Post discharge tariffs in the English NHS

Martin Campbell
Department of Health

4th June 2013

Contents

Background

The number of patients being readmitted to hospital within 28 days of discharge has been rising steadily for several years:

"Data on emergency readmissions within 28 days after discharge, analysed and published by NCHOD since 1998/9, have consistently shown a rising annual trend. This remained after taking into account differences between the years in the age and gender of patients, method of admission of the original hospital stay, diagnoses within medical specialties, and operations within surgical specialties."

Source: DH report "Emergency Readmission Rates – further analysis"

The latest data shows the emergency readmission rate is around 11%

The political imperative

- "Over the last ten years emergency readmissions have increased by over 50 per cent. Not, it seems, primarily because patients have become more frail, although some may have, but because hospitals have been incentivised to cut lengths of stay and send patients home sooner – process targets creating risks for patients.

- So in addition to getting rid of targets that have no clinical justification, we're going to ensure that **hospitals are responsible for patients not just during their treatment but also for the 30 days after they've been discharged**. It will be in the interests of the hospital for patients to be discharged only when it is ready and safe for them to do so.

- And **if a patient is readmitted within those 30 days the hospital will not receive any additional payment for the additional treatment** – they will be focused on successful initial treatment and reablement and support for people as they return home.

- The outcome for the patients is the only outcome that matters – and so we are sending a clear message to the NHS that patient care doesn't end when they walk out of the hospital door. This will have the added benefit of driving the further integration of hospital and community services where it most matters. Patients don't talk about 'primary' and 'secondary' care, they see it simply as treatment and care for the problem they have, whether at home or in hospital."

Secretary of State for Health
8 June 2010

The patient perspective

‘Everyone counts’
NHS Constitution

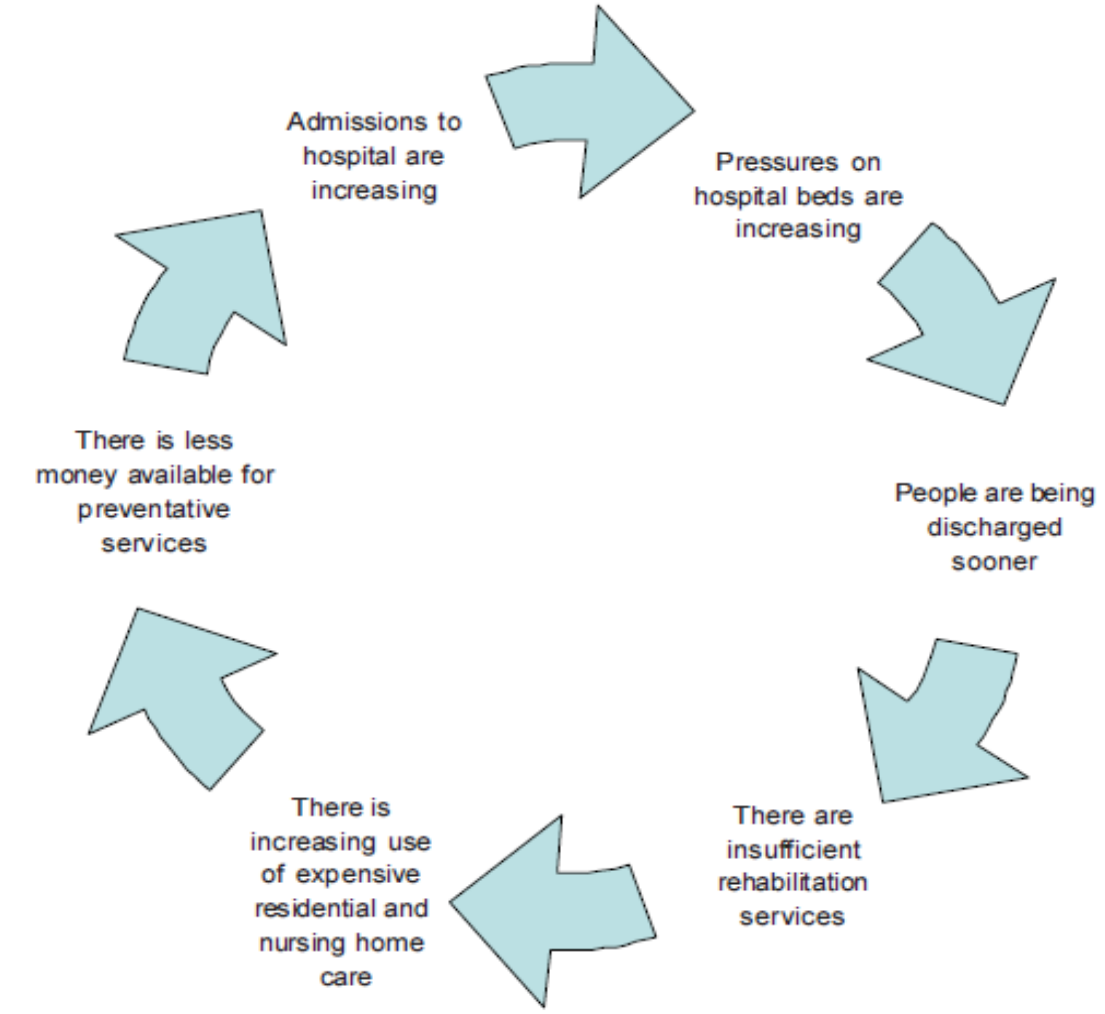
Report of the Health Service Ombudsman into NHS care of older people highlighted that some patients were been discharged when not medically fit

