Assessors with clinical expertise and who understand aged care
  – Assessor won’t know the person beforehand but can draw on informant information
  – Assessment completed in one session
    ◆ Can include clinical algorithms

◆ Potential for external or internal use for reassessment purposes
  – Reassessment protocols need to be determined

◆ Psychometric properties
Function, cognition and behaviour panel outcomes

- Domains and assessment tools:
  - Care burden due to Function
    - FIM Motor, DEMMI and RUG-ADL
  - Care burden due to Cognition/communication problems
    - FIM Cognition
  - Care burden due to Behaviour, Harm, Anxiety, Distress
    - NPI-NH
Palliative care panel outcomes

- Language – use the term ‘palliative care’ which includes ‘end of life’, ‘palliative approach’ etc

- Collect Australian-modified Karnofsky Performance Scale (AKPS) on everyone

- Admit for residential palliative care:
  - Prognosis <3 months
  - Existing palliative care plan (primary care or palliative care team)
  - Collect AKPS, RUG-ADL, Phase, Malignancy (yes/no)

- Residents who become palliative while in residential care are re-assessed as per any other change in care requirements
Wound care panel outcomes

- Wounds to be considered as a confounding factor to come in further down the classification tree
- Residents at high risk for wounds have similar care needs to those with wounds
- Assess everyone using the Braden Scale for Predicting Pressure Sore Risk:
  - 6 items - sensory perception, moisture, activity, mobility, nutrition and friction/shear
- No reassessment protocol for wounds required
Nursing specialist advisory panel

Two tasks

◆ What resident attributes drive resource consumption?
  – Are these captured in the tools identified by the other panels?
  – How to assess for any other technical nursing requirements?

◆ Data items, definitions and business rules for the service utilisation data collection
  – Shared time/ fixed costs
  – Individual time/ variable costs
Early results – RUCS Study

As at 22 June 2018
The first half of the sample in Study One
Resident information and consent: poster on display at every facility and processes for opt out

Information for Residents

The Resource Utilisation and Classification Study (RUCS)

Over the next few weeks, the University of Wollongong will be collecting information about residents for a research project funded by the Commonwealth Government. The research is to develop a new funding model for care homes.

Registered nurses will visit this care home to conduct assessments on residents at this care home. Participation is completely voluntary. You will be asked if you are happy to participate at the start of the assessment.

The assessment involves asking you some questions about the things you can do on your own, and the things you need help with. It won’t take too long. If at any time you want to the assessment to stop, just tell the nurse.

Of more than 2,100 residents, about 40 opt outs (<2%) due to either resident or family choice or because resident died before being assessed.
RUCS time and cost data collection

- Staff used bar coders and standard activity categories to collect time data on every shift
- 30 days of time data for each resident
- Staff recognised as data collection proceeded
  - Mainly chocolates
- Each day of care for each resident is being costed on a full bottom up cost basis
  - No cost results just yet
FINAL - Scan STOP

CHECK:
Did you scan the activity first?
If not, Cancel and Restart

If yes, then continue:
Did you scan the resident or residents barcode(s)?
If yes, then continue:
Did you scan STOP?
If no, Cancel and Restart

If yes, then continue:
If not, Cancel and Restart
<table>
<thead>
<tr>
<th>General Care Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined care in resident’s room</td>
</tr>
<tr>
<td>Personal care/hygiene</td>
</tr>
<tr>
<td>Assistance with mobility</td>
</tr>
<tr>
<td>Assistance with feeding</td>
</tr>
<tr>
<td>Pressure area/skin care (incl repositioning)</td>
</tr>
<tr>
<td>Assessment and/or care planning</td>
</tr>
<tr>
<td>Assistance with oral medication</td>
</tr>
<tr>
<td>Re-ablement / therapies</td>
</tr>
<tr>
<td>Social activities/talking with resident</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Nursing Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen</td>
</tr>
<tr>
<td>Enteral feeding</td>
</tr>
<tr>
<td>Tracheostomy Care</td>
</tr>
<tr>
<td>Catheter Care</td>
</tr>
<tr>
<td>Stoma Care</td>
</tr>
<tr>
<td>Peritoneal dialysis</td>
</tr>
<tr>
<td>Daily Injections</td>
</tr>
<tr>
<td>Complex wound management</td>
</tr>
</tbody>
</table>
Resource utilisation: first results

- 40% of time reported so far is individual time, 60% shared
  - This is evidence supporting a fixed and variable payment rate
- Range across homes is 30% - 65%
- Some individual time under-reported so expect about 50:50 after data editing
Resident assessments

First results
Training and support

- Assessors were all RNs with minimum 5 years experience
- Assessors received half day training
- Regular teleconferences with assessors to get feedback and ensure consistency of approach
How difficult was it to make the ratings?

