

Carrot and sticks? The Community Care Act (2003) and the effect of financial incentives on delays in discharge from hospitals in England

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ABSTRACT

Background The belief that many delays in discharge from hospital were caused by social service departments (SSDs) led to the Community Care Act 2003 giving NHS hospitals in England the power to charge SSDs.

Methods We surveyed 150 SSDs in England about the implementation of the Act and used routine data to analyse trends in the number of delayed discharge patients; the number and cause of delayed discharge bed days by sector; and the proportion of inpatient bed days that consisted of delayed discharges.

Findings Most hospitals opted not to charge SSDs for delays. Almost two thirds of SSDs (62%) made no payment of any kind to an acute hospital in 2004/05 and 2005/06, preferring to work collaboratively. The fall in number of 'delayed discharge patients' is a long term trend which precedes the implementation of the 2003 Act. Delayed discharge bed days accounted for 1.58% of all inpatient bed days in 2004/05. Contrary to popular opinion, the NHS accounted for two thirds (67%) of bed day delays, lack of suitable alternative NHS provision and services is a key factor. Patients are being discharged in greater numbers *and* earlier in their post-acute recovery phase. There are however questions about the quality and safety of early discharge. For example, emergency hospital readmissions rates have risen from 5.4% in 2002/03 to 6.7% in 2005/06, and patient dissatisfaction is significant.

Conclusion Although delays in discharge from acute hospital beds have fallen, the quality of discharge and the capacity of Primary Care Trusts (PCTs) and SSDs to ensure appropriate and adequate post-discharge care is not as it should be. Contrary to popular perception, social services delays are of less significance than delays attributable to the NHS. There is no evidence to support government policy of charging SSDs for delay. Other factors, including NHS provision, are important, and a comprehensive overview of health and social care is vital.

Keywords Hospital discharge, delayed discharge, financial incentives, community care act 2003

Background

Delays in hospital discharge have been a focus of government policy for many years. The National Audit Office (NAO) reported that 2.2 million bed days could be attributed to delays in discharge in England in 1998/99 costing the NHS £1 million a day.¹ The House of Commons Health Committee concluded that delayed discharges affected 6% of all acute beds and cost the NHS £720 million in 2001/02.² Delays in discharge can also result in patients receiving sub-optimal rehabilitation and post-acute care in a hospital ward when they could be better looked after at home or in a dedicated intermediate care facility.

The perception that many delays in discharge were caused by social service departments (SSDs) led to the Community Care (Delayed Discharges etc.) Act 2003 giving NHS hospitals in England the power to charge SSDs a daily tariff (£120 in the South East and £100 in the rest of England) in the event of their failure to provide the required social care services.³ The Act was implemented in shadow form in October 2003

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and in full in January 2004, but excluded children as well as patients admitted for acute mental health care, maternity services and palliative care.

When the Community Care Bill was first introduced, there were concerns that such an arrangement would undermine trust and cooperation between health and social services.⁴ Subsequently, the Act made 'charging' optional, although hospitals and SSDs were still obliged to measure delays in discharge (which were adopted as key performance indicators for both the NHS and SSDs) and determine the potential financial liability of SSDs.

The implementation of the Community Care Act was also accompanied by the introduction of a Delayed Discharge Grant to all SSDs worth £50 million in 2003/04 and £100 million in both 2004/05 and 2005/06.⁵ These grants were to support improvements in the transfer of care of patients from hospital and could form the basis for joint investment plans between hospitals, SSDs and PCTs.⁶ Access and Systems Capacity Grants, Building Care Capacity Grants and Intermediate Care Capital Funding between 2001 and 2006 worth hundreds of millions of pounds were also provided to increase the capacity of post-discharge care.

This paper assesses the impact of the Act with respect to whether hospitals chose to 'fine' SSDs for delays in discharge and trends in the numbers and causes of delays in discharge.

Methods

Survey of SSDs

All 150 SSDs in England were sent a postal questionnaire asking for the following data for 2004/05 and the first quarter of 2005/06:

- (i) the nature of the reimbursement arrangement for delays in discharge with up to three main acute hospital provider(s) in 2004/05;
- (ii) the total amount of payments made to hospitals because of delays in discharge; and
- (iii) the size of their Delayed Discharge Grant.

