



This article uses a modelling approach to consider the risky unintended consequences of fining local authorities for failing to provide intermediate care, made law under the 2003 Community Care (Delayed Discharges) Act.

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DELAYED DISCHARGE FINES

Local authority fines: penny wise, pound foolish

by Peter H Millard

Much is riding on the success of the Community Care (Delayed Discharges Act, etc) 2003. A general election is coming: any "trolley waits" will hit the headlines.

Scandinavian countries – Sweden in particular – solved a hospital bed crisis by fining local authorities for delays in discharge. So why shouldn't it work here?

Early signs are good: over 4,000 beds have been freed. However, success was bought at a price per day, whereas the true cost is the cost per case.

Using a modelling approach we explain why a policy initiative that ignores the genuine needs of sick and dependent people, in the long term make the problem of providing acute hospital care worse.

Introduction

London and South East local authorities are now being fined £120 a day if there is more than two days' delay in implementing acute medical discharges. Elsewhere in

England the fine is £100 a day.

The new policy does not apply elsewhere in the United Kingdom, because Scotland and Wales have devolved responsibility for health and social care and Northern Ireland has always had joint working. Why, then, was the policy introduced in England?

Fining local authorities is a sequel to the October 2001 'Cash for Change' programme. The political target is to end widespread 'bed-blocking' by 2004.

To that end, the 'Building Capacity and Partnership in Care' initiative received £300 million over two years to prevent social admissions, to foster the development of intermediate care and radically reform of the way that the NHS and social services worked together (Department of Health 2001).

The logical sequence that underpins the new policy is shown in *Box 1*.

Success at a price

The Community Care (Delayed Discharges Act, etc) 2003 became a legal

Box 1. Why fine hospitals for delayed discharges?

1. Trolley waits cause headlines: the political imperative is to solve the problem of trolley waits.
2. Trolley waits in Accident and Emergency Departments occur when acute beds are full.
3. The acute beds are full because they are 'blocked' by patients inappropriately admitted or awaiting discharge.
4. Delayed discharges are doubly bad: the acute wards create dependency and there is an increased risk of illness due to hospital-acquired (nosocomial) infections.
5. The early success of the October 2001 "Cash for Change" programme is slowing down, joint working between Hospitals and Social Service Departments has improved, but there are still delays: what can be done?
6. Fining social services solved a bed crisis in Scandinavia; let's introduce it here. So be it.

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Table 2. Impact of changing the balance of short and long stay patients in a service with a hundred beds

Beds Allocated	Number short stay	Number long stay	Admissions per bed per year		
			Short stay*	Long stay**	Total
100	20	80	260	40	300
100	40	60	520	30	550
100	60	40	780	20	800
100	80	20	1040	10	1050

* Assuming 13 admissions a year per intermediate care bed, i.e. the average stay in intermediate care beds is 28 days

** Assuming 0.5 admissions per long-stay bed per year, i.e. an average stay of two years.

Ultimately, therefore, the success of the new policy depends on the use that local authorities make of the money that is allocated. Box 2 lists the actions taken by Cornwall County Council in January 2004 to fulfil the requirements of the new law. (Cornwall County Council 2004) Note that a similar amount of long-term funding for 2005/06 was anticipated but not yet agreed.

Implementation in practice

Anecdotally, three different styles of Social Services practice have emerged: 'Wheelers And Dealers', 'Hardball', and 'Soft Touch'. The characteristics of each style need to be considered if the long-term outcome of the Delayed Discharges Act is to be understood.

'Wheelers And Dealers'

'Wheelers And Dealers' follow the spirit of the Act, but not the letter of the law. By investing in new capacity, they seek to

reduce the length of stay of a wider group of patients than just those approaching the 'delay' deadline".

In October 2003, the Reimbursement Implementation team advised that the delayed discharges grant can, with formal agreement, be used to create extra intermediate care capacity.

