

# Using SitReps performance data to monitor the delayed discharge process

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Sylvia Godden\*, David McCoy\* and Allyson M Pollock†

\**Health Care Evaluation Group, Department of Epidemiology and Public Health, UCL London;*

†*Centre for International Public Health Policy, University of Edinburgh, Edinburgh, UK*

Situation Reports (SitReps) is an internal Department of Health performance data collecting system. Although intended primarily for internal use, the data are also used to answer parliamentary questions, brief ministers and to inform national performance indicators. This paper reviews the data collection system and data-set, and shows how it can be used to evaluate delays in hospital discharge under the Community Care (Delayed Discharges etc.) Act 2003. However, limitations in the data include the fact that the data have only recently been extended to National Health Service (NHS) non-acute settings and do not include NHS patients in the private acute sector. Further, as the data-set derives from a weekly aggregate return rather than from individualized person-based records, it cannot be used to evaluate length of delay, or to link to other relevant data such as emergency readmissions. The provision of individualized data to facilitate linkage and extending coverage would increase its potential future use. Categories of delay should be further refined to facilitate monitoring of delays due to disputes about eligibility.

## Introduction

In this paper, we review the data system and data-set used to evaluate hospital discharge under the Community Care (Delayed Discharges etc.) Act 2003. This work was carried out as a by-product of a larger study funded by the Economic and Social Research Council, which analysed the implementation and impact of the Act, and the financial incentives to reduce delays in hospital discharge.

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Sylvia Godden BA MSc, Senior Research Fellow, David McCoy MFPH, Specialist Registrar, Public Health, Health Care Evaluation Group, Department of Epidemiology and Public Health, UCL 1-19 Torrington Place, London WC1E 6BT, UK; Allyson M Pollock FFPH, Professor of International Public Health Policy, Centre for International Public Health Policy, University of Edinburgh, Edinburgh, UK

Correspondence to: Ms Sylvia Godden  
Email: rmjdsag@ucl.ac.uk

Delays in hospital discharge have been a focus of government policy for many years. The Community Care Act gave National Health Service (NHS) hospitals in England the power to charge social service departments (SSDs) for failure to provide social-care services to prevent hospital discharge. This was based on the belief that many such delays in discharge were caused by SSDs. However, our analysis of the Situation Reports (SitReps) data system shows that the NHS accounted for the majority of delays and that there has been a reduction in SSD delays prior to the implementation of the Act.

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and Performance Review Team, personal communication).

Data collection commenced in Winter 1999–2000 and is conducted nationally on a weekly basis. It is approved by the Department of Health via the Review of Central Returns Steering Committee (which aims to ensure that information collections are appropriate to their purpose, do not duplicate existing collections and minimize NHS workload of submitting data). As well as delayed transfer of care (DTC) from an acute bed, SitReps returns collect data on ambulance services and other aspects of secondary care including accident and emergency activity, cancelled operations and critical care.<sup>1</sup>

Since April 2002, SitReps returns have been under the remit of the Strategic Executive Information System (STEIS) that collects weekly NHS management information in order to benchmark performance against that of other organizations.<sup>2</sup> Trusts are required to use STEIS as the single means of sharing weekly management information (STEIS is now part of 'Unify', the Department of Health's online data collection system).

SitReps returns are completed by those who supply any of the services listed on the SitRep form – at a trust, entry is likely to be by a data analyst. Private contractors providing services to the NHS are not required to submit a return as the data collection is only from NHS providers.

### **The collection of SitReps data in relation to the delayed discharge process or delayed transfer of care**

The Community Care (Delayed Discharges etc.) Act 2003 established new obligations for NHS and social-care organizations in England relating to hospital discharge arrangements. The new arrangements operated in shadow form from October 2003 and became 'live' in January 2004. Where a patient is delayed solely because a SSD has failed to make supporting community care arrangements, the responsible local authority may be required to reimburse the hospital.

Although 'charging and reimbursement' is not obligatory, the Act requires hospitals and SSDs to improve formal communication with each other, and acute trusts have a statutory duty to notify Social Services of a patient's '*likely need for community care services*' by

issuing an '*assessment notification*' or Section 2 notice which requires SSDs to make an assessment of any patient likely to require post-discharge social care. In addition, a trust must allow a minimum of 24 hour-notice of a patient's discharge date through a '*discharge notification*' or Section 5 notice before classifying occupancy of an acute bed as a delayed discharge.