Patient Associations, Patient surveys and LINK reports show a general understanding both locally and nationally that many patients do not receive the quality of service they expect or deserve when leaving hospital.

Inpatient survey and Which? Magazine report highlight dissatisfaction with hospital discharge arrangements

The challenges we face

Figure 1: The vicious circle, Audit Commission (1997, 2000)



Most Common Clinical Causes of Readmission (As a Percent of All Readmissions)

Infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infections)	15%
Long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF)	11%
Complications of medical care, surgery or medical devices	7%
Noncardiac chest pain	4%
Abdominal pain	4%

2009/2010 Hospital Episode Statistics (HES) data for acute and foundation trusts in the NHS in England and applies 2011/2012 PbR tariff and rules on emergency readmissions. Sg2 Service kit 'Reducing 30-Day Emergency Readmissions June 2011.'

Possible reasons for readmissions

- Relapse or progression of Long Term Condition
- New and unrelated illness
- Complication of first hospital admission
- Risky discharge (respecting patient's wishes)
- Failure of capacity or responsiveness in community health or social care services
- Re-attendance at A&E following self referral or referral by carer with GP not involved

Policy on non payment for readmissions

- Despite taking extensive advice from senior clinicians, and other partners, implementing a non-payment policy was challenging because:
  - Reasons for emergency readmissions are complex and multi-factorial, rather than a single, discrete cause.
  - It is not possible to have certainty about which readmission will or will not be avoidable
  - It is not possible to have certainty about which readmissions will or will not be related to the original admission
- Initially, the policy was no payment for any emergency readmission within 30 days of an elective admission plus an agreed threshold for readmissions following emergency admission
- Following evaluation, amended the policy to one based on a threshold developed by auditing a sample of readmissions

Impact of non payment for readmissions

- Following implementation, around one quarter of all emergency readmissions were found to be avoidable by the clinical reviews
- This equates to non payment of around £300m
- Through the policy, commissioners of care are required to reinvest the savings from non payment of readmissions into post discharge services which support rehabilitation, reablement and the prevention of readmission, and particularly in those areas highlighted by the clinical reviews of readmissions
- Following evaluation, amended the policy to one based on a threshold developed by auditing a sample of readmissions
- A number of services are excluded from the policy such as maternity, cancer, young children, self-discharges, dialysis and transplants

Developing post-discharge tariffs

- In December 2010 we started working with early implementers from 34 health communities, social care and other organisations