However, there is a sting in the tail. Capacity planning does not absolve local authorities from the duty to pay if the actual cost of delayed discharges is greater than the cashless transaction. And the legal requirements of the Act – to notify and calculate reimbursement – must be followed. (Department of Health 2003)

So, 'Wheelers And Dealers' are vulnerable if the acute trust does not share the risk and / or the created capacity is insufficient to meet demand. Both are vulnerable if the extra grant allocation is not sustained.

It's a gamble, and it's never clear as to how precisely managers in health care

making astute calculations on the odds.

'Hardball'

'Hardball' social services departments may have attempted negotiation, but for one reason or other they failed to get agreement: coterminous boundaries are not a feature of the NHS, and agreement may have only been possible with one acute trust.

Without a formal agreement to share the risk they spend their allocated grant only on short-term, immediate access, services that pre-empt delayed discharges.

By obeying the rules, making a clear distinction between health and social service funded intermediate care and personally funded care (see Appendix 1), 'Hardball' local authorities control expenditure within their grant. So delays in hospital are more likely to occur for PCT-funded community intermediate care and other NHS provision than for social services funded care.

'Soft Touch'

'Soft Touch' social services departments take on more responsibility than they should. They may have tried to negotiate, but 'Hardball' hospital managers and clinicians may not have perceived that part of the responsibility to change is theirs.

Ultimately, 'Soft Touch' local authorities find themselves unable to meet their other legally binding commitments. Anecdotally, this scenario is not widespread enough to cause a policy re-think. If a local authority sees its resources spiral downwards and the numbers of delays continue to rise, there will come a point where someone / body – possibly from the Change Agent Team at the Department of Health – intervenes with that one local situation, to help resolve the problem.

Money

Clearly, whichever strategy the three groups take, the gains made will not be sustainable if part of the improved performance has been gained by permanent admission to long term-care.

Figure 2 shows, as time passes, given a constant rate of arrival and departure from long-term care, annual increments in the grant are needed to maintain the

Box 2. Community Care (Delayed Discharges, etc) Act 2003.

Actions taken by Cornwall County Council

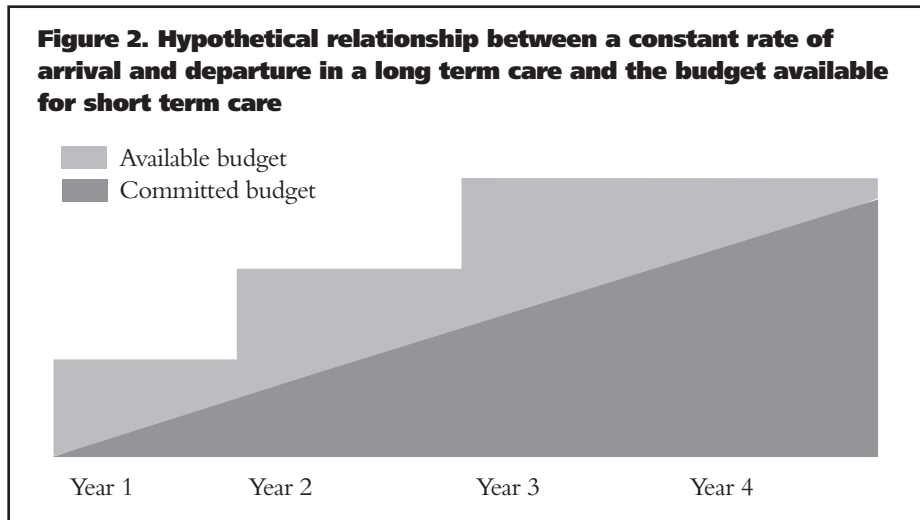
- a) Rapid assessment teams
- b) Equipment enhancements
- c) 'EPIC' preventative nursing approach
- d) Data collection and Information Management Administration enhancements
- e) Therapy enhancement at Royal Cornwall Hospital Trust

Specific resources allocated:

2003/04: £554,000;

2004/05 £1,114,000;

2005/06: 1,114,000 (anticipated but not yet confirmed)



same level of performance. This problem arises because the exponential nature of survival in long-term care systems means that the longer a resident stays, the longer they will stay. (Harrison 2001).