The reimbursement arrangement between hospitals and SSDs was categorized into one of two groups: (1) where the hospital is reimbursed by SSDs for delays in discharge *and* keeps the money; and (2) where the hospital does not charge SSDs for delays in discharge *or* agrees to reinvest any payments made by SSDs into community-based services. This distinguishes hospitals which derive income directly from delays in discharge from those which pool their resources and work collaboratively with SSDs to reduce delays in discharge.

To improve our response rate, we obtained approval from the Association of Directors of Social Services and contacted

non-respondents by telephone and by e-mail. Responses were eventually obtained from 99 SSDs, amounting to a 61.9% response rate. These SSDs reported on 197 separate arrangements with local hospital trusts.

Analysis of quantitative data on delayed discharges and hospital inpatient activity

(i) Trends in delayed discharges in England

We plotted secondary data derived from a quarterly one-day bed census conducted by the Department of Health (DH) on the number of discharged patients still occupying an acute bed from July 2001 to March 2006. We also obtained primary data from SitReps, a weekly reporting system used by hospitals to generate a variety of performance indicators for the DH including the number of patients whose discharge was delayed; the number of 'delayed discharge bed days' occupied by each patient in a given week; and the cause of delay.⁷ These data are not in the public domain or routinely published, and were obtained for the period 29th September 2003 to 31st July 2005 after invoking the Freedom of Information Act.

Finally, Hospital Episode Statistics (HES) data on inpatient bed days were obtained from the Health and Social Care Information Centre's website to estimate the proportion of all inpatient bed days that consisted of delayed discharges.

(ii) Causes of delayed discharges

SitReps designates the cause of delay into nine categories (labelled A to I)—see appendix 1. Each delay is attributed to either a SSD, the NHS or, very rarely, to both. In our analysis, we reassigned the nine categories into three groups: (1) delays caused by the failure of a SSD or NHS agency to provide a required service which includes delays caused by patients or families disputing a decision about their non-eligibility for public funding for continuing care (categories A to F); (2) delays related to 'patient or family-choice' such as patients and/or families insisting on a placement in a home with no foreseeable vacancies or failing to arrange the transport required for a patient to leave hospital (category G); and (3) delays caused by disputes between statutory agencies over who is responsible for funding post-discharge care or delays to patients not eligible for SSD-funded community care (categories H and I).

Findings

The nature of arrangements between hospitals and SSDs

The 99 SSDs reported on reimbursement arrangements with 197 hospitals. Of those, one hundred and thirty-one (66%) of hospital arrangements had opted not to charge SSDs for delays

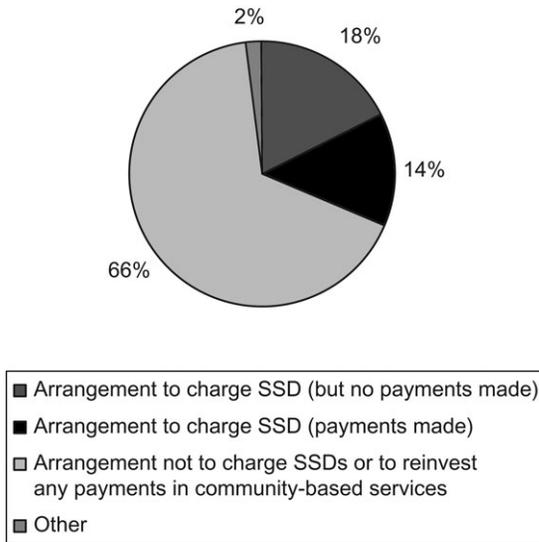


Fig. 1 Nature of the arrangement between hospitals and their local SSD, 2004/05 (*n* = 197).

in discharge in 2004/05. Only 62 of the 197 arrangements (34.4%) involved hospitals charging SSDs *and* keeping the income. However, 28 of these did not actually involve any payments because there were no delays in discharge attributed to the SSD. Survey responses indicated that nearly all arrangements remained the same for 2005/06 (Fig. 1).

Of the 99 SSDs surveyed, 62 (62.6%) reported making no payment of any kind to an acute hospital in 2004/05, and 63 (66.3%) in 2005/06. Of those that did make payments, there was enormous variation in the amounts paid to hospitals, ranging from hundreds of pounds to hundreds of thousands of pounds. Most paid out amounts that were less than 10% of their Delayed Discharge Grant (Fig. 2). Two

councils however made payments in excess of their Delayed Discharge Grant in 2004/05.

The aggregate sum of payments made in 2004/05 by the 99 SSDs was £4.90 m, less than 10% of their aggregated sum of Delayed Discharge Grants.