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very easy</td>
<td>289</td>
<td>28.6%</td>
</tr>
<tr>
<td>Moderately easy</td>
<td>465</td>
<td>46.0%</td>
</tr>
<tr>
<td>Not sure</td>
<td>111</td>
<td>11.0%</td>
</tr>
<tr>
<td>Moderately difficult</td>
<td>108</td>
<td>10.7%</td>
</tr>
<tr>
<td>Very difficult</td>
<td>5</td>
<td>0.5%</td>
</tr>
<tr>
<td>Not reported</td>
<td>33</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total</td>
<td>1011</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
How confident do you feel that the ratings that you have recorded are accurate?

<table>
<thead>
<tr>
<th>Confidence</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident</td>
<td>393</td>
<td>38.9%</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>527</td>
<td>52.1%</td>
</tr>
<tr>
<td>Undecided</td>
<td>56</td>
<td>5.5%</td>
</tr>
<tr>
<td>Not very confident</td>
<td>5</td>
<td>0.5%</td>
</tr>
<tr>
<td>Not at all confident</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Not reported</td>
<td>29</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>1011</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
External assessment - what we now know

◆ There is an appetite for change in the sector
◆ External assessment works
◆ Assessments can be conducted by RNs but not ENs
◆ ‘Can Do’ assessment supports consumer choice
◆ External assessment is acceptable to residents
◆ Experienced assessors can make confident clinical judgements and distinguish between ‘can do’ and ‘do do’
◆ Assessors need training and to operate as a networked workforce to ensure consistency
External assessment – issues not completely resolved in Study One

- Assessor skill mix – RNs, OTs and Physios
- Assessment locations - home and hospital
- Sources of information – cognition and behaviour
- Admit for end of life care
- Mode – assessment via video / telehealth?
- Recruitment and structure of the assessment workforce
- Reassessment protocols
Resident profiles
## Time in residential aged care

<table>
<thead>
<tr>
<th>Time in care</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3 months</td>
<td>69</td>
<td>6.4%</td>
</tr>
<tr>
<td>3-6 months</td>
<td>75</td>
<td>6.9%</td>
</tr>
<tr>
<td>6-12 months</td>
<td>180</td>
<td>16.6%</td>
</tr>
<tr>
<td>&gt;1 year</td>
<td>760</td>
<td>70.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1084</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Oxygen</td>
<td>961</td>
<td>41</td>
</tr>
<tr>
<td>Enteral feed</td>
<td>997</td>
<td>5</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>1002</td>
<td>0</td>
</tr>
<tr>
<td>Catheter</td>
<td>981</td>
<td>21</td>
</tr>
<tr>
<td>Stoma</td>
<td>991</td>
<td>11</td>
</tr>
<tr>
<td>Dialysis</td>
<td>1002</td>
<td>0</td>
</tr>
<tr>
<td>Daily injections</td>
<td>944</td>
<td>58</td>
</tr>
<tr>
<td>Complex wounds</td>
<td>932</td>
<td>70</td>
</tr>
</tbody>
</table>
**The RUG-ADL**

**SECTION 3**
Resource Utilisation group – Activities of Daily Living  
*(RUG – ADL)* *(See score sheet for values)*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 = completely independent  
5 = cannot do  

Note: eating scale is only 1 to 3
<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Falls in last 12 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>479</td>
<td>48.2%</td>
</tr>
<tr>
<td>Yes, once</td>
<td>252</td>
<td>25.4%</td>
</tr>
<tr>
<td>Yes, more than once</td>
<td>262</td>
<td>26.4%</td>
</tr>
<tr>
<td><strong>3 persons for transfers?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>977</td>
<td>97.5%</td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Weight loss of more than 10% in last 12 months?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>920</td>
<td>92.5%</td>
</tr>
<tr>
<td>Yes</td>
<td>75</td>
<td>7.5%</td>
</tr>
</tbody>
</table>
Australian-modified Karnofsky Performance Status (AKPS). Tick one (1) of the following boxes.

- (100) Normal; no complaints; no evidence of disease
- (90) Able to carry on normal activity; minor sign of symptoms of disease
- (80) Normal activity with effort; some signs or symptoms of disease
- (70) Cares for self; unable to carry on normal activity or to do active work
- (60) Able to care for most needs; but requires occasional assistance
- (50) Considerable assistance and frequent medical care required
- (40) In bed more than 50% of the time
- (30) Almost completely bedfast
- (20) Totally bedfast and requiring extensive nursing care by professionals and/or family
- (10) Comatose or barely rousable
The lower the rating, the more dependent.
The lower the rating, the more dependent.

