report

Nottinghamshire County Council

meeting	HEALTH AND WELLBEING BOARD		
date	6 July 2011	agenda item number	**11**

REPORT OF THE CORPORATE DIRECTOR FOR ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION

DEVELOPING RE-ABLEMENT SERVICES LINKED TO HOSPITAL

PURPOSE OF THE REPORT

1. To outline the local approach taken to the investment of dedicated Department of Health funding in services designed to reduce avoidable re-admissions to hospital and improve support for people following discharge from hospital.

INFORMATION AND ADVICE

Reablement and post-discharge support

2. The terms reablement and post-discharge support can be used differently across different agencies but broadly relate to a range of activities designed to maximise individuals' independence and reduce the need for more intensive services due to a loss of independence or following an acute period of ill health. They are therefore a key element in plans across health and social care agencies to:

- avoid the need for people to be (re)admitted to hospital
- promote integrated and joint working across health and social care
- facilitate discharge from hospital in order to avoid delays, and
- reduce the need for ongoing support/intervention following a stay in hospital.

3. Reablement services encourage individuals to develop the confidence and skills to carry out day-to-day activities themselves, and to continue to live independently at home. Recent research undertaken by the Social Care Institute for Excellence (SCIE) (*Research briefing 36: Reablement: a cost-effective route to better outcomes, April 2011*) confirms that reablement services achieve better outcomes for people and can be cost effective, avoiding crisis which may require hospital admission or a loss of independence requiring longer term care, as

well as maximising independence following an admission to hospital or a more institutional care setting.

4. Whilst often seen as social care services, reablement services, as the term is used locally, are broad ranging including lower level support services designed to increase social capital and early intervention services which may be more clinically focussed, such as physiotherapy and input from clinical nurse specialists which may focus on reducing the risk of acute ill health and hospital admission for those with long-term medical conditions.

5. In addition to those services focussed on increasing individuals' independence, the term post-discharge support is used for those services specifically focussed on supporting people leaving hospital. They may be provided to people who may not necessarily require reablement activity but who may require some short-term practical support, such as that provided by hospital discharge schemes, they may provide health care akin to that provided in a hospital setting in the community, for example, for people with non-weight bearing fractures, or they may provide support for people who wish to avoid future hospital admission such as those at end of life who wish to die at home.

Hospital Re-admissions

6. Emergency re-admission into hospital increased nationally by 50% between 1998-99 and 2007-08 (Department of Health, Payment by Results Guidance for 2011-12). To address this, the Department of Health (DH) has recently sought to create greater financial incentives for providers to ensure hospitals discharge patients at the right time, and with adequate support, so that numbers of inappropriate re-admissions are reduced.

7. Firstly, the DH announced changes to the tariff (the amount paid by the Primary Care Trust (PCT) for an in-patient spell for a particular clinical treatment) paid to acute hospitals to cover reablement and post-discharge support. Alongside this, it also announced "an intention to ensure that hospitals are responsible for patients for the 30 days after discharge. If a patient is re-admitted within that time, the hospital will not receive any further payment for the additional treatment."

8. This means that acute hospitals may, from now, only attract full tariff reimbursement if they provide sufficient quality of service and prepare patients adequately for discharge. They will not be paid for hospital readmissions within 30 days of discharge. The requirement to ensure adequate post-discharge support and the enhanced tariff to assist with the cost of this support is due to take effect from April 2012.

Funding to support system redesign

9. Two funding streams have emerged from the DH to support changes to the health and social care system to address this agenda. In October 2010, specific funding was allocated to PCTs for the period up to April 2012, to enable joint plans with social care and to increase the range and capacity of post-discharge and reablement services. Secondly, the DH announced a requirement for PCTs to support social care, recognising the reductions in local authority funding, to stimulate system redesign and to mitigate against budget pressures and reductions, where these may also impact on the NHS.

10. Locally, the first of these funding streams has been used exclusively to develop approaches to providing post-discharge support, timely transfer of care and hospital admission avoidance. The second funding stream has, in part, been used both to support this same agenda as well as addressing demographic pressures and other system pressures which may impact on the whole health and social care system.

11. Plans for the use of the dedicated post-discharge support and reablement funding were drawn up jointly with Social Care by both NHS Bassetlaw and NHS Nottinghamshire County, with the additional involvement of GP consortia, hospital trusts and the community health provider. Initially these plans were drawn up in December 2010 for 2010/11, however, plans are also now in place for 2011/12. These were developed following the mapping of existing services, a literature search to identify potential new models of service where there was evidence of service effectiveness, and a short bidding process.

12. A set of performance measures have been agreed to assess the effectiveness of each service and a research post, to provide a review of each project against the aims of the reablement programme, has been established.

13. Links have also been made with the other inter-dependent work programmes including:

- Review of Hospital Social work (NCC)
- Review of community hospitals (NHSNC)
- Aiming for excellence (NCC)
- Unplanned Care financial recovery programme (NHSNC)
- Review of Delayed Transfers of Care (DTOCs)(NHSNC)
- Day services review (NCC)
- Mental Health and older people in acute hospitals (NHT)
- Alternatives to residential care (NCC)
- Supporting People (NCC)
- Reablement, Eligibility and Review (NCC)
- Health and Social Care integrated discharge management workstream (Productive Notts/NUH).

14. Work to develop a longer term strategy to address this agenda will continue, involving GP consortia, the hospital trusts, public health and social care. This is overseen by the Executive Joint Commissioning Group.

Pilot Approaches

15. Below are examples of the schemes that were commissioned during 2010/11 as part of the reablement programme. A list of schemes approved for 2011/12 is attached as **Appendix 1**.