Trusts and SSDs must closely monitor the number of delayed discharge bed days even if charges are not levied. Data recorded on SitReps does not include the amount of any fines in monetary terms, the details of which only the acute trust and the local authority concerned know.

SitReps returns are submitted by a provider trust to the Performance Branch of the Department of Health which collects data by local authority on the number of patients whose transfer is delayed, the number of days of delayed transfer and the number of reimbursable days.

A delayed discharge or delayed transfer of care is defined as follows:

A DTC occurs when a patient is ready for transfer from acute care, but is still occupying a bed designated for acute care. A patient is designated as ready for transfer when: a clinical decision has been made that the patient is ready for transfer *and* a multidisciplinary team decision has been made that the patient is ready for transfer and the patient is safe to discharge/transfer.<sup>1</sup>

Prior to October 2003, the number of patients with a DTC was measured from a weekly 'snapshot' of the number of patients with a DTC at midnight on Thursday. After changes in 2003, the number of patients continued to be recorded on SitReps on the basis of a weekly snapshot (for example, patients delayed from Monday to Wednesday would not appear in the snapshot and so would not be included in the SitRep data). The number of *days* delayed recorded on SitReps, however, is the *total* for the week for *all* patients (not just those crossing the census day).

The reason for these two different methods of recording data is to be able to track the number of bed days lost because of DTC, as this is the basis on which trusts are entitled to claim reimbursement where SSDs are responsible, and also to track how many patients are likely to have a delayed transfer at any point in time. For this purpose, midnight on Thursday is taken to

be representative of the whole week (as it avoids bias, e.g. due to weekends).

Though local monitoring of bed days attributed to delayed discharge takes place on a daily basis, returns are only required weekly. Trusts must reach agreement with local authorities when completing the form and designate responsibility.

In summary, acute trusts monitor the following: The local authority responsible for each patient delayed; both the number of patients whose discharge is delayed and the number of reimbursable days – by the responsible local authority; the agency responsible (NHS, social services or both); and the reason for the delay.

The nine categories of reasons for delay are shown in Appendix 1. A patient is only counted in the *one* category that most appropriately describes the reason.

Although guidance states that data should be collected for all adults (over 18 years), there is an implicit understanding that data gathering applies only to patients covered by the Community Care Act, and excludes patients admitted for mental health services, learning disabilities, rehabilitation, intermediate, maternity and palliative care<sup>3,4</sup> (though reimbursement *does* apply to patients with a mental illness under the care of an acute medical consultant for a physical condition). However, since April 2006, SitReps have been extended to report on DTOC from all non-acute and mental health NHS Trusts. Although 'charging and reimbursement' currently only applies to patients receiving acute care, the Act allows discretion for charging to be instituted to cover other patient categories.<sup>5</sup>

## How SitReps data are used

Although the primary purpose of the SitReps system is to support internal management and performance review (Planning and Performance Review Team, Personal communication), the returns are used as data in the performance indicator system used to promote trusts to foundation status, and since 2005–2006 contribute to the results of the Healthcare Commission's Annual Health Check to assess NHS trusts' performance.

As well as being used to compile the Health Care Commission performance indicator for assessment on DTOC, SitReps returns are also used in the numerator of a Social Services

Performance Assessment Framework Indicator: PAF D41, which collects the number of DTOC of care per 100,000 population.

## Further sources of data on delayed transfers of care – the local delivery plan return

There is a separate source of DTOC data derived from the local delivery plan return (LDPR). Data are returned by commissioners (primary care trusts – PCTs) on the patients for whom they are responsible who experience delayed transfers at the trusts with which they commission. LDPR data are designed to complement PCT's local delivery plans in order to measure performance against their plan. These are the three-year plans produced by PCTs and submitted by Strategic Health Authorities to the Department of Health that identify how a local health service will achieve and maintain the government's national vision and targets. LDPR returns therefore provide a separate source of information from SitReps on delayed discharge – counted at a census of hospital bed use conducted one Thursday every three months (though some commissioners may choose to derive this from SitReps data). This is the main data source used in Department of Health reports on the impact of policy on delayed transfers, for example in the Statistical Supplement to the Chief Executive's Report to the NHS previously published twice yearly through to 2006. Data are presented in terms of the number and proportion of patients with a DTOC on a given day each quarter and do not provide data on bed days as in SitReps. Data have been available since the first quarter of 2001–2002 on the number of patients of all ages with a DTOC, and for patients aged over 75 since 1997–1998.