- To identify
  - what services the post discharge policy should cover (other than GMS services and residential or nursing home care)
  - what activity and cost information can be supplied about these services
  - what form a tariff might take

- The outcome from this work was that the early implementers, clinical networks and wider health community thought a condition specific tariff uplift approach to post discharge care was the best way forward. The areas selected to develop were:

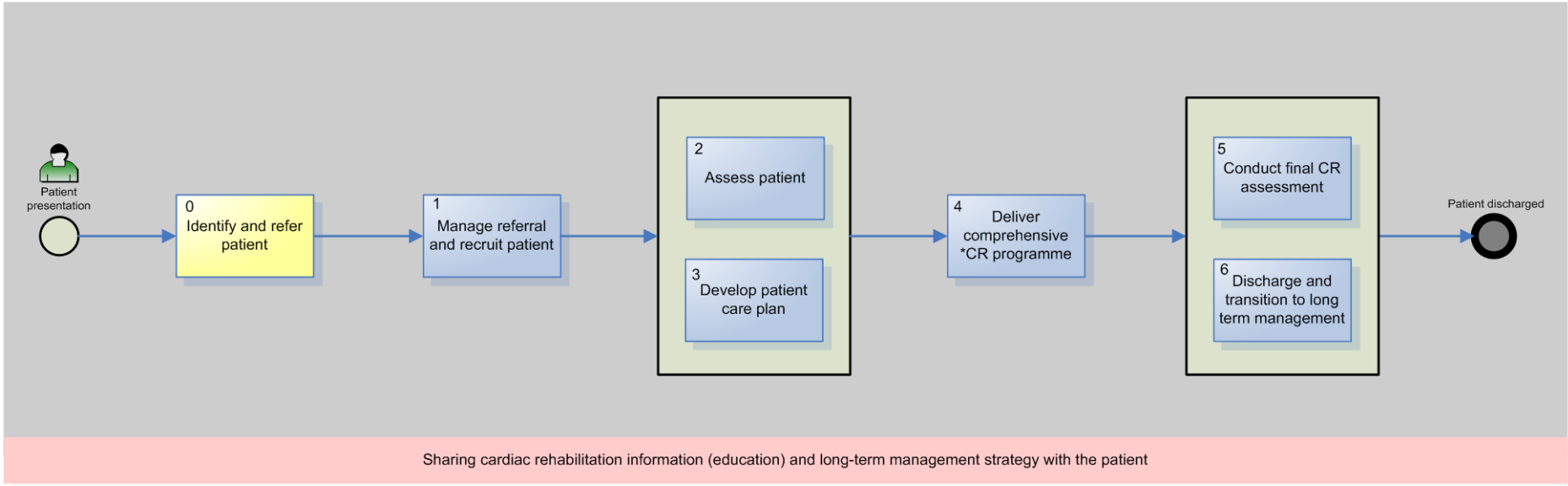
  - Cardiac Rehab
  - Pulmonary Rehab
  - Hip and Knee replacement

Cardiac rehabilitation pathway

• Cardiac rehabilitation pathway tariff covers patients discharged following a spell of hospital care for:

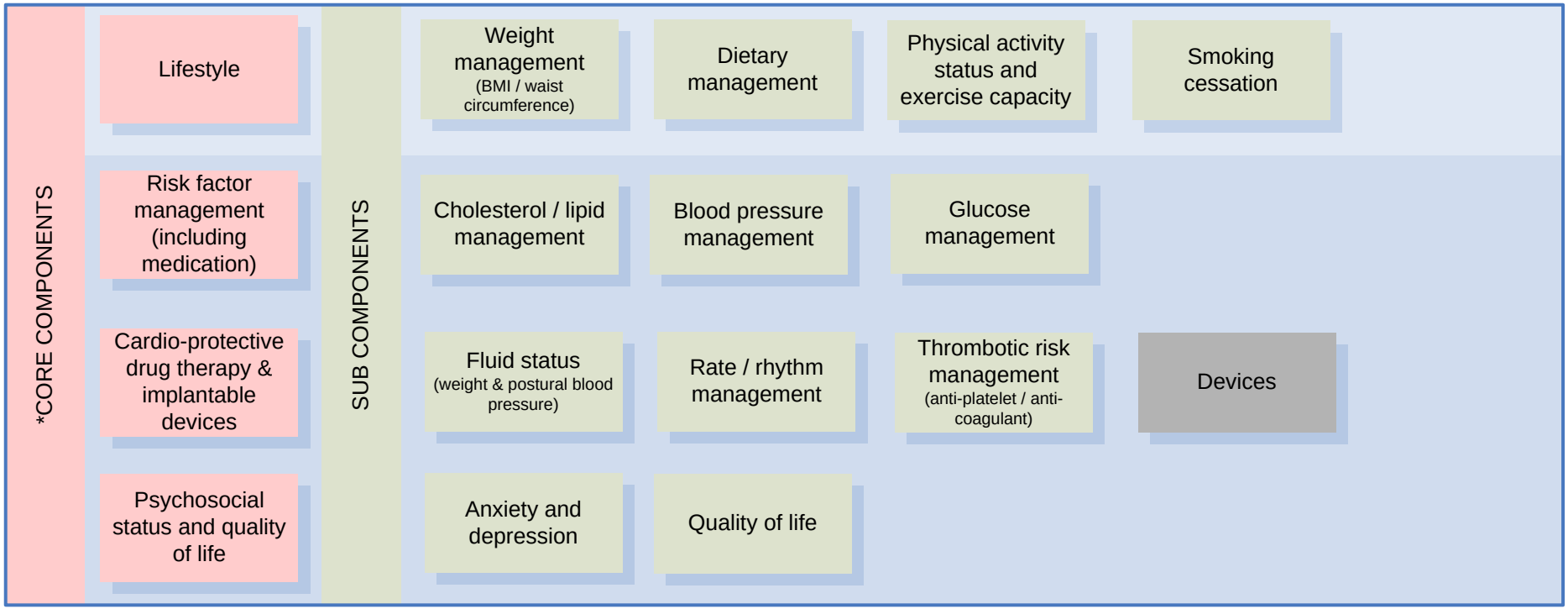
- •acute myocardial infarction
- •heart failure
- •percutaneous Coronary Intervention
- •coronary artery bypass graft (CABG)

•Current tariff is £467



*CR = cardiac rehabilitation

Cardiac rehabilitation programme



* Education and long-term management, while not assessed at this stage, are core components for service delivery.

Pulmonary rehabilitation

- Pulmonary rehabilitation tariff applies to patients discharged from an acute episode of care for Chronic Obstructive Pulmonary Disease (COPD)
- A recent study showed that providing pulmonary rehabilitation after discharge from hospital can reduce readmissions within three months from a third to just 7% of patients. Pulmonary rehabilitation is the only intervention to date shown to impact readmission rates in this way
- The rehabilitation programme should incorporate physical training, disease education, and nutritional, psychological and behavioural interventions
- The current tariff price for the pathway is £317

Hip and knee replacements

- The defined clinical pathway for post discharge activity for primary non-trauma hip and knee replacements includes:
  - nurse/physio appointments (max of 7 for hips and 10 for knees)
  - 1 occupational therapy appointment
  - 2 consultant-led clinic visits