Trends in delayed discharges—patients and bed days

According to data from the quarterly one-day bed census, the number of ‘delayed discharge patients’ has been falling since October 2001, 2 years prior to the implementation of the Community Care Act. However, the trend suggests that the announcement and implementation of the Act may have precipitated a brief acceleration of this decline (Fig. 3).

Although there are no SitReps data on delayed discharge bed days prior to implementation of the Act, the NAO estimate of 180 000 delayed discharge bed days per month in 1998¹ shows that the number of delayed discharge bed days had fallen long prior to the implementation of the 2003 Community Care Act.

According to HES data, there were 4.5 million hospital inpatient bed days per month in both 2003/04 and 2004/05 in England (this excludes day case admissions).⁸ On the basis of these figures, delayed discharge bed days accounted for around 1.9% of all inpatient bed days in 2003/04 and 1.6% in 2004/05. Delayed discharge bed days attributed to SSDs accounted for 0.38% of inpatient bed days in 2004/05. However, these calculations do not include delays in discharge that would have occurred to children, maternity patients and patients admitted to mental health trust beds, all of whom are exempted from the Community Care Act.

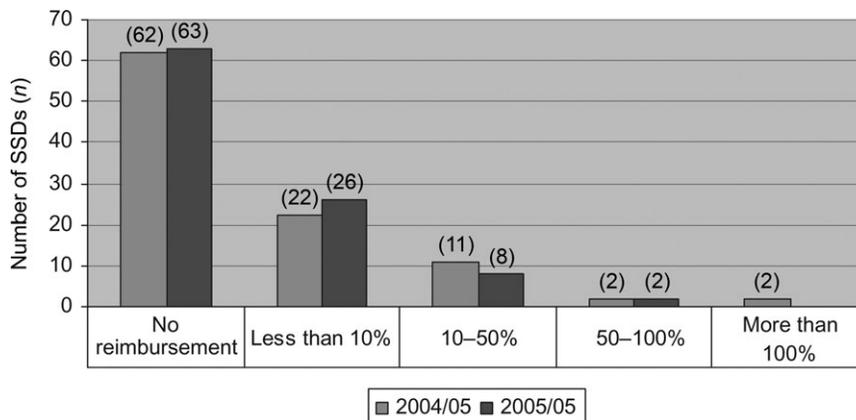


Fig. 2 Number of SSDs making varying amounts of payments to hospitals as a percentage of their Delayed Discharge Grant 2004/05 and 2005/06.

