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briefing

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NHS CONFEDERATION

Foundation Trust Network

The impact of non-payment for acute readmissions

Key points

- The Department of Health is introducing a system where local commissioners do not pay for emergency readmissions that occur within 30 days of discharge from an acute hospital following an initial planned stay.
- The new policy will mean a reduction in annual hospital income of around £790 million.
- This paper explores what the impact of this policy is likely to be, and suggests additional measures which would reduce the cost to hospitals to around £490 million.

The Department of Health (DH) has introduced a new policy of non-payment for acute hospital readmissions. This policy means that local commissioners will not pay for any emergency readmissions to hospital within 30 days of discharge from a previous planned hospital stay. The DH is instructing commissioners to extend this policy locally to cover a proportion of those readmissions following a previous emergency hospital stay.

This *Briefing* presents the results of research from CHKS into how a system of non-payment for acute readmissions within 30 days could operate. It calculates the cost of the policy to acute trusts, including how this would change if various additional exclusions were applied. The *Briefing* concludes with the NHS Confederation's consideration of the wider effects of this policy and other possible approaches to it, drawing on feedback from Foundation Trust Network members.

Background

For several years the NHS has recognised that an increasing number of patients are being readmitted to hospital as an emergency soon after their initial discharge. The reasons behind such readmissions are highly complex, and studies have so far failed to identify the definitive drivers of this trend.[1] What is clear is that there is no single cause but a combination of different potential factors, including the availability of community services, changing patient expectations, changes in clinical practice and the level of coordination between acute hospitals, community services and social services.

There are clear advantages in reducing unnecessary

Analysis provided by

CHKS

Insight for better healthcare

'8.3 per cent of all admissions are readmissions within 30 days, totalling £2.2 billion income for hospital trusts'

readmissions, both to patients and the NHS. Avoidable readmissions are not in the interests of hospitals, the NHS or individuals; patients have a right to expect that they receive proper care in the first instance and that the necessary level of support will be in place after discharge.

The proposed new policy

To help tackle this increase in readmissions, the DH is introducing a system where local commissioners do not pay for any emergency readmissions (apart from a specific set of exclusions) that occur within 30 days of discharge from an acute hospital for an initial episode of elective care. The DH has instructed local commissioners to extend this policy to at least 25 per cent of the readmissions that occur following an emergency stay in hospital.

The DH accepts that some emergency readmissions do not equate to poor quality care. Previous guidance has allowed local commissioners to decide which readmissions might be excluded in any penalty calculations.[2] The current plans for 2011/12 combine a single national approach with expectations that local commissioners will go further.

The exclusions to the non-payment rule that have been set apply for readmissions relating to maternity, children under the age of four, treatment of patients with cancer and admissions to mental health services.

The DH expects that money saved from this policy next year will be reinvested by local commissioners in other services that help patients' recovery after discharge from hospital. From 2012, hospitals will be expected to assume responsibility for many aspects of a patient's care in the 30 days after discharge. This represents a significant change from the traditional NHS policy of the GP being responsible for coordinating patients' care.

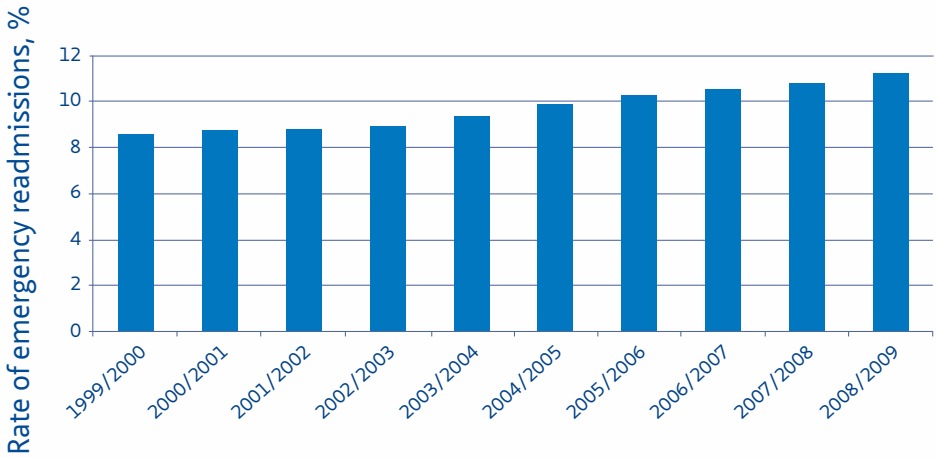
A reality check

Readmissions is a complex issue and any changes to policy in this

Readmissions – a complex issue

CHKS analysis of the hospital episode statistics database has revealed how complex some trails of hospital readmissions can be. Around 20 per cent of readmissions are to a different hospital than the original admission. Some patients, particularly those with long-term conditions, appeared to be travelling around the country for treatment. Others were being readmitted to several hospitals within the same geographical location. In one of these cases, a 63 year-old male patient had 72 separate admissions to 50 different trusts within one year for treatment relating to heart disease.

