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Show me the Way to go Home: Delayed Hospital Discharges and Older People

Final Report

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Contents

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Abbreviations

AEP	Appropriateness Evaluation Protocol
ASSIA	Applied Social Sciences Index and Abstracts
EAR	Emergency Admission Review
HSMC	Health Services Management Centre
HMSO/TSO	Her Majesty's Stationery Office/The Stationery Office
ISD	Information and Statistics Division
ISDA	Intensity-Severity-Discharge Review with Adult Criteria
NAHAT	National Association of Health Authorities and Trusts
NHS	National Health Service
OBSI	Oxford Bed Study Instrument
RCT	Randomised Controlled Trial

A Note on Terminology

Often, accounts of hospital discharge refer to the problem of 'bed blocking' as a short-hand term for people (often older people) who it is believed are occupying a hospital bed when they no longer need the services provided in an acute setting. While such phrases are in widespread usage, this terminology is felt by many to carry a highly pejorative meaning, implying that the older people concerned are themselves to blame for the situation. As is increasingly clear, however, this is often totally inaccurate, as it is the system itself which causes many such 'blockages', not the individual patient (who often wishes to return home as soon as possible). As Christina Victor (1991, p.123) explains:

"The whole notion of bed blocking seems to imply that older people enter hospital and then wilfully continue to occupy a bed which, in the views of staff, they no longer require. Older people (or indeed patients of any age) do not become bed blockers of their own intent. Rather where such cases do occur it is because the health and social care system cannot provide the type of care they need."

As a result, this report endeavours to adopt more neutral terms such as 'delayed discharge' wherever possible, referring to 'bed blocking' only where it is unavoidable, such as in a quotation from another source, and placing it in inverted commas to highlight the fact the term is an unsatisfactory one. The need to avoid use of the term 'bed blocking' is now widely recognised and accepted by the House of Commons Health Committee (2002) and the Department of Health (2002a).

SHOW ME THE WAY TO GO HOME: DELAYED HOSPITAL DISCHARGES AND OLDER PEOPLE - EXECUTIVE SUMMARY

Background

Since 1997, there have been a wide range of policies and initiatives designed to reduce the number of people (particularly older people) who experience delayed discharges from hospital. These include an inquiry by the House of Commons Health Committee, substantial extra investment in intermediate care services, the creation of a Change Agent Team to spread good practice and legislation to impose fines on social services departments for contributing to delayed hospital discharges (a measure known as reimbursement). In spite of these measures, there is a large and longstanding body of literature which suggests that hospital discharge is a problematic area of policy and practice, sometimes characterised by:

- Poor communication between hospital and community.
- Lack of assessment and planning for discharge.
- Inadequate notice of discharge.
- Inadequate consultation with patients and their carers.
- Over-reliance on informal support and lack of (or slow) statutory service provision.
- Inattention to the special needs of vulnerable groups such as frail older people.

Methodology

Against this background, this review of the literature summarises findings from studies published since 1993 which focus on the rate and causes of delayed hospital discharges for older people in the UK. In particular, this study has sought to analyse findings against a framework for understanding hospital discharge developed by the authors during a preliminary review of the literature. This framework seeks to identify and respond to the problems associated with delayed hospital discharges (and hospital discharge more generally) in terms of individual (I) factors, organisational (O) factors and factors associated with wider social policy and the structure of current services (S).

The Literature

The 21 studies included in this review report rates of delayed discharges which vary substantially (from 8 to 66%) depending on the location of the study, the sample included in the research and the approach taken. The causes of delayed discharge are equally diverse, ranging from internal hospital delays to waiting for social care assessments/funding and from factors relating to patients/carers to housing needs. However, a key aspect of a number of studies is the high number of delayed hospital discharges associated with internal hospital factors. Given the widespread assumption that delayed discharges are caused by shortfalls within social care, this is a key finding. Also significant is the need for additional rehabilitation identified by many of the studies – a finding which would appear to support the current emphasis on developing intermediate care services.

Despite the apparent insight which they provide into the rate and causes of delayed discharge, however, the 21 studies are characterised by a series of limitations which are explored in more detail in the 'Key Themes and Issues' chapter. These include:

- Methodological concerns about the approaches adopted.

- The failure in many studies to suggest policies and practices that may solve the problem of delayed discharge.

- The failure to look beyond the surface of the causes of delayed discharge. As a result of this we were unable to use the I, O, S model outlined above.

Key Themes and Issues

In particular, the review identifies five key themes and issues:

1. The literature reviewed has a number of methodological limitations which make comparisons between different studies and different locations all but impossible. In particular, the studies contained in this review tend to adopt very different definitions of delayed hospital discharge and the vast majority fail to include a patient perspective. We believe that the latter is crucial if the potential expertise of patients and their carers is to be included in debates about future health/social care policy and if effective solutions are to be found to the problem of delayed hospital discharge.

2. The majority of studies seek to investigate the rate and causes of delayed hospital discharges, but fail to explore potential solutions in sufficient detail.

3. The importance of local contexts and history in understanding and responding to delayed hospital discharges.

4. The complexity of hospital discharge and the need for a whole systems approach.

5. The studies in this review fail to consider the needs of minority groups (such as older people with mental health problems or older people from minority ethnic communities). A small number of studies also suggest that delayed hospital discharge should not necessarily be the main focus of health and social care services, pointing to significant reductions in the number of delayed discharges and the importance of also addressing premature discharge, admission avoidance, the risk of inappropriate placements and delays in accessing community services.

Conclusion

From this review of the literature on delayed hospital discharges and older people, we have come to three main conclusions:

1. From the literature reviewed in this study, it is difficult to avoid the conclusion that the existing evidence base concerning delayed hospital discharges and older people is extremely weak. Although the wider literature identifies a series of difficulties associated with hospital discharge, research into the rate and causes of delays is characterised by a series of methodological limitations which raise significant questions about the extent to which recent policy changes can be said to be evidence-based.

2. Against this background, areas for further research and consideration include:

- Ways in which hospitals can address internal causes of delayed hospital discharges.

- Local factors contributing to delayed hospital discharge in different areas of the country and local solutions.

- More sophisticated approaches which seek to combine qualitative and quantitative research methods, and which include a patient/carer perspective alongside the views of staff.

- More in-depth research which considers delayed hospital discharge in terms of its individual (I), organisational (O) and structural (S) causes.

- Longitudinal research which not only diagnoses the problem, but which also explores delayed hospital discharges over time in order to examine whether proposed solutions are actually successful.

- The needs of people from minority groups (such as older people with mental health problems or older people from minority ethnic communities).

- The importance of wider issues such as premature discharge, admission avoidance, the risk of inappropriate placements and delays in accessing community services.

3. Despite the limitations of existing research, however, the literature reviewed in this study supports the direction of some recent policy initiatives, while raising important questions about others:

- Given the methodological limitations of the literature reviewed in this study, how evidence-based is current policy and practice?

- Given the complex and diverse nature of delayed discharges, is a measure like reimbursement going to be an adequate response?

- Given the importance of rehabilitation services in the literature, it would seem as if the government is correct to emphasise the development of intermediate care services.

- Given the importance of local contexts, an initiative like the Change Agent Team would seem to be a useful way of working with local health and social care communities to resolve the difficulties associated with delayed discharges.

- Given the whole systems nature of delayed discharges, does reimbursement run the risk of damaging local relationships between health and social care?

1. BACKGROUND

The Policy Context

Securing timely and effective hospital discharge is a key concern in contemporary health and social care and a key feature of policy initiatives such as the NHS Plan, the National Service Framework for Older People and waiting time targets (Department of Health, 2000, 2001a). Throughout the Labour government's time in office, the issue of delayed hospital discharges has become an increasingly significant issue. According to former Health Secretary, Alan Milburn (Department of Health, 2001b):

"Bed-blocking is a major problem for all NHS patients. Bed-blocking leaves people in beds who should be cared for elsewhere and keeps people from beds who need treatment straight away. We are determined to tackle this problem which has bedevilled the health service for decades so that patients receive the right care in the right place at the right time."

