

What do NHS managers really think?



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May 2010

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nhsManagers.net are the publishers of a unique, discontinuous e-news letter that is mailed, directly, to the in-trays of over 11,000 health service managers across England, Scotland and Wales, at least six times a month.

It features NHS news, guidance and discussion topics and features regular polling and surveys of manager's personal thinking and attitudes.

This snap-shot survey looks at what managers think about the policy to fine hospitals if patients are readmitted within 30 days of discharge.



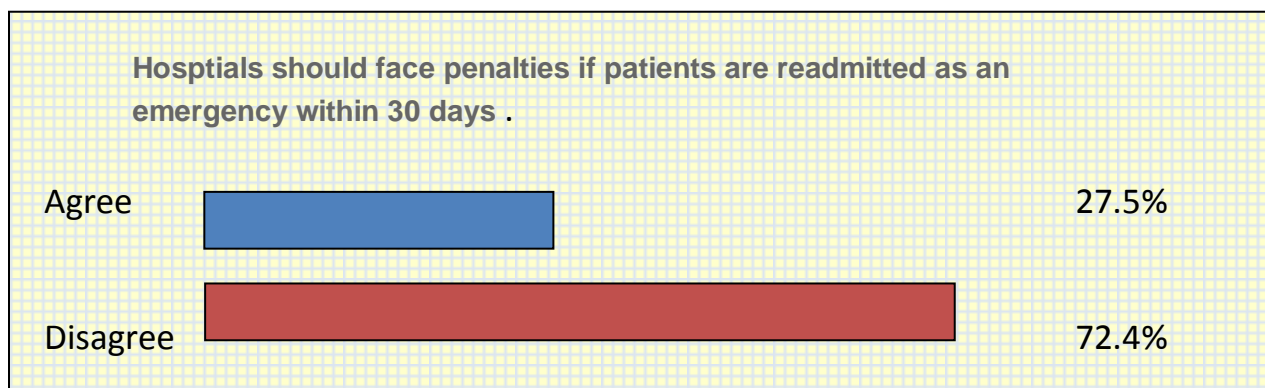
CONTENTS >>>

Click the headings to follow the links >>>

>>> [The Question](#)

>>> [The Comments](#)

THE QUESTION



Well, this is not such a popular idea! One very smart reader e-mailed this comment: “.....as total admissions have been rising it might be expected to see readmission numbers rising to. Therefore, more important is the rate of readmissions. In fact this has been rising too - from around 9.2% in 2003/4 to 10.7% in 2008/9, for example. That is a 1.5 percentage point rise - this sounds a bit less dramatic than the 50% the Secretary of State is using!

Some of you were up for the idea but the majority not. See what your colleagues said.....

[<<< Back](#)
[>>> Comments](#)

YOUR COMMENTS

- Crazy bureaucracy. We need to look at quality of the entire system, not one element. Financial incentives and/or punishments are almost always perverse. Strange that earlier in the week we were told that householders should be offered a carrot and not a stick for recycling rubbish. Why not the NHS?
- Might make it more difficult for relatives to get patients out of the clutches of the hospital . Particularly aged parents who are often better off at home in familiar surroundings and with more attention, after having had 'observations 'in hospital following a fall.
- This needs to be considered within a broader policy about pan hospital/community care systems and the "right" lengths of stay. Readmission on its own can be used as an indicator to look at systems but not as a measure on its own.
- The subject of readmissions requires careful analysis before introducing the "hammer". It may be a proxy for poor quality but not solely within one sector. I had hoped we might have a more mature approach from this new lot, but clearly it looks like it will be just more of the same, only worse.
- Hospitals must not search for beds and in so doing put a patient's life at risk. This tends to happen more with the elderly. A return home for the elderly without proper help could be disastrous
- Under certain conditions - i.e., as a result of original condition and not a new episode and that primary and community health and social care packages had been put in place. Otherwise these organisations should also face penalties.
- This would particularly penalise areas with a high elderly or deprived population - not logical