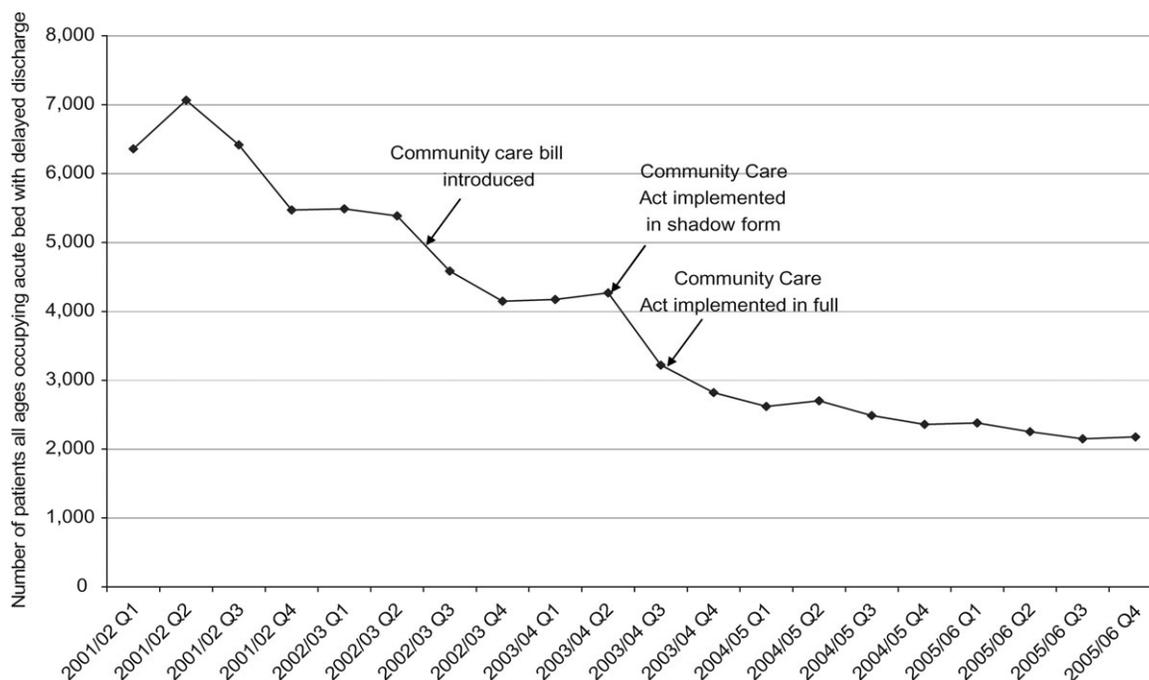


Fig. 3 Number of patients occupying an acute hospital bed in spite of having been discharged. Source: Statistical supplement to Chief Executive's report to the NHS: June 2006.

Attribution and causes of delayed discharge bed days

According to SitReps, the NHS accounted for 67.6% of delayed discharge bed days between Q3 of 2003/04 and Q1 of 2005/06, compared to 27.1% due to SSDs (see Table 1). However, most of the overall reduction in delayed discharge bed days was due to a reduction in SSD delays, much of which occurred soon after implementation of the Act (Fig. 4). The reduction in SSD delays then plateaued in 2004/05, leaving a 'residue' of about 15 900 delayed discharge bed days per month.

The total number of delayed discharge bed days attributed to SSDs in 2004/05 was 206 379 days. If acute hospitals had charged SSDs a daily tariff of £120 (the higher amount used in the south-east), NHS hospitals would in theory have gained income worth £24.8 million. This is less than a quarter of the Delayed Discharge Grants made available to SSDs.

Nearly all (92.4%) SSD-attributed 'delayed discharge bed days' delays were caused by delays in providing social services (Categories A, B, D, E and F). Of the NHS delays, 71.9% of delayed discharge bed days were related to delays

Table 1 Average monthly number and proportion of delayed discharge bed days by quarter and sector in England

Average number of delayed discharge bed days per month	2003/04 Q3	2003/04 Q4	2004/05 Q1	2004/05 Q2	2004/05 Q3	2004/05 Q4	2005/06 Q1	Total
All causes (NHS and SSD)	93 761	76 368	69 889	78 020	70 041	69 045	66 248	523 371
Attributed to SSDs	37 580	19 561	16 866	19 517	16 471	15 939	15 912	141 846
	(40%)	(26%)	(24%)	(25%)	(24%)	(23%)	(24%)	(27.1%)
Attributed to NHS	52 464	52 823	49 423	53 830	49 642	49 241	46 403	353 827
	(56%)	(69%)	(71%)	(69%)	(71%)	(71%)	(70%)	(67.6%)
Attributed to both NHS and SSDs	3717	3984	3599	4674	3927	3864	3933	27 698
	(4%)	(5%)	(5%)	(6%)	(6%)	(6%)	(6%)	(5.3%)

Source: SitReps.

