Bath & North East Somerset Council

MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	7th October 2011	**AGENDA ITEM NUMBER**
TITLE:	Re-ablement & 30 Day Post Discharge Support Services	
WARD:	ALL	

AN OPEN PUBLIC ITEM

List of attachments to this report:

Appendix I – Outline Service Specifications

1 THE ISSUE

1.1 To inform the Panel about the national re-ablement and thirty day post discharge support policy and the potential implications of the policy for commissioning and service delivery arrangements from 1st April 2012.

1.2 To provide an update on the use of the re-ablement and winter pressures funding received in 2010/11 and the re-ablement funding in 2011/12 transferred to the Council under a section 256 agreement. This funding was received in order to underpin the policy reform previously mentioned.

1.3 To outline the process that is underway to secure a number of ‘Extended Research Pilots’ which will provide evidence for the future use of re-ablement resources when tariff arrangements change in 2012/13.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to:

2.1 Note the report and signal ongoing support for the work in progress.

3 FINANCIAL IMPLICATIONS

3.1 Potential financial implications, including the impact of the changes on funding arrangements for the new Social Enterprise, are covered in the body of the report.

3.2 The final tariff arrangements, due to be implemented in acute hospitals to support the new policy framework, have yet to be announced. However it has recently become clear that the focus of the new arrangements has been narrowed to include only those patients discharged from hospital with the following conditions:

- Stroke rehabilitation
- Cardiac rehabilitation
- Fragility hip fractures

4 THE REPORT

Background

4.1 The revised NHS Operating Framework for 2010/11 detailed *"changes to the tariff to cover re-ablement and post-discharge support"* as well as an intention to ensure that acute hospitals retain responsibility for patients for up to thirty days after discharge. Readmissions during this thirty day period will no longer attract an additional tariff as they previously did, with the aim of ensuring that appropriate care and support services are in place, first time, to facilitate timely and successful discharges, effectively reducing and preventing emergency readmissions.

4.2 Therefore, from 1st April 2011 the requirement on commissioners to pay for emergency readmissions (within thirty days) was removed, with some defined exceptions, although readmissions following outpatient procedures or A&E attendances are excluded from this rule.

4.3 For emergency readmissions within thirty days of discharge following a non-elective admission, commissioners and providers are required to agree a local threshold rate based on the last complete twelve months data, above which there will be no payment. This threshold must be set to deliver at least a 25% reduction in the readmission rate of the previous year.

Policy Context

4.4 In 2010/11, Primary Care Trusts received £70 million additional funding for re-ablement and post discharge support linked with a requirement to develop local plans to inform future commissioning activity. Further allocations were made in 2011/12 and these are set to peak in 2012/13 when it is anticipated that a well evidenced and appropriate range of services will be in place to enable commissioning responsibility to transfer from PCTs/Local Authorities to acute hospitals.

4.5 The types of post-discharge support that might be included in hospitals' thirty day responsibility include homecare re-ablement, intermediate care services, rehabilitation, community health services and follow-up outpatient attendances.

4.6 A number of services will be excluded including pre-existing long-term residential and home care services provided by local authorities and care services provided under a GP contract.

Policy Implications

4.7 High level analysis of the activity of the new Social Enterprise indicates that a significant percentage of business is generated by discharges from the RUH, for example admissions to, and treatment in community hospitals. Other services delivered by community health & social care staff fall within the spectrum of 'post discharge support' including the community stroke service, COPD service, intermediate care and district nursing. The funding implications of the new policy framework for the new Social Enterprise will need to be clearly analysed once the final arrangements are announced.