Furthermore, it takes five-and-a-half years for a health care system providing acute, rehabilitative and long-term care to reach stable state. (El-Darzi, Vasilakis et al. 1998) This finding probably explains why the early success of the 2001 'Cash for Change' programme was slowing down. And it leads to the inevitable conclusion that without a continual input of increased funding for the next five years, the early gains of the new policy will not be sustained.

Efficiency savings

In recent years, annual efficiency savings coupled with headline-winning targeted grants have been a feature of government policy for health and social care services.

Anyone who has visited American health services knows that the land is littered with the remnants of grant-stimulated research projects that were not sustained.

Cynically, one could see the same happening here, especially as the new policy was funded by withdrawal of £100 million from the hospital side of the equation.

Pressure and force

The Community Care (Delayed Discharges etc) Act fines local authorities twice the cost of a day's stay in a residential home to force them to concentrate on solving the problems of acute hospitals i.e. someone else gets the blame.

Yet the cause of the current problem in acute hospitals is the running-down of hospital-based rehabilitative and community supportive services. Consider the simplicity of the 1971 advice on the organisation of Hospital Geriatric Services (DHSS 1971) (Box 3), with the complexity of modern guidelines.

Now the focus of NHS general hospitals has changed from comprehensive care to fast-track acute medical.

By denying the rights of older patients presenting with social problems admission to acute hospital beds, and by introducing legislation accepting that acute medical staff have no responsibility to change their clinical working practice to ensure that inpatient care does not create unnecessary dependency, policy-makers have broken the trust between staff, patients and their families.

For this reason alone, the policy is doomed to long-term failure. It's simply a question of time.

Furthermore, extra money was provided to 'kick-start' the change. So early success was inevitable, but the long-term outcome depends on how that money is used.

Using placement data from the London Borough of Merton, Xie et al. estimate the average stay of older people in residential homes 923 days (two and a half-years). Based on national average fees at year 2001 level, plus the London weighting, they calculate that the average cost of admission to residential is £44,044; i.e. 367 times greater than the fine for keeping a patient one day longer in a hospital bed. (Xie, Chausalet et al. 2004)

Conclusion

Fining local authorities in Scandinavia for delays in hospital discharges solved a bed crisis, so it is expected that the same will apply here.

In the short term, this has happened. Yet like was not compared with like.

Furthermore, the exclusion in the legislation of delays in discharge of patients in psychiatric beds, in intermediate care beds, in community hospitals and at home implies that the legislation is treating the symptoms of the problem, but not its cause.

Humans are ingenious creatures. In the short term, the policy has borne fruit. However, in the long run, fast-tracking everyone through acute hospital care will not solve the hospital bed crisis. Indeed,