Since May 1997, key policy initiatives have included (see Glasby, 2003 for an overview):

- The announcement of £900 million over four years to develop new intermediate care services (Department of Health, 2000).

- A £300 million 'Cash for Change' initiative to reduce the number of delayed discharges (Department of Health, 2001b). This has since been linked to a new Concordat between the public and independent sectors (Department of Health, 2001c).

- The creation in January 2002 of the Health and Social Care Change Agent Team to support the implementation of the National Service Framework for Older People, to develop a single system of health and social care and to work with local agencies to reduce delayed hospital discharges (Department of Health, 2003a).

- A House of Commons Health Committee (2002) inquiry into delayed hospital discharges and a report by the National Audit Office (2003).

- The publication of a new Hospital Discharge Workbook (Department of Health, 2003b) to replace a 1994 predecessor (Henwood, 1994). Emphasising the need for a whole systems approach, the workbook covers a wide range of topics, from user involvement to continuing care and from co-ordinating the patient journey to the role of housing services.

Above all, however, the key measure has been the introduction of new legislation (the Community Care (Delayed Discharges etc.) Act 2003) to charge social services departments for hospital beds unnecessarily 'blocked' by people awaiting social services provision. As the Department of Health (2002b, p.33) explains:

"We have been impressed by the success of the system in countries like Sweden and Denmark in getting delayed discharges from hospitals down. We intend to legislate therefore to introduce a similar system of cross-charging [also known as 'reimbursement']. The new social services cash announced in the Budget includes resources to cover the cost of beds needlessly blocked in hospitals through delayed discharges… Councils will need to use these extra resources to expand care at home and to ensure that all older people are able to leave hospital once their treatment is completed and it is safe from them to do so. If councils reduce the number of blocked beds, they will have the freedom to use these new resources to invest in alternative social care services. If they cannot meet the agreed time limit they will be charged by the local hospital for the costs it incurs in keeping older people in hospital unnecessarily. In this way there will be far stronger incentives in the system to ensure that patients do not have to experience long delays in their discharge from hospital. There will be matching incentive charges on NHS hospitals to make them responsible for the costs of emergency hospital readmissions, so as to ensure patients are not discharged prematurely."

At the time of writing, it is still too early to tell exactly how this new measure will work in practice, although it has certainly aroused considerable controversy and criticisms from a range of commentators (see, for example, Clode, 2002; Glasby, 2002a, 2002b, 2002c, 2003; Glendinning, 2002). Perhaps the highest profile of these critics has been the House of Commons Health Committee (2002), who stress the potential of the new Act to lead to (p.52):

"An unproductive culture of buck passing and mutual blame between health and social care."

Delayed Hospital Discharges

Despite all these initiatives, both research and anecdotal evidence suggest that hospital discharge continues to be a problematic area of practice, characterised by poor patient experiences, inadequate communication, cost shunting and insufficient inter-agency collaboration (see, for example, Henwood and Wistow, 1993; Henwood, 1994; Horne, 1998; Marks, 1994; Neill and Williams, 1992). As a result, the House of Commons Health Committee (2002) estimates that in the second quarter of 2001-2002 around 7,000 people were delayed in hospital at any one time (occupying six per cent of all acute hospital beds) and that delayed discharge may have cost the NHS around £720 million per year (although the rate of delayed discharge is believed to have fallen since this report). Such a situation is felt to be problematic for three main reasons:

- Hospital beds are expensive and inappropriate bed use is a waste of scarce public resources. Work undertaken by the Personal Social Services Research Unit suggests that one inpatient day for an older person costs around £144 (Netten *et al*., 2001), so there is considerable scope for efficiency savings by reducing the number of beds occupied inappropriately. Thus, a study in inner London found that 74 patients inappropriately located in hospital accrued 7,519 inappropriate bed days at a cost of £836,547 (Victor *et al*., 1993a).

- There are a finite number of acute hospital beds and sometimes there may not be enough capacity to admit patients who require hospital care. This is particularly the case during the winter months, although evidence suggests that pressures on beds can now occur at any time of year (Moore, 1995). An extreme example comes from Birmingham, where patients were treated in ambulances because the Accident and Emergency was full and the hospital was unable to free up beds by discharging patients medically fit to leave due to funding difficulties in the local social services department (Marsh, 2001a, 2001b).

- Hospital is often an unsuitable environment for people fit for discharge. Unnecessarily long hospital stays can subject patients to the risk of hospital acquired infections and delayed discharges can lead to depression or a decline in functional independence. Many patients also prefer to be in the comfort of their own homes if at all possible and many find prolonged hospital stays frustrating and/or distressing.

For economic, administrative and humanitarian reasons, therefore, delayed discharges from acute hospital beds are generally perceived to be problematic by policy makers, practitioners and patients alike.

In spite of the centrality of hospital discharge to recent NHS policy initiatives, there is a substantial body of literature dating back more than thirty years that highlights the many problems associated with the discharge of older people. Over time, this research has consistently identified a number of key themes (summarised in Tierney *et al*., 1994, pp.479-480):

- Poor communication between hospital and community.

- Lack of assessment and planning for discharge.

- Inadequate notice of discharge.

- Inadequate consultation with patients and their carers.

- Over-reliance on informal support and lack of (or slow) statutory service provision.

- Inattention to the special needs of vulnerable groups such as frail older people.

Although the remainder of this report focuses on delayed hospital discharge, therefore, it is essential that this topic is not viewed in isolation and that the experiences of and outcomes for older people are also considered alongside the following analysis of the rate and causes of delayed discharges.

2. METHODOLOGY

Against this background, the Department of Health has commissioned this review of the literature on delayed hospital discharges and older people. Although further details of our approach are set out in Appendix A, the study aimed to review published and grey literature on the hospital discharge of older people in the UK in order to identify and explore:

- The rate and causes of delayed hospital discharges.

- Policies and practices that may reduce delayed discharges and improve the experiences of older people.

In order to achieve these aims, relevant literature was identified via a series of health and social care databases (see Appendix A). Documents were then selected for their relevance to the overall aims and objectives of the study (see above) and categorised using the criteria outlined in the National Service Framework for Older People (Department of Health, 2001a). As an example, a sample search strategy and exclusion/inclusion criteria are included in Appendix B. This is an approach which a member of the research team has recently adopted in a Department of Health-funded literature review of adult mental health services (*Cases for Change*) (Glasby *et al*., 2003). By cataloguing documents in this way, it is possible for different types of evidence to be included (from peer-reviewed academic papers to material by practitioners and service users), and for readers to be aware of the type and nature of the material that is being reviewed.

Throughout this process, all abstracts identified during the initial literature search were read independently by each member of the research team and discussed in team meetings before inclusion in the study.

Once documents had been identified, they were summarised using the pro forma in Appendix C. This front sheet has been designed from the criteria for assessing the quality of qualitative research proposed by Mays *et al* (2001). Once again, this is an approach that has already been taken in the *Cases for Change* review and which has proved successful in assessing the quality of the available evidence. During this process, all three researchers read each of the documents before meeting to discuss and agree classification/interpretation.

Throughout, the main focus has been on the hospital discharge of older people, since this user group makes considerable use of health/social services and may have complex needs that straddle the boundaries of several different agencies/services (Victor, 1997). Despite this, the issues highlighted are likely to be just as relevant for other user groups (see, for example, Glasby, 2003; McDonagh *et al*., 2000).

