

Unbundling Rehabilitation

1. We recognise that the approach described in this paper is not perfect. It is a first step, and we will continue to work on and refine the approach for the future. This process will remain clinically led. The tariffs are indicative, and there is room for different local solutions. If, however, there is failure to agree locally, then the indicative tariffs will be the starting point for dispute resolution. This should be either by SHAs, or in line with the arrangements set out in NHS FT contracts.
2. The indicative tariffs only relate to the acute phase of care. We do not yet have a robust rehabilitation classification on which to base a rehabilitation tariff. Funding for discrete rehabilitation remains outside of the scope of tariff and is for local negotiation.
3. The implementation of unbundled tariffs should be undertaken in line with the following principles:-
 - A commissioner should not inappropriately disrupt high quality rehabilitation in an acute setting.
 - A commissioner should ensure that rehabilitation, wherever it is delivered, meets high quality standards appropriate for the clinical condition and the patient. The rehabilitation component of care should be consistent with the wider national guidance for older people and stroke (forthcoming). The unbundling of the tariff should be seen in the context of wider health reforms, including:
 - spreading best practice in intermediate care, falls services and older people's mental health services,
 - integrated care records
 - investment and reform of community hospital services.
 - The development of local models of post-acute care should be determined locally by commissioners using multidisciplinary teams with the involvement of local clinicians and providers of post-acute care.
 - The indicative tariffs, like all other tariffs, reflect the average length of stay of all patients. We expect some patients to have a longer length of stay than the average acute phase length of stay, others less. Analysis of unbundling between providers and commissioners in contract monitoring should therefore focus on the total cohort of patients not individuals.
 - During the acute phase, an assessment should be made of functional status (using Barthel Index, or similar) cognitive status (using Abbreviated Mental Test, or similar) and of co-morbidity, in order to plan for the management of the post-acute care phase. Stroke patients should, in addition, be tested for swallowing and communication functions.
 - Patients with complex needs, will on average, require a longer period of post-acute care. All patients with complex needs will require comprehensive

assessment. In the case of stroke, this should be undertaken by a specialised stroke multi-disciplinary team. Care by a multidisciplinary team for patients with complex needs has been shown to improve outcomes, reduce hospital length of stay and reduce the proportion of patients requiring long-term institutional care following an acute episode. No patients should transfer directly from acute or post-acute care to long-term institutional care without the benefits of a comprehensive assessment.

- Stroke patients with non-complex needs should be assessed to determine whether they need rehabilitation in a single domain. Uni-disciplinary rehabilitation should be provided for these patients where appropriate.

4. For other clinical problems where commissioners or providers wish to unbundle the national tariff, in order to provide high quality rehabilitation, the expectation is that this should happen in 2007/08. The principles outlined above should form the framework within which a local solution is found. It is not intended to dictate the clinical care of an individual patient, which must always remain the responsibility of local clinicians.

The methodology

5. Rehabilitation is recognised as an essential component of care for most patients ensuring they are able to achieve maximum functional recovery. Rehabilitation is and can be delivered in a variety of settings eg. acute hospital, community hospital and home. The setting for rehab varies considerably around the country dependant on a variety of factors unbundling the medical condition, local facilities and local geography.

6. In order to facilitate local solutions to rehabilitation the department has been asked to provide solutions to unbundling tariff. The approach the department has taken is to ask Prof Ian Philp (National Clinical Director for Older People), Prof Roger Boyle (National Clinical Director for Heart Disease) and Dr Ian Rutter (GP and clinical adviser to the Policy and Strategy Directorate) to lead a multidisciplinary piece of work to advise the department on an appropriate approach which has a clear clinical focus.

7. The areas that have been considered are rehabilitation for:

- a fractured neck of femur
- elective hip replacement
- community acquired pneumonia
- stroke patients

Older Peoples Services

Fractured Neck of Femur

8. There are 8 HRGs covering fractured neck of femur, with the following average lengths of stay and tariffs. The majority of activity is non-elective:

			No of Spells	Average Length of Stay
H82	Extracapsular Neck of Femur Fracture with Fixation w cc	Non Elective	2,022	19.4
H83	Extracapsular Neck of Femur Fracture with Fixation w/o cc	Non Elective	2,615	15.3
H84	Intracapsular Neck of Femur Fracture with Fixation w cc	Non Elective	2,584	18.3
H85	Intracapsular Neck of Femur Fracture with Fixation w/o cc	Non Elective	5,803	13.7
H86	Neck of Femur Fracture with Hip Replacement w cc	Non Elective	5,732	21.7
H87	Neck of Femur Fracture with Hip Replacement w/o cc	Non Elective	8,282	16.5
H88	Other Neck of Femur Fracture w cc	Non Elective	6,361	29.1
H89	Other Neck of Femur Fracture w/o cc	Non Elective	6,936	18.9