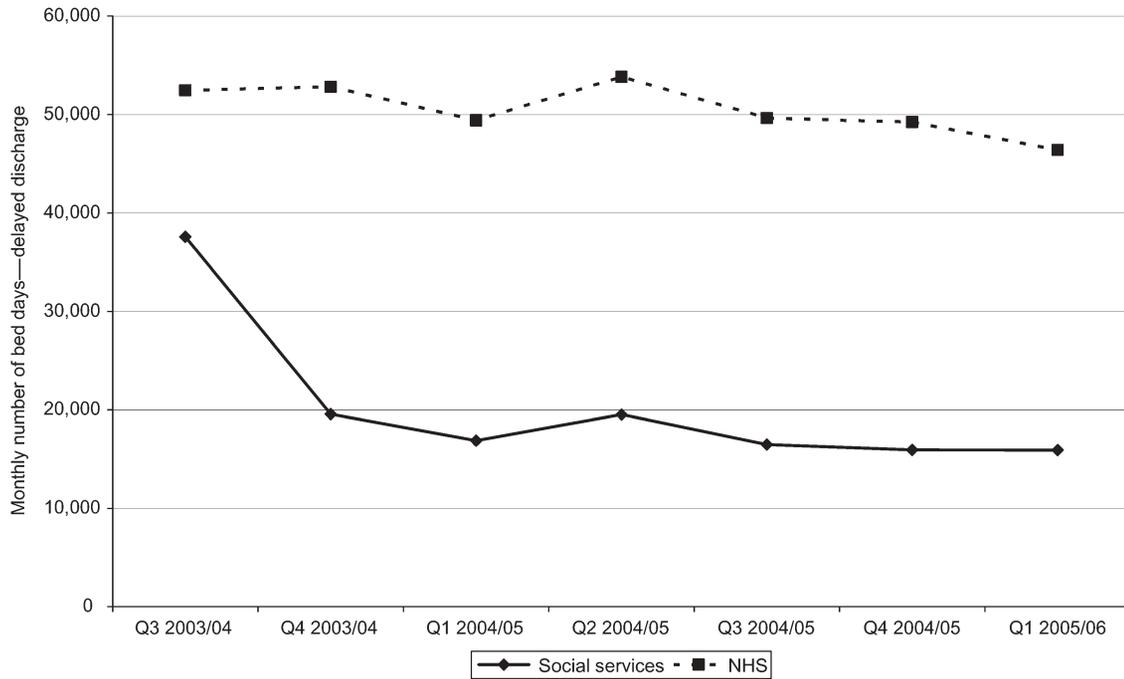


Fig. 4 Average number of delayed discharge bed days per month and by sector (29th September 2003 to 3rd July 2005). Source: SitReps.

in the provision of some form of health care (Fig. 5). NHS-attributed delays caused by ‘patient and family-related reasons’ were less significant (22.6%), but still amounted to approximately 11 400 bed days per month. Of these, NHS-attributed delays caused by statutory disputes amounted to about 2800 bed days per month.

Discussion

According to our survey, most hospitals chose not to charge (the stick) SSDs for delays in discharge. Many others reinvested SSD payments into community-based services rather than keep the income. The availability of the Delayed

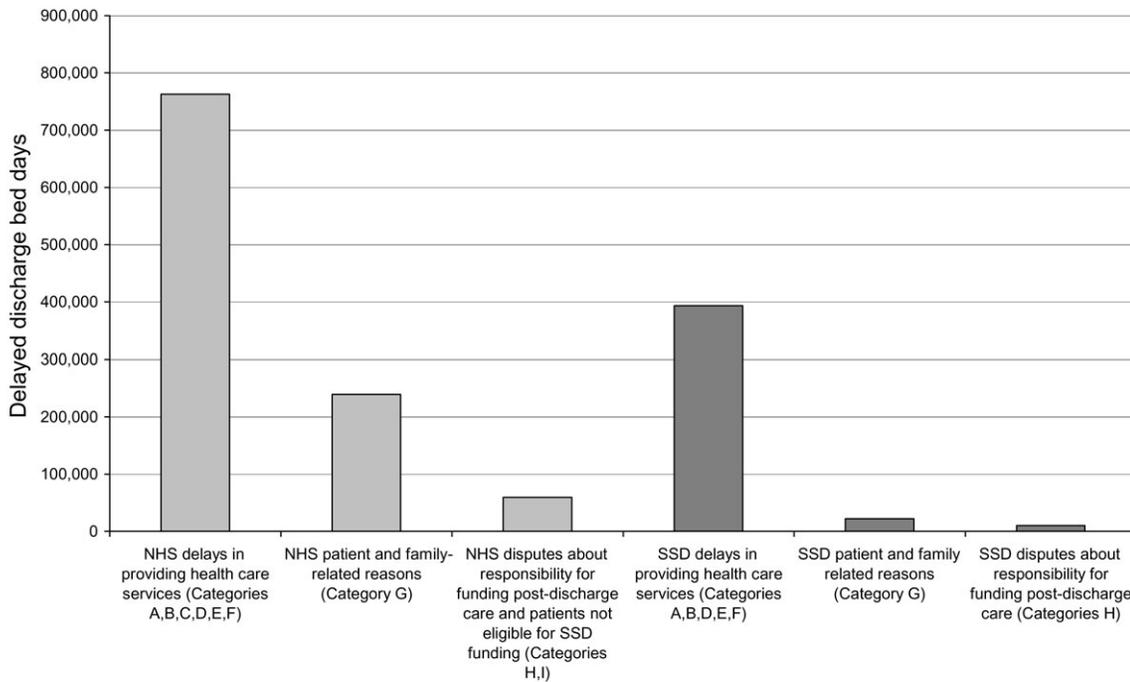


Fig. 5 Number of delayed discharge bed days by cause and sector (NHS and SSD) (29th September 2003 to 3rd July 2005). Source: SitReps.