At national level, data from the LDPR census week should be consistent with the total number of patients delayed from SitReps data for the corresponding week, though it is an ongoing process to match provider and commissioner returns (as in other areas, e.g. waiting times [Planning and Performance Review Team, personal communication]). As LDPR delayed patient numbers are based on just one census day per quarter, the data from SitReps based on a weekly return should be more accurate.

## Data quality and ascertainment

In our study, we found that SitReps performance data can provide a useful source to monitor the delayed discharge process. However, we identified a number of issues relating to data quality and ascertainment:

- (1) SitReps data are not linked to individualized patients. Data relies on a weekly episode count which does not allow linkage, so a patient is counted more than once if delayed for longer than a week. This may artificially inflate the perceived scale of the problem. It is not possible to calculate length of delay from the data.
- (2) Coverage. Private sector contractors are not required to submit returns on NHS patients. As the number of such contractors is increasing this is likely to be an increasing weakness in the system. Data has only recently been required to be collected on NHS patients in non-acute settings (including PCTs and mental health).
- (3) Under ascertainment. The measurement of delays in discharge can be influenced by configuration and classification of NHS beds. For example, shifting a patient from an acute to an interim bed within a hospital can mean that delays are not recorded, and can mask the extent to which delays occur within hospitals. In our study on discharge from hospital, we found that delays in discharge had fallen dramatically over time. While this was the intention of the legislation we found that this reduction had been ongoing for some while before the introduction of the Act. Further, from data available it cannot be discerned if some of that fall may be due to the policy of shifting NHS patients into beds that have been redesignated as intermediate care.
- (4) Categories available. The categories available used to designate cause of delay lack precision. Delay due to an assessment from a psychiatrist in a mental health trust is in the same category as one due to an Occupational Therapist from within the acute trust.

Another issue is that delays in making a decision about eligibility for public funding of post-discharge care (due to delays in submitting to a panel) cannot be disaggregated from delays that arise due to an individual disputing a decision

- about eligibility for funded NHS continuing care. All are included in Category B.
- (5) Trends. Changes in data collection and definitions make it difficult to compare the data before and after 2003. SitReps data before the 2003 Act were not only collected on a different basis but were of questionable quality (Planning and Performance Review Team, personal communication).
  - (6) Reliability of data and lack of standard definitions. Variations in medical opinion about the readiness of a patient for discharge and the concept of patient safety and risk will result in variations in the number of delayed discharges identified.<sup>6</sup> Further NHS-related delays are locally determined and only SSD delays are subject to Section 2 and 5 notices, and stipulations about the time available to complete an assessment or provide a required service so there is a lack of consistency between delays attributable to the two agencies.
  - (7) Administrative complexity. The requirements for capturing accurate data in the SitReps system are considerable. Clinical and ward management staff have to understand the definitions of delays in discharges and the administrative systems to ensure that notifications are sent promptly to the relevant SSD. Many hospitals admit patients from a large number of SSDs, all of which will need to be sent the relevant 2 and 5 Section notices. Such demands might result in under-recording of the frequency and volume of delays.

## Discussion

The SitReps performance system was modified in 2003 to enable hospitals to identify and calculate the financial liability of respective SSDs for delays in discharge, as well as to monitor delays in discharge caused by the NHS and patients themselves. It was extended to record the total number of 'delayed discharge bed days' throughout the week using an expanded range of categories of reasons for delay.

These data are not in the public domain or routinely published and are part of an internal Department of Health performance data collecting system. We found that it is possible to obtain and use data from the SitReps system since 2003 to measure and monitor the volume

of acute hospital bed days lost to delayed discharge, as well as to determine the reasons for delay over time. However, improvements to the data-set could be made by extending its coverage and completeness, and adapting it to provide person-based data. It is recommended that this data source is reviewed by the Department of Health Performance Monitoring Team to extend its potential use in the future.