Figure 1. Growth in emergency readmissions over time



Part of the rise in readmissions can be accounted for by the overall rise in emergency admissions (11.8% since 2004/05[3]). However, this cannot completely explain the trend.

Source: National Centre for Health Outcomes Development; Hospital Episode Statistics online

area should be implemented carefully. Researchers at CHKS have undertaken in-depth research into emergency readmissions and the potential financial impact of any penalties. The NHS Confederation believes that the findings offer a reality check on the current proposals and raise questions about how the policy should be implemented locally to avoid unintended consequences.

What did the research find?

CHKS examined emergency readmissions for all hospitals in England using the hospital episode statistics database for July 2009–June 2010. During this period, 1,182,000 patients were readmitted to hospital within 30 days. This is equivalent to around 8.3 per cent of all admissions. When the tariff is applied this equates to an income of £2.2 billion for hospital trusts. Of these 30-day readmissions, CHKS found that in 70 per cent of cases the original admission was for emergency care and in 25 per cent of cases it related to elective care (in other words, to planned treatment). The remaining 5 per cent of cases were either babies or transfers from one hospital to another. Some analysis of trends in emergency admissions from 2003–2009 was undertaken, but no strong relationship between length of stay and proportion of readmissions was observable.

The analysis also revealed that around 20 per cent of readmissions are to a different provider to the original hospital, with particularly high rates in urban areas such as London. This raises issues around establishing responsibility and administering the non-payments policy.

Integrating hospital and community care

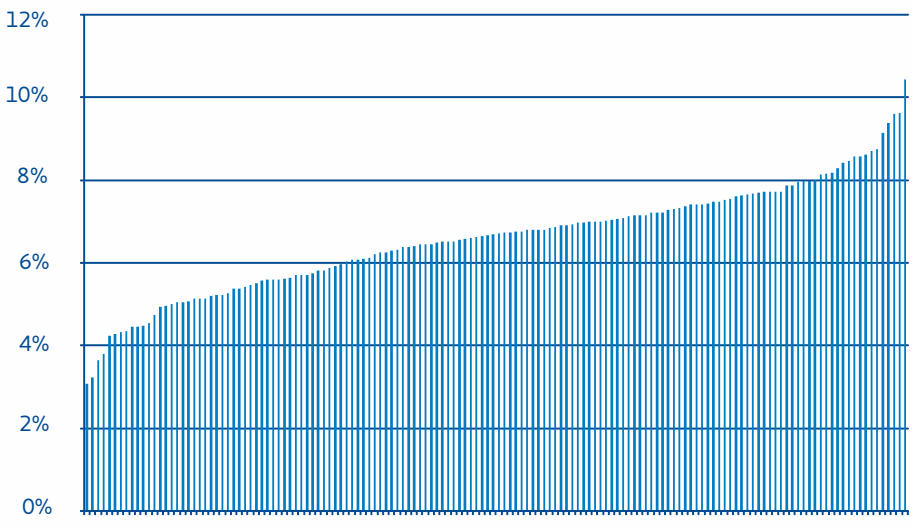
The language used by the Secretary of State has been about the better integration of hospital and community care to reduce unnecessary admissions and to avoid patients being discharged without appropriate support. There is some evidence that readmission rates are partly driven by the availability of community services (see Figure 3). However, it is hard to put a figure to this relationship. Anecdotal evidence, collected by CHKS, revealed one hospital treating patients from two primary care trusts (PCTs) where the readmission rates for patients are significantly different depending on which PCT they are from.

What does a readmission mean?

One of the fundamental problems facing policy-makers is the difficulty in establishing whether an individual readmission is in any way linked to the previous episode.