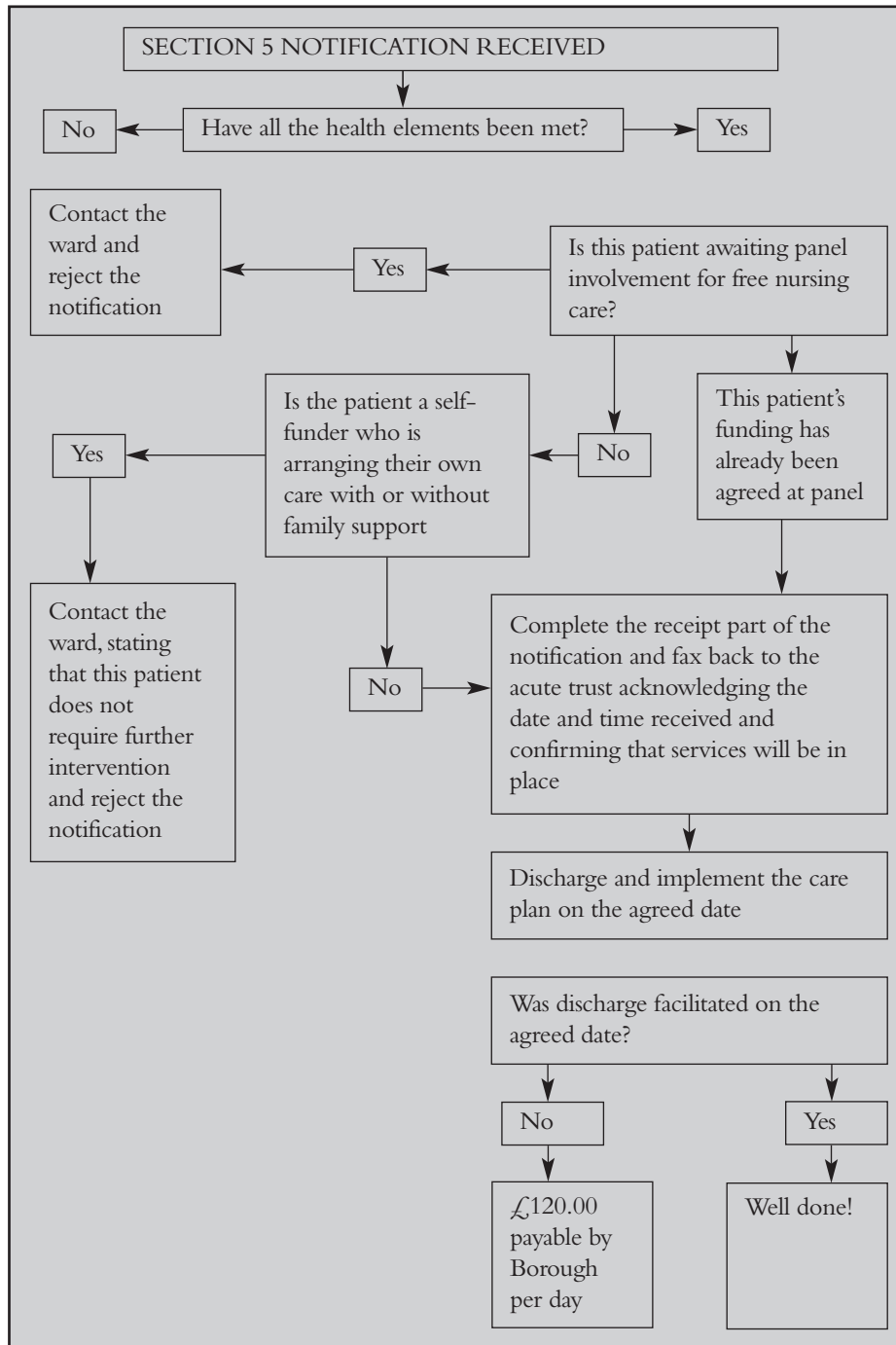
Box 3. 1971 Guidelines for Hospital Geriatric Services: DS 329/71

Appendix A: Siting of hospital services for geriatric patients

One-half of beds allocated to geriatric medicine (about 5 beds per 1000 aged 65 and over) should be in district general hospitals. So consultant physicians in geriatrics could assess and immediately treat patients referred by general practitioners and hospital consultants; and provide joint assessment with psychiatrists and intensive rehabilitation for patients who are likely to respond quickly.

The other half (about 5 hospital beds per 1000 aged 65 and over) provided for patients requiring less intensive rehabilitation who are likely to respond and those patients who have not responded, or who are unable to respond to efforts at rehabilitation, and who need continuing medical treatment and care, and nursing care beyond that which the family or residential home might normally be expected to provide.

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in a total system of care, policies based on prevention of social admissions, rapid discharge, fining local authorities and speedy transfer to intermediate and long-term care are counter productive.

Sustainable long-term solutions depend clinically, numerically and mathematically on excellence in the management of the few at the interface between home and institutional care.

To move forward to a better world,

Government needs to recognise the unique place of consultant leadership in driving forward rehabilitation and community support within the long-term care system in the past success of the National Health Service, and plan accordingly (Millard 1991).

For the epitaph to the current plan will be "Penny wise, pound foolish".

Acknowledgements

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