9. The coding of rehabilitation in HES does not give us a robust enough basis for tariff unbundling and there was a need for clinical advice to take us forward. The judgement of the clinicians on the group was that it is possible to identify three phases of care:

- An acute surgical phase that typically lasts 3 days.
- An acute medical phase, as patients admitted with fractured neck of femur often present with co-morbidities that need to be managed and stabilised. This can typically take an additional 7 to 10 days after the acute surgical phase.
- After 10 days the typical patient is usually medically stable and primarily in hospital for the purposes of rehabilitation. This is the phase of care where a patient can be moved to alternative providers and which needs to be unbundled.

Hip replacement

10. There are two primary hip replacement HRGs (the bilateral hip replacement HRGs are low volume and have not been considered). The majority of activity is elective:

			No of Spells	Average Length of Stay
H80	Primary Hip Replacement Cemented	Elective	33,909	8.4
H81	Primary Hip Replacement Uncemented	Elective	8,667	7.6

The judgement of the clinicians in this case was that there was an acute surgical phase of 3 days, after which the typical patient was largely in hospital for rehabilitation.

Community Acquired Pneumonia

11. There are two pneumonia HRGs. The majority of activity is non-elective:

			No of Spells	Average Length of Stay
D13	Lobar, Atypical or Viral Pneumonia w cc	Non Elective	22,802	12.0
D14	Lobar, Atypical or Viral Pneumonia w/o cc	Non Elective	34,109	6.1

In this case, the view of clinicians again was that the end of the acute phase is when patients are medically stable. This was defined for pneumonia as when the patient was no longer on IV antibiotics and oxygen support. On average, patients are medically stable after 3 days.

Co-morbidities/mental health/functional capability

12. The clinicians considered a range of other factors that might impact on typical lengths of stay.

13. Co-morbidities and functional capability have a significant impact on lengths of stay, and this is reflected in the longer lengths of stay for the “with complications” HRGs. However, the view was that in both cases the more significant impact is on the length of the post acute rehabilitation phase rather than the acute surgical and medical phases.

14. In the case of mental health, again the view was that the impact on length of stay was primarily on the rehabilitation phase. However, there was also a view that mental health issues would increase the cost of the acute phase of care.

15. The clinicians also advised that it is good clinical practice amongst older people with these conditions to undertake an assessment of functional status (ADL) and mental functioning (cognition and depression) in order to plan the next stage of care.

Stroke

16. There are two stroke HRGs, and the majority of activity in non-elective:

			No of Spells	Average Length of Stay
A22	Non-Transient Stroke or Cerebrovascular Accident >69 or w cc	Non Elective	42,544	20.1
A23	Non-Transient Stroke or Cerebrovascular Accident <70 w/o cc	Non Elective	11,566	9.8

In the case of stroke, the clinicians considered that 7 days was the typical point by which the acute phase had come to an end and the patient was assessed for continuing care. The clinicians were keen to emphasise that under best practice, rehabilitation would start from day 1, and therefore that there is significant rehabilitation taking place during the acute phase. They also emphasised the specific nature of stroke rehabilitation, and that it is different to either wider neurological or general rehab. It would be important for commissioners to ensure that, if they decide to move rehabilitation to an alternative provider, they are commissioning the appropriate form of care.

17. We did not have a discussion about other factors determining length of stay, though in this case the majority of activity is in A22.

18. We also discussed whether the costs of thrombolysis should be unbundled. However, the view was that for 2007/8 the service was still at the early stages of development, and that this was not therefore an issue that needed to be addressed at this point.

From Clinical Judgements to Unbundled Tariffs

19. The following table summarises the views of the two workshops with clinicians. In order to reflect their view that the length of the acute phase does not vary as much as total length of stay when there are complications, we have taken a working assumption that the length of the acute phase only increases by half as much as total length of stay in HRGs with complications.