To help identify patients who are readmitted for the same health issue as their first admission, CHKS used healthcare resource groups (HRGs), which are used to calculate the payment for the patient's hospital episode. These showed that 24 per cent of patients were readmitted for the same HRG as the original admission. Given the specificity of HRGs, CHKS also looked at readmissions by HRG chapter (a more general grouping with less variability for

Figure 2. Readmission rates by trust



(average = 6.6%)

'Half of readmissions have the same HRG chapter for both the original admission and the readmission, but identifying a causal link is difficult'

slight differences in the patient's presentation) and found that 50 per cent of patients were readmitted in the same chapter.

This means that half of readmissions are for a very different health issue. However, it is still not entirely clear whether these are connected or not. Some will undoubtedly be for unrelated incidents, such as a simple elective procedure followed by a trauma caused by an accident. Others may be causally linked, such as a surgical admission followed by a readmission for a respiratory problem. These are very difficult to identify, however, because the majority of emergency readmissions are amongst the elderly, who often have multiple complex conditions (for example, diabetes, heart and respiratory problems).

To avoid some of these highly complex issues, various types of readmission are excluded from any system of non-payment. A judgement will also need to be made on what is a clinically acceptable level of readmission for different conditions. CHKS has analysed the exclusions that the government has set, as well as putting forward some further potential exclusions. The following section outlines what the financial impact of each of these modifications would be on acute trusts.

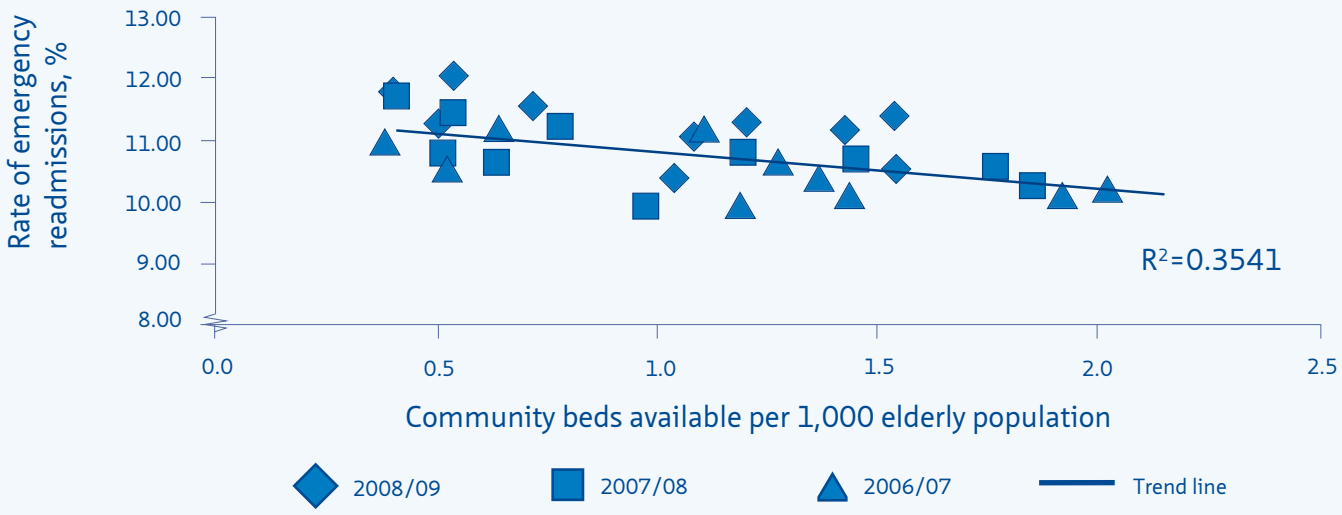
Potential exclusions and their impact

The initial announcement of the policy quoted total annual readmission figures of "around 500,000 patients" nationally.[4] This appears to be based on the National Centre for Health Outcomes Development (NCHOD) report on emergency readmissions, which included a number of exclusions. It explained:

> "Patients within the mental health and maternity specialties, as well as those with a diagnosis of cancer, have been excluded because in these cases emergency readmission is often considered a necessary part of care."[5]

It is probably fair to exclude all cases with a primary cancer diagnosis, maternity events and readmissions of young children as all of these are likely to fall into the category of open access services (patients being given the option to come back whenever they need to). Readmissions for mental health have already been excluded

Figure 3. Regions with a higher number of community beds have lower readmission rates



Source: National Centre for Health Outcomes Development; Department of Health; Office of National Statistics

'Establishing causation is very difficult because the majority of readmissions are amongst the elderly, who often have multiple complex conditions'

throughout this *Briefing*, as there is currently no tariff for it. Excluding **cancer, maternity and children under four** reduces the impact on acute trust income from £2.2 billion to £1.7 billion for 910,000 episodes.