- **Short-term Physiotherapy input into START (Short-term assessment and reablement team)** - This Bassetlaw pilot saw the addition of physiotherapists to the County Council's assessment and reablement service, with the aim of delivering better outcomes for some service users and extending the longevity of the improvement in independence. This service is currently being evaluated and could be rolled out countywide.

- **Assessment beds for long-term care** - This is a pilot project in Bassetlaw testing the effectiveness of assessment beds for people who are at risk of being admitted into a residential care home following a hospital admission. The service will provide an alternative environment for recuperation, assessment and reablement of older people who are medically fit and no longer need to remain in hospital, but at the time of discharge are unable to return home and so are at risk of being admitted into long term residential care.

- **Crisis Intervention Community Support Service (CICSS)** - Nottingham West Consortium received funding to work with the British Red Cross to trial and evaluate CICSS. The service aims to provide emotional support and assist people with low level social needs in maintaining their independent living skills. The service provides a rapid response, seeing a patient within one hour of the referral being processed.

- **High Volume Service User Nurse Specialist** - This is a NHS Nottinghamshire County commissioned service to develop a case management approach to High Volume Service users and related pathways.

- **Emergency Department Avoidance Support Service** - This project, in place since March 2011, is piloting an admission avoidance service from the emergency departments within Nottingham University Hospitals and Sherwood Forest Hospitals Trust. This is a responsive service provided by generic health and social care staff which returns people home with support to avoid readmissions. The pilot is focussing on out of hours as national

statistics indicate that 35% of admissions to hospital are out of normal opening hours and locally this is reported as a priority.

- **Bridge the care package gap** - This is a Lings Bar Community Hospital initiative to provide interim home care support to enable patients to be discharged safely and return home whilst awaiting a social care package.

STATUTORY AND POLICY IMPLICATIONS

16. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder and those using the service. Where such implications are material, they have been described in the text of the report.

Financial Implications

17. Reablement and Post discharge support funding of £168k and £879k was paid to NHS Bassetlaw and NHS Nottinghamshire County respectively for 2010/11 with this allocation doubling in 2011/12. The £1.1m figure allocated through the NHS Nottinghamshire County 2011/12 bidding process is that remaining taking into account funding committed as part of the 2010/11 commissioning process.

18. NHS funding 'support for social care' for the county totals £9.6m in 2011/12 and £9.3m in 2012/13. 2011/12 funding has been paid by the Primary Care Trusts to the County Council by way of section 256 agreements.

RECOMMENDATIONS

19. It is recommended that the Board:

(a) notes the work being undertaken using dedicated monies to test new approaches to delivering reablement and post-discharge support services

(b) receives future reports regarding the developing approach to hospital focussed reablement services

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FINANCIAL COMMENTS OF THE SERVICE DIRECTOR (FINANCE)
(RWK 17/06/2011)

20. The financial implications are set out in the report

LEGAL SERVICES COMMENTS (LMC 16/06/2011)

21. The report is for noting only.

BACKGROUND PAPERS AVAILABLE FOR INSPECTION

22. NHS Bassetlaw and NHS Nottinghamshire County Reablement Plans for 2010/11 Social Care Institute for Excellence, Research briefing 36: Reablement: a cost-effective route to better outcomes.

ELECTORAL DIVISIONS AFFECTED

23. Nottinghamshire.

HWB10

APPENDIX 1

NHS Nottinghamshire County Reablement Funding 2011/12 (£1.1m)

SERVICE/INTERVENTION	LEAD AGENCY
Signposting service for Fallers at the Emergency Department*	NUH/City and County PCTs
Mental Health Intermediate Care Service - Weekend cover	Notts Healthcare
Lings Bar Hospital Supporting timely discharge	CHP
Intermediate Care Spot Purchasing	NWC/CHP
Integrated Physiotherapy Service	Principia
Personal Care – Crisis Intervention Community Support Service	NNEC- Red Cross
Intensive COPD Discharge Support Programme	NNEC- NUH
COPD Early Assessment & Discharge	Sherwood Forest Hospitals
Geriatric admission avoidance and early discharge service	Sherwood Forest Hospitals
Rapid Discharge End of Life Service	Sherwood Forest Hospitals
Assessment Beds Pilot	NCC/CHP
Urology Outreach Service	Sherwood Forest Hospitals
Extended Elective Orthopaedic Outreach Service	NCC/SFH
Joint Therapy Post-discharge Telephone and Outreach Service	NUH
Nurse Practitioner - Care Homes	N&S/CNCS
High Point GP Consortia Care Homes Project	High Point

*Subject to further discussion

NHS Bassetlaw Reablement Funding 2011/12 (£336k)

SERVICE/INTERVENTION	LEAD AGENCY
Short term physio input into START	Bassetlaw Community Health
Community matron to be based in A and E	Bassetlaw Community Health
Multi-disciplinary support into A&E to support community matron	Bassetlaw Community Health and Adult Health and Social Care
Assessment beds for long term care including therapy assessment	Adult Health and Social Care
Trainer for I-tracker	Bassetlaw Hospital
Additional support into Integrated Discharge Team. Money from Phase 1	Bassetlaw Community Health/DBH
Expand rapid response criteria to include all adults (currently 60yrs and over)	Bassetlaw Community Health
COPD post discharge follow up – pro-actively support COPD patients to prevent re-admissions	Bassetlaw Community Health
Respiratory community physiotherapy	Bassetlaw Community Health
Post discharge Stepdown scheme	Bassetlaw Community Health
Additional transport to support discharges	Gibson Ambulance Service