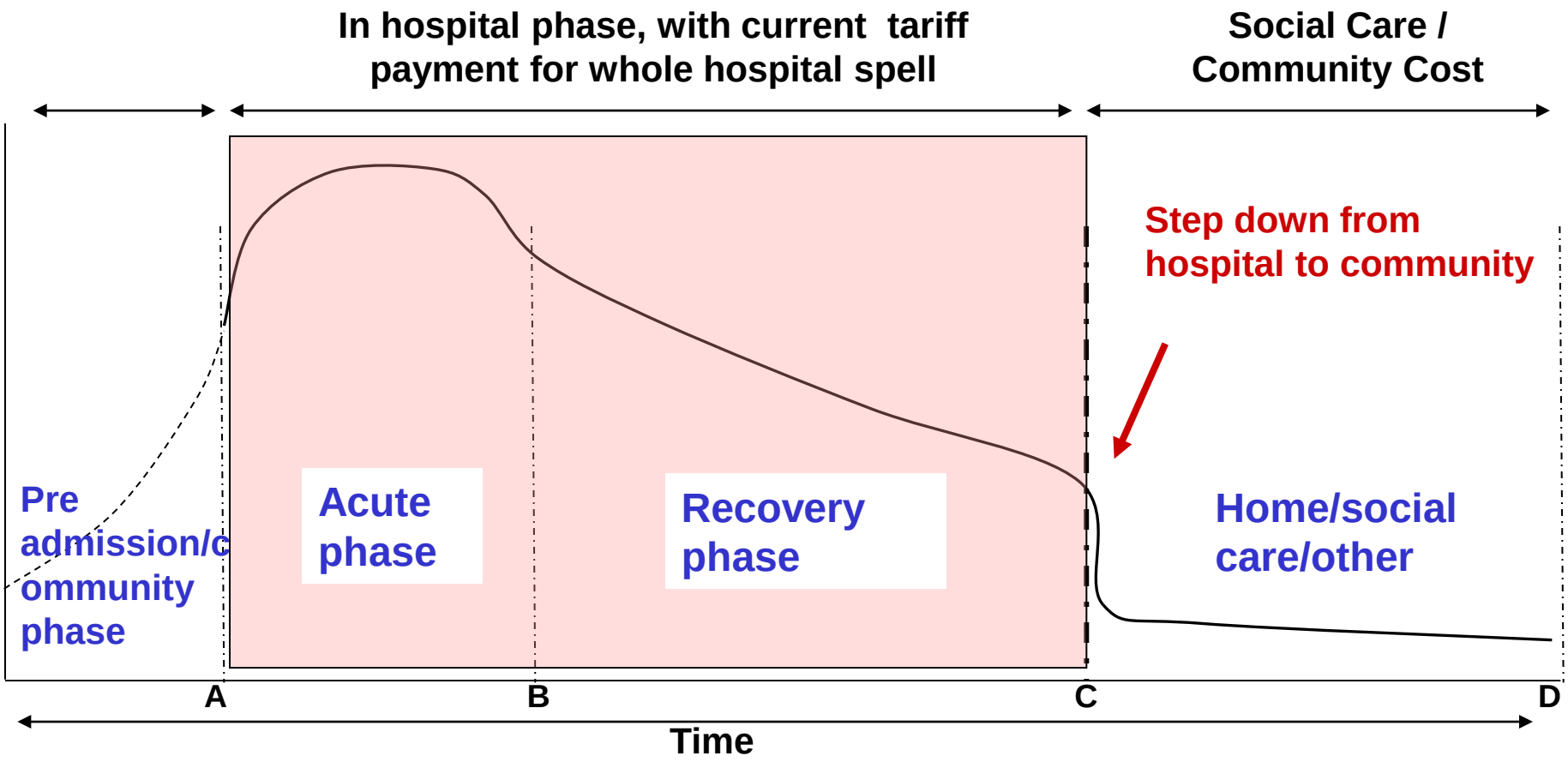
- This pathway, and the associated tariff, represents the maximum level of post-discharge care and patients who require less intensive care will attract lower payments

- The current tariff price for the pathway is £487 for hip replacements and £582 for knee replacements

Future of post-discharge tariffs

- The current post-discharge tariffs offer a limited start to further development of models of payment for patients with long-term conditions, such as “year of care” models
- Other work is looking to release funds locked into acute hospitals to fund other models of care in community settings
- The Recovery, Rehabilitation and Reablement (RRR) model is looking to change the way services are currently paid….