- Your response [*Addressed to our Editor Roy Lilley*] is that of a typical short-sighted NHS manager. See a problem and invent a bureaucratic manual system to monitor it. The normal PAS in hospitals is capable of identifying such patients already. THERE IS THEREFORE NO NEED FOR ANY OF THE SILLY MONITORING you describe. Only the patients re-admitted as an emergency need investigating after the fact to see if it could have been prevented.
- But only if the reason for the 2nd admission was as a direct consequence of the hospital action and not because their condition was bound to deteriorate or due to a planned series of readmissions.
- Absolutely 'bonkers' and demonstrates a total lack of understanding of the complexities associated with discharge and potential readmission.
- The amount of bureaucracy this will make if it is passed will result in an industry of its own.
- This will encourage hospitals to keep patients in for longer - and if they are full there won't be space for anybody to be readmitted.....
- Sounds like someone's using a hammer to crack a nut, AGAIN
- Yet more financial penalties we will soon be bankrupt
- This will ensure that inpatients are properly 'worked up' prior to discharge. Everyone has been talking about patient care pathways for years but with the advent of PbR, proper patient care, i.e. good evaluation of the patient's condition plus their social circumstances seems to come second to tossing them into the community to save some money - a tariff for 5 days care and only giving 4. Review PbR as this is unfair as hospitals are struggling, so 'game'.
- Absolute tosh! How can acute units be held responsible for activities out of the hospital and for which they have no control. Yet another example of crass ineptitude from this, so called 'new thinking' government. Old wine in new bottles springs to mind!
- It will increase length of stay as doctors will be more cautious when discharging so as to be less likely to have a re-admission. It will encourage A&E dep'ts to not admit patients (who may need it) to avoid fines and patients may miss out on care. Government should stop threatening hospitals with fines and allow them to get on with their work in treating patients.

- Why cannot we just focus on best care and get people well?
- Length of stay will go up. Patients often have a number of long term conditions and whilst the one they were admitted for may be ok, they may be readmitted with another. Will penalties still apply? How many people will it take to argue and decide which readmissions will attract penalties?
- Penalises good hospitals unfairly where post-op infection is not picked up quickly enough in community. However, penalises those who chuck patients out too quickly. Surely there must be another way to get community, GPs, OOH and acutes working, cohesively, to keep people well, post discharge? Better a ring fenced shared incentive for reduction in readmissions
- As ever, the devil will be in the detail; if it encourages more robust discharge planning (which for planned admissions should begin before the patient arrives) all well and good. But I thought we were supposed not to get any more political stunts imposed from the top down - oh well, silly me.
- Complete b*ll*cks
- This will incentivise them to keep patients in and will incur excess bed days for commissioners. It does not address the need for improved/increased provision of step down beds etc.
- If introduced it will only lead to inventive ways to keep them on leave rather than discharge, unless there is another penalty for an increase in leave days. I can see health informatics departments growing!
- There are too many factors that could bring about the readmission and the cost of playing the blame game will far outweigh any potential "savings".
- Only if the discharge planning is poor. However, this may lead to delayed discharge anyway and greater costs as they will not discharge until belt and braces are in place!
- It'd need a lot of ifs and buts and maybes to ensure it was operated fairly. Hospitals in poorer/deprived communities are likely to experience this more and be more penalised - again!

- If we are driving up quality, this should certainly be one of the indicators for illustrating performance. Although, clearly a balance is necessary as emergencies do happen.
- "Readmissions" are only counted as such if they are to the same hospital trust. So, in London a patient could be readmitted to a different trust and it would not count. In rural areas where trusts manage multiple sites these readmissions would lead to fines
- Well meaning - but the bureaucracy!! And there is already worry about vertical integration having a negative effect on public health.....
- Interesting. I guess we will start to see hospitals working together to re-admit at another trust.
- A classic case of generating unintended consequences:
 - It will delay discharges
 - It will not eliminate the natural rate of readmission amongst very sick people
 - It will create extra costs of administration

[<<< Back](#)