This data source has not been reviewed previously and our study was based on an evaluation of an extract of SitReps data obtained after invoking the Freedom of Information Act. It proved to be a useful source of data to measure and monitor trends in, and reasons for delays in, discharge. To be of further use to health service researchers, we recommend that it could be made even more useful by developing and refining as follows:

## Recommendations

### (1) *To collect person-based data*

Person-based, linked data needs to be collected in order to understand whether delays in discharge relate to a large number of patients delayed for a short time or a small number of patients with long delays. Individualized patient records would also facilitate linkage to relevant data, in particular readmissions data. This would enable evaluation of the wider impact of policy aimed at reducing delays in hospital discharge, i.e. to explore the effects of policies to discharge patients more quickly results on readmissions.

### (2) *To identify more precisely the category of bed in the returns*

The data collecting system has recently been extended to all NHS non-acute (PCT and mental health) patients, though not to private providers or beyond the NHS. It is important that the data are able to identify delays according to the precise category of bed, e.g. whether an interim, or intermediate bed in order to monitor delays throughout the whole system.

### (3) *To evaluate the quality and safety of hospital discharge and post-acute care*

It should be possible to link hospital discharge data to emergency readmissions data (the numbers of which are increasing) in order to evaluate the quality and safety of hospital discharge.

### (4) *To review and revise the categories of delays*

Category E, waiting for a care package in the patient's own home and Category F, waiting for community or home-based equipment and adaptations, could be merged into a single category relating to delays in the provision of home-based care and services, while Category B, waiting for a decision about eligibility for public funding of post-acute care, should be separated into two categories: delays in reaching a decision about the eligibility of public funding for post-discharge care; and delays that arise from disputes over decisions made about eligibility. It is important to monitor the number of disputes, particularly because of concerns about the decreasing eligibility for NHS care and closures in the NHS long-term care sector. It would also be useful to create a new and separate category to monitor delays arising from patient/family disputes.

We believe that implementation of these recommendations would significantly improve the usefulness of this previously unpublished data source to monitor the delayed discharge process.

## Acknowledgements

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## Appendix 1 Summary of delayed discharge categories

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| Category |   |
|----------|---|
| A        | Waiting for completion of an assessment of a patient's future care needs  |
| B        | Waiting for a decision about eligibility for public funding of post-acute care. This may be due to delays in getting a case to the panel making the decision about funding, or to incomplete information submitted to a panel. Delays caused by an individual disputing a decision over fully funded NHS continuing care also falls in this category  |
| C        | Patients whose assessment is complete but where transfer is delayed due to waits for further NHS non-acute care, including intermediate care and rehabilitation services and continuing health care fully funded by the NHS in the independent sector – but excluding delays in providing NHS care in the patient's home which is recorded under Category E   |
| D        | Waiting for a placement, because of a lack of availability of a suitable place. This category is broken down into Di (residential home) and Dii (nursing home). It excludes delays caused by the patient or family exercising their right to choose a home under the Direction on Choice (Category G)   |
| E        | Waiting for a care package in the patient's own home. NHS causes may be due to a delay in organising a district nurse, occupational therapist or physiotherapist service  |
| F        | Waiting for community or home-based equipment and adaptations   |
| G        | Delays caused by patient or family choice, after an assessment has been completed and a reasonable offer of services made. This covers patients responsible for funding their own social care who, for example, insist on a placement in a home with no foreseeable vacancies. As long as patients have been offered an appropriate interim placement, and the patient or his/her family is causing an unreasonable delay, SSDs are not liable for reimbursement and delays are attributed to the NHS |
| H        | Delays caused by disputes between statutory agencies over who is responsible for a patient's onward care, or concerning an aspect of the discharge decision. The delay may not be recorded as the responsibility of both agencies – one or other of the agencies should be allocated responsibility even while the dispute is being resolved  |
| I        | Delays incurred in patients who are not eligible for SSD-funded community care, for example, asylum seekers or single homeless people   |

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