Whilst previous reviews have sought to highlight the difficulties associated with hospital discharge (see, for example, Marks, 1994; Taraborrelli *et al*., 1998; McDonagh *et al*., 2000), this study makes a new contribution to the debate by utilising a new framework developed by the research team during a preliminary review of the literature[1]. In an introductory textbook on hospital discharge policy and practice, Glasby (2003) proposed a new model for understanding the problematic nature of hospital discharge and identifying possible solutions. This model was developed via a grounded theory approach (Glaser and Strauss, 1999) which seeks to generate theory from empirical data via three steps (Punch, 1998):

- Exploring data with a view to developing conceptual categories.

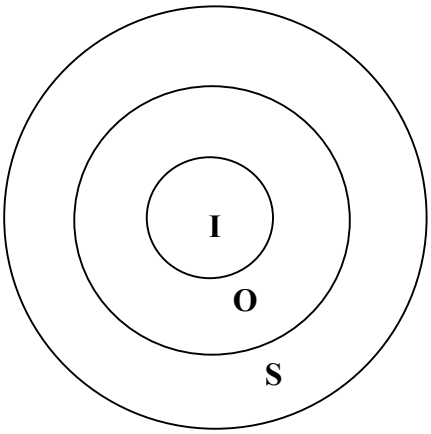
- Finding relationships between these categories.

- Conceptualising and accounting for these interrelationships.

[1] Please note that this framework was developed out of the literature on hospital discharge in general (that is, on older people's experiences of discharge, on levels of co-ordination and planning etc.), not just the literature on delayed discharges.

With regard to hospital discharge, a grounded theory approach to the literature has led to the identification of a series of common difficulties associated with the discharge process. As these difficulties began to emerge, they were constantly re-tested against the literature in order to ensure that they provided a satisfactory explanation of the empirical data. During this process, it became apparent that the issues identified fell into three distinct categories: individual, organisational and structural. These categories can be presented diagrammatically (see figure 1) using a model already popularised in research into anti-discriminatory practice (Thompson, 2001) and adapted in fields such as occupational stress (Glasby, 2000) and organisational change within the voluntary sector (Glasby, 2002d).

Figure 1: Understanding partnership working in health and social care



I: the Individual level

O: the Organisational level

S: the Structural level

(adapted from Glasby, 2000, 2002d; Thompson, 2001)

The implications of this analysis for understanding delayed hospital discharge are explored in the discussion section of this report.

3. THE LITERATURE

The literature search described above identified 865 documents, of which 21 were included in this review. These were categorised using the typology set out in the National Service Framework for Older People (Department of Health, 2001a; see table 1). Findings are summarised in tables 2-4, including:

- Authorship, date, sample and rate of delayed discharge (table 2).

- Definitions of delayed hospital discharges (table 3).

- Potential approaches or alternative services that may help to reduce delayed discharges (table 4).

Despite the apparent insight which they provide into the rate and causes of delayed discharge, however, the 21 studies are characterised by a series of limitations which are explored in more detail below and in section 4 of this report. These include:

- Methodological concerns about the approaches adopted (see pp.29-34).

- The failure in many studies to suggest policies and practices that may solve the problem of delayed discharge (see pp. 26, 35-36).

- The failure to look beyond the surface of the causes of delayed discharge. As a result of this we were unable to use the I, O, S model outlined above (see pp. 26, 35-36).

Table 1: The nature of the evidence

Type of evidence	A	B	C	Other
Number of studies	1	9	9	2

Type A Evidence:

- (A1) Systematic reviews which include at least one Randomised Control Trial (RCT).
- (A2) Other systematic and high quality reviews which synthesise references.

Type B Evidence:

- (B1) Individual RCTs.
- (B2) Individual non-randomised, experimental/intervention studies.
- (B3) Individual well-designed non-experimental studies.

Type C Evidence:

- (C1) Descriptive and other research or evaluation not in B.
- (C2) Case studies and examples of good practice.

Other:

- (D) Summary review articles and discussions of relevant literature and conference proceedings not otherwise classified.
- (P) Professional opinion based on clinical evidence or reports of committees.
- (U) User opinion.
- (C) Carer opinion.

The Rate of Delayed Discharge

Estimates of the rate of delayed hospital discharge in the 21 studies above range from 8 to 66 per cent (see table 2). However, there are considerable methodological limitations to a number of these studies, and the findings are not necessarily directly comparable. This is discussed in more detail in section 4 of this report (see also table 3 for the different definitions of delayed discharge).

Table 2: Delayed hospital discharge and older people

Authors	Location	Sample	Rate of Delayed Discharges
Armstrong *et al* (2001)	Forth Valley, Scotland	200 patients admitted to two hospitals in the same Trust, February 2000-May 2000. The mean age of patients was 67 and 63.	Hospital A: 46% (363) of 787 acute patient bed days were inappropriate. Hospital B: 44% (363) of 810 acute patient bed days were inappropriate.
Fenn *et al* (2000)	Kent	1,139 patients admitted to a district general hospital, June-July 1994. Patients aged 65 and over accounted for 62% of total bed days.	30% of bed days were inappropriate. Patients aged 65 and over were in hospital inappropriately for 37% of the patient days compared with 22% in younger patients.
Houghton *et al* (1996)	East London	625 adult patients admitted to Homerton hospital, 1992-1993. Of these, 77% were aged 55 or over.	66% of the last days of stay were inappropriate.
House of Commons Health Committee (2002)	-	National totals supplied by the Department of Health for the second quarter of 2001-02	7,065 delayed discharges of patients of all ages. This represents 6% of all acute beds and delayed discharge may cost the NHS £720 million per annum. 12% of people aged over 75 occupying acute beds are inappropriately placed.
House of Commons Select Committee on Public Accounts (2001)	-	National total (England)	Two million bed days lost each year due to delayed discharge. On any given day, 6,000 people aged 75 and over experience delayed discharge, costing hospitals around £1 million per day.

ISD Scotland (2003)	All NHS Trusts in Scotland	All patients in Scotland in hospital on 15th October 2002	2,798 patients were ready for discharge (88% of which were aged 65 and over). 1,902 patients were outside the 6 week period allowed for assessment and making follow-up arrangements.
Koffman *et al* (1996a)	Inner London teaching hospital	118 patients admitted to three acute wards (54% of patients were aged 65 and over)	16 patients (13.5%) were inappropriately located, 14 of which were aged 65 and over. The 16 patients accrued 331 inappropriate bed days, costing around £73,000.
Kutiyanawala *et al* (1998)	Leicester	157 patients admitted to an adult surgical ward, November-December 1996	19% bed days (246 out of 1,243) were 'blocked' by 32 patients. Of the 157 patients, 41 were aged over 70, of whom 16 (39%) had a period of overstay.
McDonagh *et al* (2000)	-	Systematic review of studies of appropriate use of acute beds	Approximately 20% of days of stay were inappropriate for older people.
McWhirter (2002)	Northern Ireland	National total (Northern Ireland) as at 31st March 2002	375 patients experienced delayed discharge. 93% were aged 65 and over; 81% were aged 75 and over.
Mohammed *et al* (2001)	Adult orthopaedic ward, Scotland	621 patients admitted September-November 1998 (occupying a total of 3,159 bed days)	255 bed days were 'blocked' by 46 patients (8% of the total bed days). Of these, a substantial but unspecified amount appear to have been older people.
Namdaran and Sherval (1995)	Edinburgh	Five surveys in Edinburgh general hospitals of the number of patients awaiting long-term care, 1988 –1994	The number of patients awaiting long-term care has fallen from 217 to 80 between 1988 and 1994 (21.2% of patients to 9.2%).
National Audit Office (2000)	England	National totals based on NHS data	6,000 older patients (12-13% of all older patients in hospital) experience delayed discharge.