The new policy applies only to readmissions following an initial planned admission to hospital. The logic behind this is that hospitals should have 'got it right first time' and therefore subsequent admissions within a month should be unnecessary. While there is some sense in this, given that only half of readmissions are to the same clinical area, establishing causality is difficult, as outlined above. Looking at only **readmissions that followed a previous elective admission** reduces the impact on income to £480 million from 270,000 episodes.

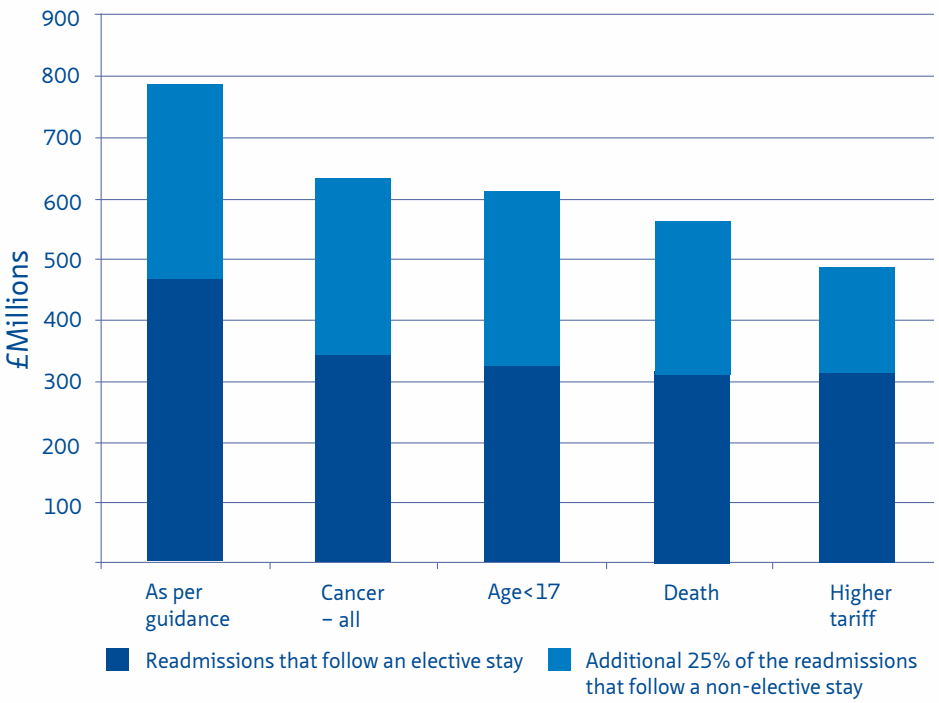
The DH has also instructed local commissioners to deliver at least a 25 per cent reduction on emergency readmissions that follow an initial non-elective admission. This rate will be negotiated locally and should be based on clinical audit. Nationally, **an additional 25 per cent of these readmissions** equates to an additional 160,000 patients, assuming the same exclusions are used.

Taken together, therefore, the total impact on hospital income will be at least £790 million from 430,000 patients.

In addition to the current exclusions proposed by the DH, CHKS has examined other potential exclusions. The NHS Confederation believes that these could help ensure the policy is applied fairly and only captures readmissions that are genuinely likely to be inappropriate. These exclusions could either be applied locally or in future national policy.

Firstly, a couple of specific conditions/problems are included in this policy that should probably

Figure 4. Financial value of readmissions following potential exclusions



Exclusions	Value of non-payments	Patient spells affected
Primary cancer, under 4s and maternity. Mental health	£790 million	430,000
As above, plus all cancer patients	£630 million	350,000
As above, plus all children under 17	£610 million	330,000
As above, plus end-of-life care	£570 million	320,000
As above, plus definitive treatment adjustment	£490 million	320,000

'The total financial impact of the new policy would be around £790 million'

be excluded as they would seem to be clear examples of necessary care. Local commissioners should consider these when calculating the local reduction targets:

- threatened or spontaneous miscarriage (9,000 patients)
- poisoning, toxic, environmental and unspecified effects (11,500 patients).