			No of Spells	Average Length of Stay	Length of Typical Acute Phase
H82	Extracapsular Neck of Femur Fracture with Fixation w cc	Non Elective	2,022	19.4	9.6
H83	Extracapsular Neck of Femur Fracture with Fixation w/o cc	Non Elective	2,615	15.3	8.5
H84	Intracapsular Neck of Femur Fracture with Fixation w cc	Non Elective	2,584	18.3	8.9
H85	Intracapsular Neck of Femur Fracture with Fixation w/o cc	Non Elective	5,803	13.7	7.6
H86	Neck of Femur Fracture with Hip Replacement w cc	Non Elective	5,732	21.7	10.6
H87	Neck of Femur Fracture with Hip Replacement w/o cc	Non Elective	8,282	16.5	9.2
H88	Other Neck of Femur Fracture w cc	Non Elective	6,361	29.1	13.3
H89	Other Neck of Femur Fracture w/o cc	Non Elective	6,936	18.9	10.5
	Average for Fractured Neck of Femur				10.0
H80	Primary Hip Replacement Cemented	Elective	33,909	8.4	3.0
H81	Primary Hip Replacement Uncemented	Elective	8,667	7.6	2.9
	Average for Primary Hip Replacement				3.0
D13	Lobar, Atypical or Viral Pneumonia w cc	Non Elective	22,802	12.0	3.7
D14	Lobar, Atypical or Viral Pneumonia w/o cc	Non Elective	34,109	6.1	2.5
	Average for Pneumonia				3.0
A22	Non-Transient Stroke or Cerebrovascular Accident >69 or w cc	Non Elective	42,544	20.1	7.6
A23	Non-Transient Stroke or Cerebrovascular Accident <70 w/o cc	Non Elective	11,566	9.8	5.0
	Average for Stroke				7.0

20. As a proxy for the average cost per bed day for the post acute phase of care we have used the existing excess bed day tariffs (on the basis that once a patient has reached in hospital for as long as the trim point, costs are unlikely to include acute phase costs).

	Average Excess Bed Day Tariff (2006/7)
Fractured Neck of Femur	£192
Hip Replacement	£206
Pneumonia	£165
Stroke	£133

21. The average excess bed day tariff can then be multiplied by the different between total length of stay and the length of the acute phase. This is then subtracted from the tariff to give an indicative acute phase tariff as follows:

			Indicative Acute Phase Tariff	
			Tariff	Tariff
H82	Extracapsular Neck of Femur Fracture with Fixation w cc	Non Elective	£5,391	£3,509
H83	Extracapsular Neck of Femur Fracture with Fixation w/o cc	Non Elective	£4,635	£3,329
H84	Intracapsular Neck of Femur Fracture with Fixation w cc	Non Elective	£5,099	£3,294
H85	Intracapsular Neck of Femur Fracture with Fixation w/o cc	Non Elective	£4,451	£3,280
H86	Neck of Femur Fracture with Hip Replacement w cc	Non Elective	£7,742	£5,611
H87	Neck of Femur Fracture with Hip Replacement w/o cc	Non Elective	£5,851	£4,449
H88	Other Neck of Femur Fracture w cc	Non Elective	£5,939	£2,905
H89	Other Neck of Femur Fracture w/o cc	Non Elective	£4,408	£2,795
H80	Primary Hip Replacement Cemented	Elective	£5,176	£4,064
H81	Primary Hip Replacement Uncemented	Elective	£4,967	£3,999
D13	Lobar, Atypical or Viral Pneumonia w cc	Non Elective	£2,895	£1,526
D14	Lobar, Atypical or Viral Pneumonia w/o cc	Non Elective	£1,808	£1,214
A22	Non-Transient Stroke or Cerebrovascular Accident >69 or w cc	Non Elective	£4,293	£2,631
A23	Non-Transient Stroke or Cerebrovascular Accident <70 w/o cc	Non Elective	£2,814	£2,176

22. The above tariffs are in 2006/07 prices, and these need to be uplifted by 2.5% to give tariffs in 2007/08 prices:

2007-08 Indicative Tariff to support Unbundling of Rehabilitation

Code	Description	Elective Acute Phase Tariff (£)	Non-Elective Acute Phase Tariff (£)
A22	Non-Transient Stroke or Cerebrovascular Accident >69 or w cc		2,697
A23	Non-Transient Stroke or Cerebrovascular Accident <70 w/o cc		2,230
D13	Lobar, Atypical or Viral Pneumonia w cc		1,564
D14	Lobar, Atypical or Viral Pneumonia w/o cc		1,244
H80	Primary Hip Replacement Cemented	4,166	
H81	Primary Hip Replacement Uncemented	4,099	
H82	Extracapsular Neck of Femur Fracture with Fixation w cc		3,597
H83	Extracapsular Neck of Femur Fracture with Fixation w/o cc		3,412
H84	Intracapsular Neck of Femur Fracture with Fixation w cc		3,376
H85	Intracapsular Neck of Femur Fracture with Fixation w/o cc		3,362
H86	Neck of Femur Fracture with Hip Replacement w cc		5,751
H87	Neck of Femur Fracture with Hip Replacement w/o cc		4,560
H88	Other Neck of Femur Fracture w cc		2,978
H89	Other Neck of Femur Fracture w/o cc		2,865