National Audit Office (2003)	England	National totals (based on Department of Health data), September 2002	4,150 older patients are delayed in hospital on any given day (8.9% of all older people occupying acute beds) out of a total of 5,384 people of all ages delayed (5.1% of the total hospital population).
Panayiotou *et al* (1995)	Walsall	4,488 admissions to three acute wards and five rehabilitation wards of a care of the elderly unit over a 12 month period	92 patients (2%) had stays of more than three months, occupying 13,064 bed days. Of these, the case notes of 15 patients were studied in more detail. For these 15 patients, the mean length of stay after being declared ready for discharge was 24 days (16.5% of their stay).
Pascoe (2001)	North Essex	Not specified, but appears to be all patients aged 65 and over in one health authority	280 beds occupied by patients awaiting discharge at any one time in 2000 (10% of entire bed stock and 25% of the bed stock in one hospital).
Roberts and Houghton (1996)	Birmingham	Full survey of a large teaching hospital, March 1996 (705 beds)[2]	58 patients (8.2%) were delayed in hospital, with a total of 3,456 days' delay.
Tracey *et al* (1998)	Belfast	65 cases of older people experiencing the assessment and care management process (mean age of patients was 82 years)	17 people (24%) experienced a prolonged hospital stay as a result of a delay in the assessment and care management process.
Vaughan and Withers (2002)	England	21 hospitals across England	On average, 29% of patients no longer needed acute care (four-fifths of whom were aged 65 and over). On elderly care wards an average of 43% of patients no longer required hospital care.

[2] Although age is not specified, a substantial proportion of the sample were older people (personal communication)

Victor *et al* (2000)	3 hospitals in England	456 patients aged 75 and over admitted from home and discharged from designated elderly care wards, February-September 1997	27% experienced a delay of 3 days or more.
Williams (2002)	Wales	National total (Wales), 2001-2002[3]	Delays averaged 806 per day (resulting in the loss of 220,632 bed days per year).

[3] Although age is not specified, a substantial proportion are assumed to be older people, as is the case in England, Scotland and Northern Ireland.

Table 3: Definitions of delayed hospital discharges

Authors	Method of calculating delayed discharges
Armstrong *et al* (2001)	Delayed discharge was defined in terms of the proportion of bed days occupied by patients not meeting agreed criteria for acute care. This was determined using the Emergency Admissions Review (EAR), an audit tool adapted from the Appropriateness Evaluation Protocol (AEP).
Fenn *et al* (2000)	Delayed discharge was defined in terms of inappropriate bed usage, using the Oxford Bed Study Instrument (OBSI).
Houghton *et al* (1996)	Appropriateness of admission and of last day of stay were assessed using the AEP (an instrument designed to assess the appropriateness of adult patient admission to, and specific days of care in, acute hospital beds through case-note review against a structured set of clinical criteria).
House of Commons Health Committee (2002)	National total cited in official report (data supplied by the Department of Health).
House of Commons Select Committee on Public Accounts (2001)	National total cited in official report.
ISD Scotland (2002)	Delayed discharge was defined as 'where a patient remains in hospital after his/her clinical readiness for discharge has been determined by the lead clinician in consultation with all agencies involved in planning that patient's next stage of care'.
Koffman *et al* (1996a)	Delayed discharge was defined in terms of inappropriately located patients using a modified version of the Oxford Bed Study Instrument (OBSI).

Kutiyanawala *et al* (1998)	Delayed discharge was defined as the occupation of a bed by a patient who no longer needs the expertise assigned to it (with patients assessed daily by a higher surgical trainee).
McDonagh *et al* (2000)	Not applicable - systematic review of studies of appropriate use of acute beds.
McWhirter (2002)	Delayed discharge was defined as 'remaining in hospital after they (patients) were medically fit for discharge because they were awaiting delivery of a community care package'.
Mohammed *et al* (2001)	Delayed discharge was referred to as 'overstay' and defined as 'the time spent in an orthopaedic bed after discharge had been deemed appropriate'. Daily assessment of patients was carried out by a Specialist Registrar.
Namdaran & Sherval (1995)	This study examined the number and proportion of older people (65 and over) who are waiting in hospital for long stay care.
National Audit Office (2000)	National total as cited in official report.
National Audit Office (2003)	National total as cited in official report (based on Department of Health data).
Panayiotou *et al* (1995)	Delayed discharge was defined as the period between the time a patient was declared ready for discharge and actual discharge.
Pascoe (2001)	Not specified.
Roberts & Houghton (1996)	Bed occupancy data collection form completed by health and social care.

Tracey *et al* (1998)	Focuses on increased hospital stays as a result of delays in the assessment and care management process.
Vaughan & Withers (2002)	Delayed discharge was defined in terms of patients no longer requiring acute care (as assessed by senior doctors).
Victor *et al* (2000)	Delayed discharge was defined as patients who had a recorded delay in their discharge of three days or more.
Williams (2002)	National total as cited in official report.

The Causes of Delayed Discharge

The 21 studies included in this review reveal a wide range of contributing factors to delayed hospital discharges (see table 4). In particular, three main issues emerge. These are discussed in further detail in sections 4 and 5 of this report:

1. A large number of studies highlight the need for more rehabilitation services (see for example, Armstrong *et al*., 2001; Fenn *et al*., 2000; Koffman *et al*., 1996a).

2. A large number of studies identify internal hospital factors as a prime cause of delayed hospital discharge. Thus, Armstrong *et al* (2001) found that 60 per cent of inappropriate bed use in one hospital was the result of waiting for another opinion, a planned investigation or a decision from the consultant. Similarly, Fenn *et al* (2000) suggest that waiting for a consultant ward round was a significant cause of delayed discharge, while Houghton *et al* (1996, p.551) conclude that:

   "In the study reported here, evidence… shows that there is clearly considerable room for improvement [within hospitals]. Delays due to waiting for pharmacy, results of investigations and review by the consultant suggest that inappropriate rates could be reduced through increased efficiency or increased provision in these areas."

3. Overall, the causes of delayed discharge are extremely diverse, ranging from internal hospital delays to waiting for social care assessments/funding and from factors relating to patients/carers to housing needs. Indeed, the diversity of the results cited above points towards the need for a whole systems approach to tackling delayed hospital discharges and raises questions about the extent to which the current reimbursement policy can tackle an issue this complex and multi-faceted.

Table 4: The main causes of delayed discharges

Authors	Main Causes of Delayed Discharges/Alternative Services Required
Armstrong *et al* (2001)	• Rehabilitation (23-29% non-acute bed days) • Short-term delays (for example, waiting for another opinion, planned investigation or consultant decision) (28-60% non-acute bed days) • Other (includes patients undergoing observation or other types of treatment, such as blood sugar monitoring for older patients with newly diagnosed diabetes) (9-17% non-acute bed days) • Long-term delays (for example, waiting for transport to another hospital, residential or nursing home) (8-14% non-acute bed days) • Uncertainty over what nursing care was needed on discharge (0.5-12% non-acute bed days)
Fenn *et al* (2000)	• Lack of rehabilitation (609 inappropriate bed days, 29%) • Lack of non-acute or nursing home beds (474 bed days, 22.5%) • Waiting for consultant ward round (417 bed days, 20%) • Suitable for transfer to non-acute hospital (280 bed days) • Waiting for another opinion (116 bed days) • Uncertainty over social aftercare (112 bed days) • Waiting for investigation results (111 days) • Awaiting transport (100 bed days)
Houghton *et al* (1996)	• Waiting for laboratory results (24% of patients) • Waiting for medication from pharmacy (22%) • Condition worsened/needed more treatment (17%)