More broadly, the current policy only excludes patients who are recorded as having a primary diagnosis of cancer or are receiving radiotherapy or chemotherapy. This means that if a patient is admitted for a problem related to their cancer but not actually for cancer treatment, this admission would not be paid for. If we excluded **all cancer patients** from the policy it would reduce the impact to £630 million from 350,000 episodes.

Most paediatric services operate with an open access policy and therefore it would seem logical to exclude all children. Certainly it is important to avoid any perverse incentives for hospitals to refuse to admit children who have uncertain diagnoses. CHKS examined the number of readmissions by age and decided to use the age of 16 as a cut-off, although the difference for a variation in this is marginal. So, excluding **all children** below the age of 17 reduces the financial impact to £610 million from 330,000 episodes.

End-of-life care also needs to be taken into account. CHKS looked at readmissions where the outcome was death (where this had not already been excluded above). The reasoning was that if an emergency readmission ending in death occurs within 30 days of a preceding admission then it might be that the person was at the end stage of their life and that any follow-up care was entirely appropriate.

The additional exclusion of **readmissions with an outcome of death** would reduce the financial impact to £570 million from 320,000 episodes.

One further exclusion that CHKS considered was for cases where the readmission provided a more definitive treatment than the original admission. This was identified as where a higher tariff was paid for the second admission than the first. This appears to reflect occasions when a definitive diagnosis is not always available at the time of initial presentation. It is not until the problem exacerbates that a more definitive diagnosis and treatment can be provided.

In such cases it could be argued that the hospital should have 'got it right first time'. However, to pay for only the first admission (the lower tariff) would deny the hospital remuneration for the more definitive, and more expensive, treatment that took place on the second admission. A reasonable option for these situations would be to pay the higher of the two tariffs that applied to the two episodes, even if this was the second admission, and not pay the lower one. Applying this rule only to initial emergency admissions, CHKS analysis showed that adjusting for **the higher tariff between the two episodes** would reduce the total non-payment amount to £490 million.

Additional exclusions that could be considered locally include those relating to drug and alcohol abuse, self harm and trauma (for example, where a patient has been in an accident that may have had nothing to do with their original admission).

Setting a local approach

Having a policy of local negotiations supports the wider agenda of moving responsibility to local clinicians and freeing providers to innovate. However, it would inevitably lead to greater variation in practice across the country.

The NHS Confederation has collected alternative suggestions for how the local aspect of this policy could operate, including some from Foundation Trust Network members. One alternative approach to focusing on which groups of patients could be excluded would be to examine which patients should be included. Ambulatory care sensitive (ACS) conditions are a set of clinically-identified conditions that could more frequently be treated in the community. They highlight conditions where timely and effective care outside hospital can help to reduce the risks of readmission. The NHS Institute has published a directory of these conditions that could provide

a sensible starting point.[6] One possible local approach would be for commissioners not to pay for readmissions of those with an ACS condition, in order to incentivise the joined-up management of these patients.

Another approach that local commissioners and providers might wish to take is to focus on the key local priorities and conditions rather than trying to achieve relatively arbitrary reductions across the board. Analysis by CHKS has identified the most frequent conditions that are readmitted nationally, each of which poses a different set of issues and solutions.

Chronic Obstructive Pulmonary Disease (COPD) – 'managing long-term conditions'

40,000 patients in England had an emergency readmission with COPD following a previous emergency admission. In half of these cases it was for a related respiratory problem. Here the challenge for providers and commissioners is to support patients with long-term conditions to live at home and manage their own condition, reducing their need to reappear at A&E when their condition worsens.

Surgical abdominal problems – 'getting it right first time'

26,000 patients were readmitted in the 12-month period for HRGs that were concerned with general abdominal disorders. The vast majority were related to surgery, but frequently resulted in a very short stay in hospital. These patients may have been categorised under classifications that are used for a range of issues or when the original diagnosis was not clear. This suggests that there is definite scope for hospitals to ensure that they get the diagnosis and the treatment correct first time.