4.8 Under the current post discharge commissioning arrangements, GPs take a lead role in influencing the services that are put in place to support re-ablement. The new policy framework could potentially take away from GPs the responsibility for the key period post discharge, which tends to be the determinant of whether someone heads to independence or to long term institutional care. Similarly Local Authority commissioners are also likely to be impacted by the change in policy, for example increase/decrease in demand for LA funded/contracted services such as domiciliary care, however it remains unclear at the present time what the full extent of any impact might be

4.9 The long term sustainability of services and the balance of health & social care re-ablement provision within the local market will need to be closely monitored as the new policy framework emerges. Whilst it is unlikely that any acute trust would deliberately de-stabilise its local system of provision, any un-intended consequences of change may be detrimental to the long term sustainability of local services. In particular, a number of services are commissioned from the voluntary sector, tied into three year contracts and the implications of this policy on personal budgets and the likely roll out of personal health budgets also need to be understood more fully.

Early Implementer Sites

4.10 Earlier in 2011 commissioners took part in a series of three Early Implementer Project workshops with the DH policy team where it was acknowledged that post discharge support was not only about preventing readmissions to hospital, but also to residential care, and that a focus on the provision of early re-ablement support could help prevent escalations in both health and social care needs and promote independent living.

4.11 On this basis a scoping exercise was completed with a number of local provider organisations to identify potential areas for further market testing of re-ablement services. This was further refined, between January and March 2011, by the work of an experienced OT who worked alongside the RUH's Discharge & Therapeutic Evaluation Team to identify current gaps in health and social care provision. Eight key areas were identified as follows:

- Mental health liaison support across secondary, community and primary care
- The integrated re-ablement & ICT teams
- Home from Hospital scheme
- Handyperson services
- Community transport
- Medicines management support

- Assistive technology, in particular telehealth
- Alcohol liaison services in secondary care

Extended Research Pilots

4.12 Five of these areas were felt to be suitable for attracting expressions of interest from qualified local providers to deliver the 'Extended Research Pilots' previously mentioned. The aim of the pilots will be to establish a firmer evidence base for a range of health and social care interventions and enhance understanding of the likely future demand for re-ablement and post discharge support services.

4.13 Outline service specifications (attached as Appendix 1) were drawn up and circulated to local providers at the beginning of August 2011 with a closing date for expressions of interest of 2nd September 2011. The service specifications were designed to encourage partnership arrangements and innovative proposals by keeping them 'open to interpretation' with the provision of detailed information being kept to a minimum. The intention was to encourage providers to signal, through their submissions, the types of interventions they believed worked well in practice and to provide evidence for this.

4.14 Fourteen expressions of interest were received across all five categories; several of these offer creative and flexible solutions and provide good evidence of outcomes for service users. Submissions are currently being evaluated by health and social care commissioners with input from the GP Accountable Officer of the CCG and a service user representative.

4.15 At the time of writing, it is anticipated that final decision will be made during the week commencing 26th September 2011 and that ERPs will be awarded on the following basis:

Integrated health & social care re-ablement	Two providers	Total funding £208k
Intensive home from hospital support	Two providers	Total funding £50k
Handyperson & Minor Adaptations	One provider	Total funding £50k
Step down accommodation & support	One provider	Total funding £100k
Telehealth (to support congestive heart failure)	One provider	Total funding £75k

5 RISK MANAGEMENT

5.1 Although this work is supported by the RUH who have been fully involved and consulted throughout the process, with future tariff and commissioning arrangements still unclear there are a number of risks associated with initiating ERPs at this stage:

- Lack of clarity in relation to future funding leading to market instability
- Lack of stability for staff recruited to facilitate/deliver ERPs

- Potential disruption for service users when ERPs end

5.2 In order to minimise and mitigate risks it will be important, as soon as tariff and policy arrangements are clarified, to communicate this to successful providers and emphasise the requirement to ensure that robust evaluation data is collected throughout the lifespan of each ERP.

5.3 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 Until the new policy framework has been clarified by the DH it will be difficult to complete a full equalities impact assessment.

7 CONSULTATION

7.1 Consultation with a range of stakeholders was carried out earlier in the year at the Health & Wellbeing Partnership Network Event.

7.2 *Ward Councillor; Cabinet Member; Overview & Scrutiny Panel; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners;*

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Customer Focus; Sustainability; Impact on Staff

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Council Solicitor) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

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Background papers	None
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