House of Commons Health Committee (2002)	• Awaiting completion of assessment of future care needs and identifying appropriate care setting (22.2% of delays) • Awaiting social services funding for residential or home care (21.9% of delays) • Awaiting further NHS care (11.5% of delays) • Awaiting care home placement (20.4% of delays) • Awaiting domicillary package (6.7% of delays) • Patient and/or their family exercising right to choose a residential or nursing home (8.1% of delays)
House of Commons Select Committee on Public Accounts (2001)	• Poor co-ordination within hospitals (arising from the timing of consultants' decisions to discharge and delays in provision of transport and pharmacy) • Delays in assessing the ongoing care needs of older patients • Lack of appropriate facilities in the community • Insufficient partnership working between hospitals, GPs and social services
ISD Scotland (2002)	• Awaiting post-hospital social care assessment (627 patients) • Awaiting community care arrangements (for example no funding to purchase residential or nursing home placement) (1,454 patients) • Awaiting health care assessment (57 patients) • Awaiting health care arrangements (for example, transport or bed availability in other NHS facilities) (234 patients) • Legal and financial (for example intervention by a patient's lawyer) (78 patients) • Disagreements (for example between family and health or social services) (47 patients) • Other patient/carer/family related reasons (for example, patient exercising statutory right of choice) (298 patients)

Koffman *et al* (1996a)	• No available hospital rehabilitation facilities (5 patients, 117 inappropriate bed days) • No available part III accommodation (2 patients, 55 days) • Temporary absence of occupational therapist on ward (2 patients, 39 days) • No available care of elderly facilities (2 patients, 39 days) • Rehousing required by patient (1 patient, 35 days) • No available home help (1 patient, 21 days) • Carer refused patient home (1 patient, 17 days) • Late consultant round (1 patient, 4 days) • Other unspecified rehabilitation issues (1 patient, 4 days)
Kutiyanawala *et al* (1998)	• Delay in arranging/availability of rehabilitation bed (86 bed days) • Inappropriate admission (66 bed days) • Social circumstances (36 bed days) • Patient waiting for investigations (36 bed days) • Awaiting oncologist/medical opinion (16 bed days) • Cancellation/delay of operation (3 bed days) • Request by patient to extend stay (3 bed days) • Difficulty in obtaining transport (2 bed days)
McDonagh *et al* (2000)	• Lack of care at an appropriate level (primarily long-term care) • The need for care that is between the level of a 'patient hotel' and the acute hospital
McWhirter (2002)	• Awaiting nursing care package (54% patients) • Awaiting residential care package (13% patients) • Awaiting domicillary care package (33% patients) • No funding available for care (35% patients)

Mohammed *et al* (2001)	• No orthogeriatric beds (16 patients, 136 bed days) • No young disabled beds (3 patients, 69 bed days) • Delay in transport (9 patients, 16 bed days) • Cancelled theatre (11 patients, 13 bed days) • Social circumstances (1 patient, 14 bed days) • Patient waiting for investigation (2 patients, 2 bed days) • Delay in transferring to another speciality (1 patient, 3 bed days) • Request by patient to extend stay (1 patient, 1 bed day) • Inappropriate admission (1 hospital, 1 bed day)
Namdaran & Sherval (1995)	• Awaiting geriatric long stay: 168 patients (75%) in 1988 – 11 patients (12.8%) in 1994 • Awaiting psychogeriatirc long stay: 12 (5.4%) – 2 (2%) • Awaiting local authority/voluntary/private residential care: 25 (11.7%) – 16 (18.6%) • Awaiting private nursing home: 19 (8.5%) – 53 (61.6%)
National Audit Office (2000)	• Time of day consultant decides to discharge • Poor co-ordination of services (for example, medication not available to go home with or lack of transport) • Awaiting social service assessment/funding • Lack of nursing and residential home places • Delay in provision of home care services • Delays in reaching agreement with family and patient over the nature of continuing care services
National Audit Office (2003)	In addition to standard Department of Health categories (see, for example, House of Commons Health Committee, 2002) for causes of delay, the National Audit Office emphasises the complex network of (often interdependent) local causes that impact on delayed discharge. These include: • Internal hospital factors (such as focusing on a particular ailment rather than on the whole patient or the shortage of specialist staff) • Relationship factors (such as slow assessment processes or the lack of a single patient record) • External factors (such as lack of social services funding or lack of capacity in the residential sector)

Panayiotou *et al* (1995)	• Slow response of social services to assess patients' circumstances and needs, implement care packages and provide or install aids needed for maximal function • Waiting for vacancies in suitable residential or nursing homes • Difficulties liaising with community social workers • Physiotherapy and Occupational Therapy shortages of staff resulting in slower rehabilitation and inadequate provisions for visiting the homes of individual patients
Pascoe (2001)	• Assessments took too long from six weeks to six months • Shortage of social workers • Different working practices between each Trust • Clinical behaviour/patient expectations (for example, families' belief patients could be cared for whilst awaiting their choice of residential or nursing home) • Access to residential and nursing care • Lack of home care support • Budgetary inefficiencies and reduction in available funds
Roberts & Houghton (1996)	• Social services-related delays (such as waiting for assessment, waiting for funding or waiting for home equipment) (10 patients, 80 days of delay) • Hospital-based delays (such as awaiting consultant opinion, hospital acquired infections and awaiting occupational therapy) (16 patients, 173 days of delay) • Delays outside the control of the individual hospital or social services (such as awaiting community health services, patient/carer-led reasons and awaiting transfer to another hospital) (32 patients, 3,203 days of delay)
Tracey *et al* (1998)	• No place in home of choice (4 patients) • Relative not available for contact (2 patients) • Relative disagreed with recommendations of Assessment and Care Management team (2 patients) • Waiting release of funds from care manager (1 patient) • No social work cover (1 patient)

Tracey *et al* (1998) cont	• Patient did not want to go to nursing home despite disability (1 patient) • Doubt in Assessment and Care Management team as to appropriate placement (1 patient) • Patient changed mind (1 patient) • Patient's wife changed mind about patient coming home (1 patient) • Relative lives overseas (1 patient) • Awaiting home oxygen (1 patient) • Awaiting stairlift installation (1 patient)
Vaughan & Withers (2002)	• Awaiting home care package (19% patients) • Awaiting rehabilitation (6% patients) • Awaiting intermediate care/recuperation (15% patients) • Awaiting tests (8% patients) • Awaiting social services assessment/funding (17% patients)
Victor *et al* (2000)	• Absence of family or carer • Entry into nursing/residential care (which can entail lengthy assessment procedures, uncertainty over who will pay for nursing/residential care and waiting lists) • The type of hospital care team (with late referrals and the lack of multi-disciplinary teamwork associated with delayed discharge)
Williams (2002)	• Awaiting funding agreement from local authority for residential/nursing home care provision (18.8% patients) • Awaiting bed availability in other NHS hospital/speciality/facility (13%) • Awaiting place availability and completion of relevant social care arrangements in nursing home (not NHS funded) (8.6%) • Awaiting completion of post hospital social care assessment (5%) • Other patient/carer/family related reason (4.5%) • Patient exercising statutory right of choice (4%)

I, O, S Analysis

Although we initially intended to analyse the causes of delayed hospital discharges in terms of individual (I), organisational (O) and structural (S) factors, limitations within the literature prevented such an approach. In particular, studies often failed to look beyond the surface of the causes of delayed discharges, for example suggesting that lack of rehabilitation services may be a factor but failing to explore the factors contributing to a lack of such provision. We discuss this in further detail in section 4 below.

Policies and Practices that may help Reduce Delayed Discharges

An additional weakness of the studies summarised above is the general failure to outline detailed policies and practices that may help to reduce delayed hospital discharges. Often, the solution to the problem is implicit within studies, and is not explored in full. Thus, a study that concludes that delayed hospital discharges are caused by a lack of rehabilitation or of home care, will implicitly conclude that the solution is 'more rehabilitation' or 'more home care' without any consideration whatsoever of the strengths or limitations of such services in the locality concerned. Very rarely do articles tell us about any changes that take place in local services as a result of research findings or the outcome of such alterations.