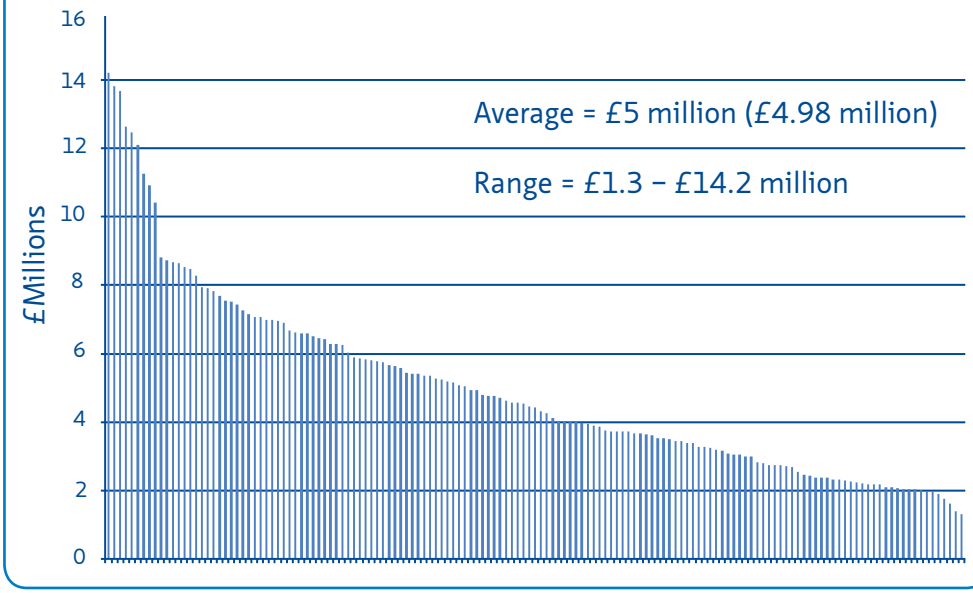
Cardiac problems – 'worried "not too unwell"'

32,000 patients had an emergency readmission with chest pain or generic cardiac problems. The majority (60 per cent) of these admissions had very short stays of one day or less. This suggests that concerned patients are arriving at A&E with relatively minor issues and being admitted temporarily for observation and stabilisation. Here the challenge is not only treating the long-term conditions but also providing primary care and urgent care support. Patients who feel unwell outside normal primary care hours should have alternatives to going direct to A&E.

> 'Focusing on specific conditions that are a high priority would be a more intuitively 'fair' policy'

In future, NHS organisations could expand these priority areas to agree the right rate of readmissions for many more conditions. Focusing on specific conditions that are a high priority would be a more intuitively 'fair' policy as it recognises that not all readmissions are due to the fault of the original provider. The problem, however, is that it would be very difficult to create a set of rules to cover all the range of patients given the number of people with multiple and long-term conditions, let alone deciding what constitutes the 'right' level of admissions for each condition or what to do with patients who move between hospitals.

Figure 5. Potential lost income for each trust if they receive no payment for emergency readmissions within 30 days



'It is vital that local organisations take a sensible, clinically evidenced approach when deciding appropriate readmission rates this year'

Confederation viewpoint

The analysis provided by CHKS highlights the cost, complexity and impact on hospitals and the system that will be involved in non-payment for readmissions. The intention of this policy is to improve the integration of acute and community care and to tackle the rise in readmissions. The NHS Confederation supports these aims. However, we are concerned that the new policy will not achieve these goals. The principal difficulty lies in how problematic it is to identify an individual readmission as inappropriate. The exclusions suggested in this *Briefing* are a useful starting point for local discussions, and further exceptions should be considered with the involvement of clinicians. Even with extensive further development, however, it is unlikely that an algorithm can be produced that will accurately be able to categorise the appropriateness of a readmission.

The system will therefore be reliant on overall rates, but this is no less problematic. We do not have a good understanding of what the optimum rate of readmission for a hospital should be; however, it is unlikely to be as low as possible, which a policy of blanket non-payment incentivises. Recent research from the USA suggests that a high readmission rate may in fact be related to lower mortality, as more of that hospital's patients survive to be readmitted later on.[7] It is right that discharge practices encourage more care to be delivered from the home and community – this necessarily involves taking some risk in anticipating that a proportion of patients will need to return to hospital.

Other possible effects of this policy of non-payment for readmissions will include the considerable additional administration costs that will be involved in tracking and paying for patients who are admitted and readmitted to different hospitals. The previous system, which involved local commissioners setting individual benchmark rates, calculating exclusions and tracking responsibility, was already extremely complex and this policy adds an additional layer of complexity. There is also danger in the potential for confusion that may arise over who, between the hospital, GP and community services, is responsible for a patient in the 30 days after admission.