A typical patient acute episode pathway

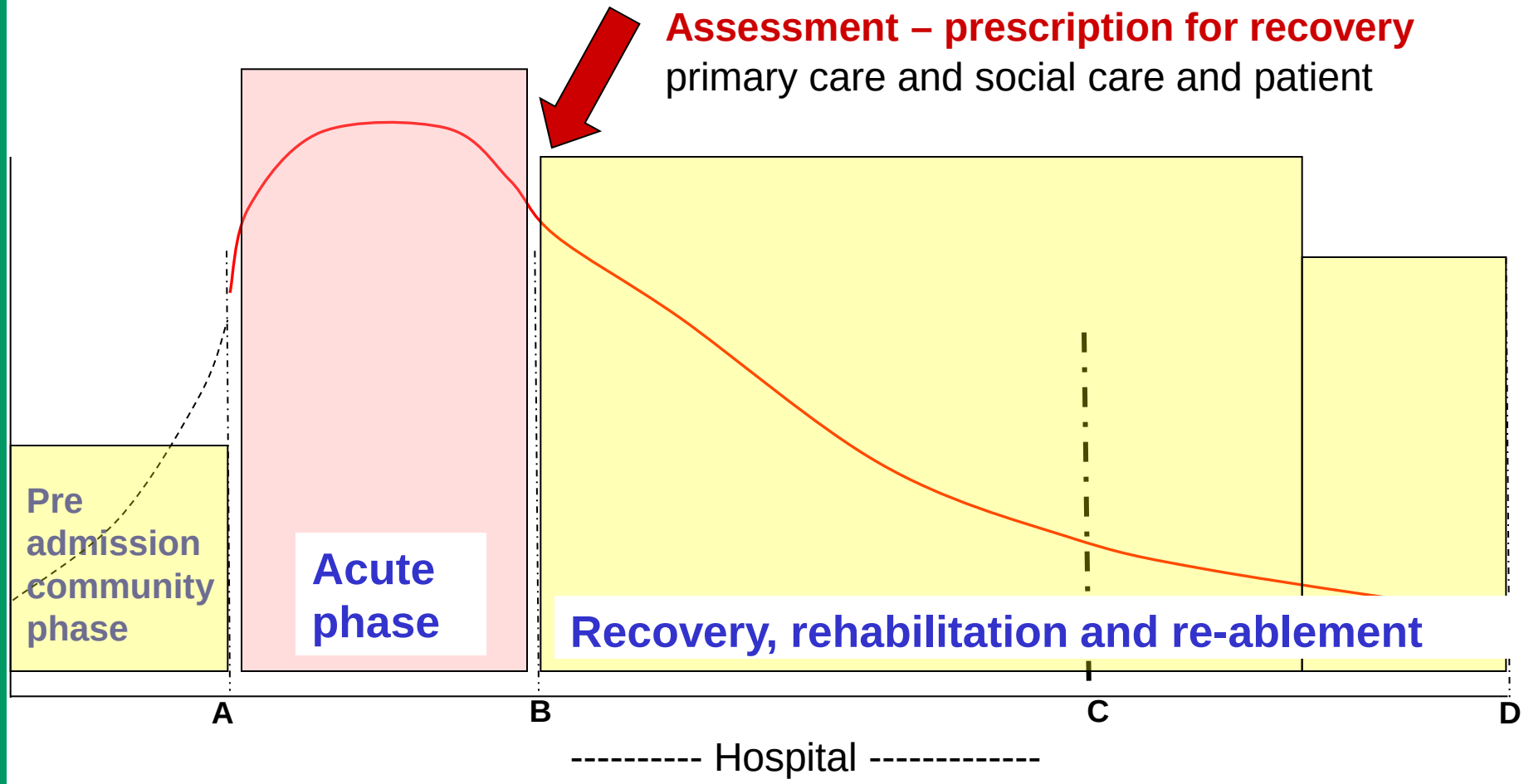


1. Rehab resources locked-in acute unit 2. Wrong match nursing : rehab

3. Step down to community, 4. primary care and social care recipients but no influence

"change the tariff at the point when the patients' needs change and not when they change institution"

Post-discharge tariffs in the English NHS



1 crosses secondary – community, 2. unlocks rehab resource for different models

3. Puts primary care and social care at earliest point in rehab, 4. sustainable discharge

Any Questions