This is discussed in more detail in section 4 below, but key exceptions include official documents by bodies such as the National Audit Office (2000, 2003) and the House of Commons Health Committee (2002), which make detailed recommendations about future policy and practice. Also relevant are some of the more journalistic accounts of action taken in particular localities to tackle delayed discharges, which are often poor at specifying the methodology adopted by their organisation to identify the rate of delayed discharge, but which pay much greater attention to the practical outcomes of action taken (see table 5 for a summary).

Table 5: Examples of studies which have sought to identify new ways of reducing delayed discharges

Study	Recommendations/action taken
Fenn *et al* (2000)	Findings from the original research were fed back to local consultants and a steering group chaired by the Chief Executive of the acute trust established. A diverse range of approaches have been adopted, including nurse-led discharge planning, a discharge lounge, and changes in local rehabilitation services. While some of these measures have proved more successful than others, the rate of inappropriate bed usage has fallen from 37 to 25 per cent, and repeated surveys have been undertaken.
House of Commons Health Committee (2002)	This Select Committee report makes a wide range of recommendations about hospital discharge policy and practice, and is one of the most useful documents available in terms of not only diagnosing the rate of delayed discharge, but also proposing practical ways forward.
National Audit Office (2000, 2003)	Studies from the National Audit Office identify problems associated with delayed hospital discharges, but also cite a number of good practice examples to illustrate how practice could be improved. Recommendations are made to the Department of Health, acute trusts and Strategic Health Authorities.
Pascoe (2001)	Although giving very few details on methodology, this article describes a wide range of initiatives taken to reduce delayed discharges. These range from to changes to assessment practice to developing intermediate care provision, and from patient education to access to residential care. As a result, delayed discharges fell from 280 to 60.
Roberts and Houghton (1996)	This article describes work undertaken in Birmingham health and social care services to develop jointly agreed data collection mechanisms and provide more accurate information with which to respond to delayed hospital discharges.

4. KEY THEMES AND ISSUES

Despite the potential insight which they provide into the rate and causes of delayed hospital discharge, the 21 studies included in this review have a large number of limitations which raise significant issues about current policy initiatives and research. Key themes and issues include:

1. The research methodologies adopted.

2. The lack of insight which these studies provide into possible solutions/the way forward.

3. The importance of local contexts and history.

4. The need for a whole systems approach.

5. Gaps in research/our current knowledge.

Each of these issues is explored in turn.

1. Methodological Limitations

While the wide range of results summarised in tables 2 to 4 above may point to genuine differences in the rate and causes of delayed discharges in different areas of the country, they may also be indicative of underlying methodological limitations[4] and confusion in the literature. In particular, there are seven main issues:

Limits of subjective approaches

Traditionally, many studies have adopted extremely subjective approaches, labelling admissions and subsequent days of care as appropriate or inappropriate either on the basis of the author's opinion or with reference to some sort of expert panel of medical practitioners. Unfortunately, such inherent subjectivity makes it very difficult to compare results with findings elsewhere, and some studies are unclear as to whether they are measuring the number of people who, in an ideal situation, could be cared for in alternative settings or those inappropriately placed within the context of existing local services. There is also evidence to suggest that results vary according to the seniority and/or professional background of the 'expert' being asked to assess 'appropriateness' (see, for example, Bartlett *et al*., 1999; McCulloch *et al*., 1997; McDonagh *et al*., 2000).

Limits of clinical review instruments

More recently, researchers have sought to develop more rigorous and objective methods of assessing the extent of inappropriate admissions and delayed discharges in different hospitals in different areas of the country. Often this has revolved around the use of clinical review instruments - standardised lists of criteria, usually relating to the severity of a patient's condition and the type and intensity of service provided. If a specified number of these criteria are satisfied, the patient is considered to be appropriately located in hospital. Examples of instruments used in recent British studies include the Intensity-Severity-Discharge Review System with Adult Criteria (Coast *et al*., 1995, 1996a, 1996b), the Appropriateness Evaluation Protocol (Gertman and Restuccia, 1981; Houghton *et al*., 1996) and the Oxford Bed Study Instrument (Anderson *et al*., 1988;

[4] NB Often, similar approaches are adopted to assess the appropriateness of hospital admissions and of subsequent days of care. As a result, many of these issues relate to inappropriate admissions as well as to delayed discharges.

Fenn *et al*., 2000) (see also Appendix D for a practical example). While these instruments produce easily quantifiable results and reduce the inherent subjectivity of previous methodologies, they have a number of limitations when used in isolation (see Glasby and Littlechild, 2000, 2001; Littlechild and Glasby, 2000, 2001; McDonagh *et al*., 2000 for a summary of these limitations and a more detailed discussion of the bullet points below):

- Clinical review instruments are often applied as if in a 'vacuum' and take no account of local circumstances or the availability of alternative services.

- Researchers applying clinical review instruments often do so retrospectively and therefore enjoy the benefit of hindsight.

- Some clinical review instruments are not as reliable or as valid as is sometimes suggested, frequently overestimating the number of inappropriate admissions/days of care.

- On their own, review instruments simply classify admissions/days of care as appropriate or inappropriate. This is only half the story, and more detailed research is required to answer more significant questions such as why those admissions/days of care deemed inappropriate took place in the first place and how they could have been prevented.

- Some tools exclude specific groups of people, such as children or those with mental health problems.

- How instruments are applied can influence the results (for example, whether they are applied concurrently or retrospectively, to a cross-sectional sample of days or to entire hospital stays for a sample of patients etc).

Limitations of official statistics

In addition to expert- and clinical review instrument-based studies, this review contains a number of documents based on official statistics (see, for example, McWhirter, 2002; National Audit Office, 2000, 2003; Williams, 2002). While these are often based on clearly articulated official definitions of 'delayed hospital discharges' and on relatively well established data reporting mechanisms, there is significant concern about the accuracy of such figures. For example, both the House of Commons Health Committee (2002) and the National Audit Office (2003) have queried official statistics collected in England. According to the National Audit Office (2003, p.2):

"The Department [of Health] have collected data on delayed discharges since 1997. Historically, hospitals have applied a range of interpretations from when a delay begins and, although the Department issued a standard definition in April 2001, a number of problems remain. Only 27 per cent of Trusts responding to our survey indicated that they were following the definition in full. Twenty two per cent of Trusts allow a 'breathing space' of some kind before declaring a discharge to be delayed (9 per cent of Trusts reported a delay as starting seven days after the official definition). There are also discrepancies between data reported by acute trusts to the Department and quarterly data collected and reported by Primary Care Trusts through Strategic Health Authorities… The impact of problems with data collection is difficult to gauge as the effects of some types of error may be compensated for by others. However, a significant number of health and social care communities appear not to have accurate data on which to base key decisions about the care of older people."

Elsewhere, statistics from Wales (Williams, 2002, p.53) acknowledge that considerable work has been undertaken to ensure a more consistent collection of information (presumably indicating that data has not been consistent until recently). While detailed data is produced in Scotland (ISD Scotland, 2003), some commentators have suggested that there are too many categories of delay to be operationally useful. Also, it has been suggested that the information concerned can be perceived as NHS data and that local validation with social services produces a more accurate result (personal communication).

Different definitions of delayed discharge

Irrespective of the overall methodological approach adopted, different authors have adopted very different definitions of delayed discharge (see table 3). These include studies which are based on:

- Patients who remain in hospital after the date at which they are felt to be medically fit for discharge by medical staff (see, for example, Mohammed *et al*., 2001; Kutiyanawala *et al*., 1998; Vaughan and Withers, 2002).

- 'Breathing spaces' between being medically fit for discharge and the date of discharge (to allow for transport, medication and other discharge preparations). These can range from anywhere between 48 hours (Koffman *et al*., 1996a) and six weeks (ISD Scotland, 2003).