While a scheme of non-payment for readmissions will be cost-neutral to the health system overall (excluding the costs of administration and bureaucracy), the estimates of the financial impact on acute providers – around £790 million – is very significant indeed. These organisations are already facing serious financial challenges over the next few years and there is a risk that additional costs on this scale could be too large for some organisations to manage.

The provision of community services also needs extensive investment to cope with the shift in demand, and there is already wide variation in the capacity of such services across the country. All this means that any implementation of readmissions charging will have to be measured and carefully coordinated, otherwise there is a danger of penalising and destabilising some hospital providers at a time when the system is already going through radical change. It is vital, therefore, that local organisations take a sensible, clinically evidenced approach when deciding appropriate readmission rates this year and do not succumb to the temptation of trying to save money by applying blanket, unrealistic expectations.

There is a significant risk in using the tariff to micro-manage the provision of healthcare rather than creating broad incentives and freedoms that enable the NHS to improve patient care. We would like to see a commitment that the DH will conduct a study on the impact of these changes and identify whether non-payment is actually successful in preventing readmissions, before making decisions on whether to extend or continue this policy approach. It will also be important to establish whether commissioners are using the funds appropriately by investing them in the services that will enable providers to manage their 30-day responsibility.

This *Briefing* provides some idea of what the costs and risks of charging for readmissions will be. The question now is: are we anywhere near as confident in what it will achieve?

For more information on the issues covered in this *Briefing*, please contact Paul Betts, Economic Adviser, Foundation Trust Network, at paul.betts@nhsconfed.org

For more information about the data analysis, contact Paul Robinson, CHKS, at probinson@chks.co.uk

Commissioner viewpoint

There are good reasons for commissioners of NHS services to want to reduce readmission rates, which have grown significantly over the last decade. Unplanned readmissions are not good for patients and their families who want treatment to be right first time and want to avoid the anxiety and inconvenience caused by having more than one spell in hospital. Equally, avoidable readmissions are not good for taxpayers as the NHS bears unnecessary costs of care, leading to resources being wasted. Finding ways of incentivising reductions in readmissions through better treatment or discharge planning is therefore attractive.

There are examples where local commissioners have already negotiated penalties with providers for breaching agreed readmission levels, for example in NHS Croydon where this has led to improved performance by the local acute provider. Local agreements of this sort are powerful, but some sort of national framework would offer greater consistency across the country.

However, there are a number of practical difficulties. It is difficult to establish the cause of a readmission – is it the fault of the hospital's care or a lack of investment in social care or community health services? Any system that tries to attribute responsibility would be very complicated and time-consuming, but the alternative, based on benchmarking of appropriate readmission rates, means some degree of rough justice. There will also be transaction costs associated with readmissions that happen in a different provider from the initial admission. It is therefore important that the practicalities of the policy are fully considered to ensure that the laudable aims of reducing readmissions are achievable in practice.

Proposals to include the cost of the first 30 days of care post discharge in the acute tariff from April 2012 also raise a number of questions. Does this mean acute hospitals will need to subcontract with community service providers or that they will take on responsibility for direct provision of these services? Who will take responsibility for clinical risks? Is the commissioner or acute provider responsible for planning these services? Will existing community service providers be at risk of losing income? Considerably more work is required to ensure these proposals can be practically implemented.

References

1 For example, see *Emergency readmission rates: further analysis*. Department of Health, 31 October 2010

2 *Payment by results guidance 2010/11*. Department of Health, 2010

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4 www.bbc.co.uk/news/10262344

5 *Emergency readmission rates: further analysis, Appendix B. op.cit*

6 *The directory of ambulatory emergency care for adults*. NHS Institute, 2007

7 Gorodeski et al 'Are all readmissions bad readmissions?', *New England Journal of Medicine*; 363;3; 15 July 2010

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Methodology

CHKS examined one full year of the hospital episode statistics database for July 2009–June 2010. For tariff assumptions they used HRG v3.5 and applied the 2008/09 tariff.

Further information

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The NHS Confederation

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. Our ambition is a health system that delivers first-class services and improved health for all. We work with our members to ensure that we are an independent driving force for positive change by:

- influencing policy, implementation and the public debate
- supporting leaders through networking, sharing information and learning
- promoting excellence in employment.

The Foundation Trust Network

The Foundation Trust Network (FTN) was established as part of the NHS Confederation to provide a distinct voice for NHS foundation trusts. We aim to improve the system for the public, patients and staff by raising the profile of the issues facing existing and aspirant foundation trusts and strengthening the influence of FTN members.

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