Discharge Grant, (the carrot) helped fund interventions to reduce delays in discharge but also encouraged hospitals to enter into partnerships and joint investment plans with SSDs.

Contrary to common perception, SSDs were not the major cause of delays in discharge at the time the Community Care Act was implemented. By the middle of 2005, SSDs accounted for only about a quarter of all delayed discharge bed days. In terms of overall hospital activity, they accounted for 0.38% of all inpatient bed days in 2004/05.

Most of the delayed discharge bed days were attributed to the NHS. It was not possible to differentiate between delays of PCT or hospital origin. However, NHS-attributed delays included delays caused by 'patient and/or family reasons', 'disputes between statutory agencies' and delays to patients 'who are not eligible for SSD-funded community care', which are not necessarily the 'fault' of NHS service providers.

The long-term trend in reductions in numbers of delayed discharge bed days may have accelerated briefly with the introduction of the Act. However, it is not possible to ascertain the extent to which the Community Care Act (and in particular the option for hospitals to charge SSDs) contributed to the decline because of the concurrent impact of the Delayed Discharge Grant.

The data also suggest that further reductions in delayed discharges, especially those attributed to SSDs, may have plateaued. At the end of the period under study, delayed discharges only accounted for 1.58% of all inpatient bed days.

Reductions in the number and length of delayed discharges from acute hospital beds have also been accompanied by increases in hospital throughput and shorter lengths of stay. Between 2001/02 and 2004/05 in England, the number of inpatient admissions rose from 7.5 to 8.2 million per annum, and the average length of stay decreased from 8.1 to 7.1 days.⁸ Patients are now being discharged from hospital in greater numbers *and* earlier in their post-acute recovery phase. Although this implies a more efficient use of acute beds, it says nothing of the quality of discharge nor the capacity of PCTs and SSDs to ensure appropriate and adequate post-discharge care.

However, a major cause of delay was 'patient and/or family reasons', which suggests that many patients are experiencing hospital discharge negatively. There has also been a rise in the rate of emergency hospital readmissions in England, from 5.4% in 2002/03 to about 6.7% in 2005/06.⁹ Although this might reflect changes in the age and case mix of hospital admissions, it could reflect a lowering of the thresholds for discharge.

Finally, the lack of data on intermediate care or community-based services means that it is not possible to determine whether patients are experiencing delays in receiving post-discharge care, or whether the quality of care has been maintained in the face of rising numbers of post-discharge patients. There is a dearth of data on 'interim care', a term usually used in relation to the transfer of patients from an acute hospital bed to an interim bed when the long-term residential placement of choice is temporarily unavailable. Although in theory, interim care should provide a more appropriate setting for patients than a busy, acute hospital ward, there are no routine data on the number of patients transferred to 'interim care', their length of stay in interim beds, nor the impact of interim care on their well being.

What this study adds and where it is limited

A popular view is that the Community Care Act (2003) established a new, quasi-market relationship between acute hospitals and SSDs. The reality was that most hospitals chose to strengthen partnership and joint working arrangements with their local SSDs. However, further qualitative research would be required to look at the effect of financial incentives and cross-charging between the NHS and SSDs on hospital discharge practices.

This is the first study to provide England-wide data on delays in discharge from acute hospital beds, as well as their cause and attribution. However, one limitation of this study is that it did not validate the SitReps data. It is possible that hospitals define delays in discharge in different ways and expend different amounts of energy and time to accurately identify and record all delays in discharge. The adoption of delays in discharge as a key performance indicator may also subject some of the data collection to 'gaming' between hospitals, SSDs and PCTs. The large variation in the amount of reimbursements paid by SSDs to their local hospitals suggests that further studies are required to explain why large differences in the number and length of delays in discharge occur.

Finally, the evidence of patient and family dissatisfaction with the discharge process, together with rising readmission rates and previous findings of poor quality hospital discharge¹⁰⁻¹² suggest that there is cause for concern. It is conceivable that the apparent success in increasing hospital throughput, shortening lengths of hospital stay and reducing delays in discharge has been accompanied by deterioration in the overall quality of care. The further fragmentation of services accompanying the current reforms of the health and social care system may make it harder to establish a holistic information system to monitor the provision of care for patients across all levels and parts of the health and social care system. This will therefore require close research attention.

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Appendix 1 Categories of delayed discharges

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 organizing 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.