- The appropriateness of patients' last day of stay (a time when the rate of delayed discharge is likely to be highest) (see, for example, Houghton *et al*., 1996).

- The proportion of older people experiencing delayed discharge as a percentage of all older people in hospital (see, for example, National Audit Office, 2003).

- National totals (see, for example, McWhirter, 2002; Williams, 2002).

- The number of people awaiting long-term care (Namdaran and Sherval, 1995).

- Delays in the care management and assessment process which contribute to increased hospital stays (Tracey *et al*., 1998).

- Delays can also be expressed in terms of the number/proportion of people occupying a hospital bed after they are ready for discharge (i.e. the percentage of patients in a particular sample delayed in hospital) or the number/proportion of bed days they occupy after they are ready for discharge.

On some occasions studies do not report any details of the methods adopted at all (see, for example, Pascoe, 2001). In the wider literature, moreover, some studies do not actually attempt a definition of delayed discharge, but focus on a range of proxy measures such as length of stay (Hakim and Bakheit, 1998; Parker *et al*., 1998) or the low number of discharges which take place at weekends (Varnava *et al*., 2002). In these studies, there is no explicit assessment of delayed discharges, but an implicit assumption that people who stay in hospital for long periods of time do not need to do so or that people discharged immediately after a weekend could have gone home earlier had medical staff been available to discharge them.

Hospital admission

A number of studies (both in this review and in the wider literature) focus primarily on the inappropriate use of hospital beds, and thus tend to combine patients inappropriately admitted with those appropriately admitted to hospital but remaining longer than they need to due to delayed discharge (see, for example, Houghton *et al*., 1996; Kutiyanawala *et al*., 1998; Smith *et al*., 1997).

Lack of detail

Some of the studies reviewed are strikingly short on detail, and their usefulness is limited as a result. As an example, Kutiyanawala *et al*'s (1998, p.224) observation that 36 bed days were lost in a Leicester surgical ward due to "social circumstances" is not especially helpful without any further explanations to what this category might mean. Similarly, Roberts and Houghton's (1996) conclusion that 2,800 bed days out of 3,456 were lost due to delays caused by "patient/carer-led reasons" is frustratingly short on detail and the research does not tell us exactly which factors may be included under this heading. Perhaps indicative of the quality of some of the research is to be found in the wider literature, with Smith *et al*'s (1997, p.529) statement that "the commonest reason for inappropriate days of care was patients remaining in hospital after the medical purpose of hospitalization had been accomplished" – an observation which does little to further our knowledge of the causes of delayed discharges and the best way to respond.

Failure to include a patient perspective

Above all, however, one of the most substantial limitations of the delayed discharge literature reviewed here is the failure to include a patient and carer perspective. With a few notable exceptions (see, for example, Houghton *et al*., 1996) the majority of studies focus on the use of clinical review instruments or the opinions of medical staff without considering the potential input of individual patients and their carers. This is an approach which the current authors have criticised on a number of grounds in previous research into hospital admission and older people (see, for example, Glasby and Littlechild, 2000, 2001; Littlechild and Glasby, 2000, 2001). In our opinion, including a patient perspective is crucial in order to understand the context within which the older person is using health and social services and develop an appropriate response. As we have argued elsewhere with regard to inappropriate hospital admissions (Glasby and Littlechild, 2000, p.116):

"... the use of clinical review instruments needs to be accompanied by research methodologies which include and empower the individuals involved. Patients admitted to hospital are often, after all, the best qualified people to talk about their own conditions, the circumstances of their admissions and possible alternatives to hospital. No one else, no matter how well educated or trained, can possibly have experienced the same process of deteriorating health, initial contact with service providers and admission to hospital. At the same time, a patient perspective can also provide a more holistic, long-term view of the factors that contribute to hospital admissions, helping to build a picture of how best to respond to the needs of people starting to experience ill-health. This is a view that it is easy to overlook, with health professionals often having little choice but to focus on how best to respond to patients when they have been admitted to hospital, not on how such admissions could have been prevented in the first place. If inappropriate hospital admissions really are to be identified and investigated thoroughly, therefore, the expertise and potential contribution of patients needs to be acknowledged and incorporated into mainstream research and audit techniques."

2. Possible Solutions/The Way Forward

Despite the methodological limitations outlined above, the studies in this review are able to shed a degree of light (however imperfect) on the rate and causes of delayed hospital discharge. With the exceptions of some of the material cited in table 5 above, however, the vast majority of the literature fails to identify potential solutions or ways forward. This is particularly the case in two main areas:

The failure to put proposed remedies into action and test them out over time

In many studies, there is a tendency to identify a particular service that may allow older people to be discharged from hospital (for example, rehabilitation) and conclude (either explicitly or implicitly) that the solution to delayed discharge is 'more rehabilitation.' On no occasion are there any attempts to consider such proposals in any detail – for example: what would such a rehabilitation service include? What impact would it have on the wider health and social care community? Who should fund it? How would it be staffed and what impact would it have on recruitment and retention elsewhere in the local area? Would it really reduce delayed discharges? Would there be a risk that a new rehabilitation service could become just as 'blocked' as the hospital beds it sought to free up? How could such a service be evaluated? What impact has the service had over time?

While it is beyond the remit of this review to explore this issue in much greater depth, we believe that research which explores the causes of delayed hospital discharges, develops practical alternatives to hospital and evaluates the impact of these over time would be significantly superior to the 'more rehabilitation' approach all too common in the literature.

The failure to explore the causes of delayed discharges in detail

In addition, a second limitation of the literature with regard to possible ways forward is the failure to look beyond the surface of the causes of delayed discharges. For example, where a cause of delayed discharge is perceived to be lack of rehabilitation services, is there really a lack of such provision? If so, why? Who should be providing this service?

Has there always been a lack of such provision or is this a recent development? Is this unique to a particular locality or is it a regional/national issue?

It is questions like these that the 'I, O, S analysis' introduced above is intended to stimulate. This is an approach which the current authors have found helpful in understanding the difficulties associated with hospital discharge more generally and in developing potential responses to the problematic relationship between health and social care (see Glasby, 2003 for further discussion). For example, if a number of delayed discharges are found to be the result of patients waiting for places in residential/nursing homes, is this because of a lack of local provision or are local health professionals too ready to place older people in permanent residential care? If the former, is this due to rising property prices or to the perceived low level of fees paid by social services? If due to fee levels, is this because the council has chosen to prioritise other areas of service provision or is it due to underfunding from central government? Similarly with internal hospital delays – are these the results of a 'difficult' medical practitioner not prepared to alter his or her ward round to facilitate speedier discharges or are delays here to do with the way the hospital is organised or national trends and pressures which prevent the consultant from conducting ward rounds more often?

Depending on your view, the real cause of a delayed discharge might be located at an I (individual), O (organisational) or S (structural/social policy) level, or frequently at all three, with different factors interacting to contribute to the current situation. While it has not been possible to analyse the literature in this way for reasons outlined above, we believe that an approach which consistently seeks to explore the root causes of delayed discharges and analyse them in terms of our I, O, S framework will provide a better understanding of the issues at stake than a 'more rehabilitation' approach.

3. Local Contexts and History

From the literature summarised in table 4 above, it is clear that different health and social care communities are facing different pressures and that delayed hospital discharges can be caused by a different combination of factors in different areas. Thus, case studies and official statistics quoted by the National Audit Office (2003) reveal significant variations in the rate and causes of delayed discharge in different areas of the country, while Namdaran and Sherval (1995, p.377) emphasise the difficulty of extrapolating from their experience in Edinburgh to other areas on the grounds that "each has its unique problems depending on the local demography and level of provision by different agencies." Even in Edinburgh itself, the researchers found that different hospitals were affected in different ways, with very high pockets of delayed discharges in some hospitals. In addition, Armstrong *et al* (2001, p.393) found significant variations between two hospitals in the same Trust, concluding that:

"The reasons why a patient's care was deemed non-acute did differ between the two hospitals, which reflects both the differing internal organisational pressures, delivery of services within each hospital, the socio-economic influences and social work back-up in each hospital."