AKPS (palliative performance) profile

- Residential aged care
- Hospital palliative care
- Community palliative care
Rockwood Frailty Score

10 = very fit

90 = terminally ill
Rockwood Frailty Scale
### The FIM

#### FIM Motor score – first 12 items

‘Stairs’ item removed from analysis

Range 12 (total assistance on every item) to 84 (complete independence on every item)

#### FIM Cognition score – last 5 items

Range 5 (total assistance on every item) to 35 (complete independence on every item)

---

### Functional Independence Measure (FIM)

<table>
<thead>
<tr>
<th>Function</th>
<th>Score 1 – 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
</tr>
<tr>
<td>Dressing - Upper Body</td>
<td></td>
</tr>
<tr>
<td>Dressing - Lower Body</td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
</tr>
<tr>
<td>Bladder Management</td>
<td></td>
</tr>
<tr>
<td>Bowel Management</td>
<td></td>
</tr>
<tr>
<td>Bed, Chair, Wheelchair</td>
<td></td>
</tr>
<tr>
<td>Toilet</td>
<td></td>
</tr>
<tr>
<td>Tub, Shower</td>
<td></td>
</tr>
<tr>
<td><em>Walk or Wheelchair (</em>)</td>
<td></td>
</tr>
<tr>
<td>Stairs</td>
<td></td>
</tr>
<tr>
<td>Comprehension</td>
<td></td>
</tr>
<tr>
<td>Expression</td>
<td></td>
</tr>
<tr>
<td>Social Interaction</td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
</tr>
<tr>
<td>Memory</td>
<td></td>
</tr>
</tbody>
</table>
FIM Motor Score (stairs item excluded)
### SECTION 7

**Braden Scale – Predicting pressure sore risk**

(See score sheet for values)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description and score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Sensory Perception</td>
<td>Completely limited</td>
</tr>
<tr>
<td>Is sensory perception rating based on</td>
<td>Communication □ Sensation □ both</td>
</tr>
<tr>
<td>Moisture</td>
<td>Constantly moist</td>
</tr>
<tr>
<td>Activity</td>
<td>Bedfast</td>
</tr>
<tr>
<td>Mobility</td>
<td>Completely immobile</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Very poor</td>
</tr>
<tr>
<td>Friction and Shear</td>
<td>Problem</td>
</tr>
</tbody>
</table>
Braden Scale - Sensory Perception

- Completely limited: 5%
- Very limited: 15%
- Slightly limited: 40%
- No impairment: 35%
Braden Scale - Nutrition

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very poor</td>
<td>10%</td>
</tr>
<tr>
<td>Probably inadequate</td>
<td>20%</td>
</tr>
<tr>
<td>Adequate</td>
<td>50%</td>
</tr>
<tr>
<td>Excellent</td>
<td>10%</td>
</tr>
</tbody>
</table>
Braden Scale - Friction and Shear

- Problem: 0%
- Potential problem: 40%
- No apparent problem: 45%
An extract of the NPI screening tool

12 screening questions

A ‘Yes’ triggers further questions

A. Does the resident have beliefs that you know are not true? For example, saying that people are trying to harm him/her or steal from him/her. Has he/she said that family members or staff are not who they say they are or that his/her spouse is having an affair? Has the resident had any other unusual beliefs?

☐ No

☐ Yes → Complete NPI-NH Part A

B. Does the resident have hallucinations – meaning, does he/she see, hear, or experience things that are not present? (If “Yes,” ask for an example to determine if in fact it is a hallucination). Does the resident talk to people who are not there?

☐ No

☐ Yes → Complete NPI-NH Part B

C. Does the resident have periods when he/she refuses to let people help him/her? Is he/she hard to handle? Is he/she noisy or uncooperative? Does the resident attempt to hurt or hit others?

☐ No

☐ Yes → Complete NPI-NH Part C
**Neuropsychiatric Inventory NPI - 12 items**

- No problems: 30%
- 1-3 problems: 40%
- 4-6 problems: 25%
- 7 or more problems: 15%
Hypothetical model – 1st split

Admit for residential palliative care?

No

N=997

Yes

Class 1

N=5
Hypothetical model – 2nd split

All

Palliative care at admission?

No

Mobility
N=997

Independent
N=217

Mobile with assistance
N=550

Yes

Class 1 (n=5)

Non-weight bearing
N=189
Hypothetical model – independent branch

Independent N=217

High Function
- Without CF: Class 2
- With CF: Class 3

Medium Function
- Without CF: Class 4
- With CF: Class 5

Low Function
- Without CF: Class 6
- With CF: Class 7

CF = Compounding Factors
Compounding factors

- Variables that explain differences in resource consumption that will be incorporated to create the final branches of the tree
  - Being determined empirically using cost data collected in Study One
  - Will probably vary from one branch to another
  - Testing cognition, behaviour, technical nursing requirements etc both as single items and in combination
  - Being careful to ensure that they do not create perverse incentives
    - Behaviour, pressure ulcers etc
Hypothetical model – mobile with assistance branch

Mobile with assistance
N=550

High Function
Without CF
Class 8
With CF
Class 9

Medium Function
Without CF
Class 10
With CF
Class 11

Low Function
Without CF
Class 12
With CF
Class 13

CF = Compounding Factors
Hypothetical model – non-weight bearing branch

Non-weight bearing
N=189

- Without CF
  - Class 14

- With CF
  - Class 15

CF = Compounding Factors
Next steps

- Work in progress
  - final results from Study One plus the other studies
- Results at end 2018
- Policy decisions need to be made after that
Stakeholder engagement and buy-in

- There is an obvious appetite for change
- The sector response to RUCS and to the broader model has been overwhelmingly positive
  - But note genuine concerns about adequacy of overall funding levels
- Now need to capitalise on that and plan for change