To us, this suggests that responses to delayed hospital discharges need to be equally localised, based on a detailed understanding of local services, the local context and the history of local agencies. This is supported by the wider literature, which emphasises the importance of local contexts and histories in helping/hindering attempts to work in partnership and which stresses the need to develop local responses (see for example, Glendinning *et al*., 2002; Poxton, 2003).

4. A Whole Systems Approach

Given the diversity of the causes of delayed discharges set out in table 4, it is clear that delayed discharge is a multi-faceted issue with a wide range of contributing factors. These include (Roberts and Houghton, 1996):

- Factors within the control of social services.

- Factors within the control of the NHS.

- Factors outside the control of either health or social care (such as housing or issues relating to individual service users and their carers).

As a result, we believe that any response to delayed hospital discharges needs to be equally multi-faceted and diverse, adopting a whole systems approach to what is clearly a whole systems issue (see, for example, Department of Health, 2003b; House of Commons Select Committee, 2002). Of course, this is entirely consistent with the wider literature, which sees hospital discharge as an example of the contested boundary between health and social care and which emphasises the importance of health, social care, housing and the independent sector working together to develop joined up solutions to joined up problems (see, for example, Audit Commission, 2003; Glasby, 2003; Henwood, 1994).

5. Gaps in Research

In addition to the methodological limitations discussed above, there are a number of gaps in the existing research:

- Almost none of the studies reviewed draw specific attention to the needs of older people with mental health problems (see House of Commons Health Committee, 2002, pp.9-10 for an exception). Given that this user group is increasing in size and is a key element of the National Service Framework for Older People (Department of Health, 2001a), this omission is surprising and regrettable. Anecdotally, we know that some services are finding that the most complex cases of delayed discharge involve older people with mental health problems (personal communications) and the wider literature certainly suggests that finding appropriate placements for this user group can be difficult (see, for example, Change Agent Team, 2003; Hudson *et al*., 1995; Koffman *et al*., 1996b).

- In the same way, none of the studies reviewed identify the needs of older people from minority ethnic communities. Given our longstanding awareness of the difficulties people from minority ethnic communities face when trying to access health and social care (see, for example, Norman, 1985; Blakemore and Boneham, 1994), this is a significant omission.

- In addition, a small number of studies begin to suggest that delayed hospital discharge may not necessarily be the most important issue at stake, but that other topics require further study. Thus, Namdaran and Sherval (1995) suggest that the rate of delayed discharges (due to waits for long-term care) in Edinburgh has been steadily reducing over a number of years and may be reaching acceptable levels. Instead, this study asks whether we should be focusing on monitoring discharge planning and on the risk of premature discharges. Similarly, Tracey *et al* (1998) identify the risk of inappropriate placement that is sometimes caused by the pressure to discharge older people from hospital as soon as possible, while McWhirter (2002) emphasises that delays in accessing community services are much more widespread than delayed discharges. Also neglected in much of the literature is the importance of admission avoidance, preventing people from being admitted to hospital in the first place rather than focusing on what happens at discharge (House of Commons Health Committee, 2002). In a similar vein, other commentators have suggested that delayed hospital discharge is possibly not the main issue that should be exercising government and frontline services, but that premature and poorly handled discharges may be just as significant (Glasby, 2002e; 2003; House of Commons Health Committee, 2002).

5. CONCLUSION

In this study we have reviewed the literature on delayed hospital discharges and older people and explored the rate and causes of those delays. However, significant limitations in this data have prevented us from analysing hospital discharge using our I, O, S model as originally intended. However, from the review we have come to three main conclusions:

1. From the literature reviewed in this study, it is difficult to avoid the conclusion that the existing evidence base concerning delayed hospital discharges and older people is extremely weak. Although the wider literature identifies a series of difficulties associated with hospital discharge, research into the rate and causes of delays is characterised by a series of methodological limitations which raise significant questions about the extent to which recent policy changes can be said to be evidence-based.

2. Against this background, areas for further research and consideration include:

- Ways in which hospitals can address internal causes of delayed hospital discharges.

- Local factors contributing to delayed hospital discharge in different areas of the country and local solutions.

- More sophisticated approaches which seek to combine qualitative and quantitative research methods, and which include a patient/carer perspective alongside the views of staff.

- More in-depth research which considers delayed hospital discharge in terms of its individual (I), organisational (O) and structural (S) causes.

- Longitudinal research which not only diagnoses the problem, but which also explores delayed hospital discharges over time in order to examine whether proposed solutions are actually successful.

- The needs of people from minority groups (such as older people with mental health problems or older people from minority ethnic communities).

- The importance of wider issues such as premature discharge, admission avoidance, the risk of inappropriate placements and delays in accessing community services.

3. Despite the limitations of existing research, however, the literature reviewed in this study supports the direction of some recent policy initiatives, while raising important questions about others:

- Given the methodological limitations of the literature reviewed in this study, how evidence-based is current policy and practice?

- Given the complex and diverse nature of delayed discharges, is a measure like reimbursement going to be an adequate response?

- Given the importance of rehabilitation services in the literature, it would seem as if the government is correct to emphasise the development of intermediate care services.

- Given the importance of local contexts, an initiative like the Change Agent Team would seem to be a useful way of working with local health and social care communities to resolve the difficulties associated with delayed discharges.

- Given the whole systems nature of delayed discharges, does reimbursement run the risk of damaging local relationships between health and social care?

6. APPENDICES

Appendix A: Methodology

This study is based on a narrative, analytical literature review (Mays *et al*., 2001) using the framework recommended by the NHS Centre for Reviews and Dissemination (2001):

- Identifying the need for a review.
- Preparing a proposal.
- Developing a review protocol.
- Identifying research.
- Selecting studies.
- Study quality assessment.
- Data extraction.
- Data synthesis.
- Outputs.
- Dissemination.

The literature search was undertaken by Rachel Posaner in HSMC's specialist library and documents were identified via the following databases:

- The Health Management Information Consortium database (HMIC) combines three separately produced databases: the King's Fund Library & Information Services database, the Department of Health Library, and the Nuffield Institute for Health's HELMIS database. HMIC includes bibliographic references often with abstracts of journal articles, monographs, reports, government documents and grey literature all focusing on health policy and management related information.

- Medline is the electronic version of the printed *Index Medicus*, *Index to Dental Literature*, *International Nursing Index* and other health-related indexes. It is produced by the U.S. National Library of Medicine, updated monthly and includes

journal articles from 1966 onwards on the subjects of medicine, nursing, dentistry and allied health.

- HealthStar's database goes back to 1982 and incorporates both clinical and health care administration, management and planning information.

- The Social Science Citation Index dates back to 1981 and is a general social science database which includes some health-associated material. It is accessed via the "Web of Science" database and allows for cited reference searches.

- ASSIA (Applied Social Sciences Index and Abstracts) is a general social science database incorporating over 255,000 records from 650 journals.

- AGEINFO is an information service run by the Library and Information Service of the Centre for Policy on Ageing. Focusing on old age and ageing it provides access to databases incorporating the following: a bibliographic database of over 40,000 books, articles and reports; details of over 4,000 organisations; and a calendar of courses, conferences, meetings, training sessions and future events world-wide.

- CareData Abstracts is a UK-based social care database provided by the former National Institute for Social Work. Dating back to 1989, it contains a continually updated list of over 50,000 journal articles, research reports, central and local government publications and monographs.

Additional searches were also conducted of the reference lists from each document included in this review.

As outlined in the main body of this report, each document has been selected for its relevance to the overall aims and objectives of the study (see above), checked against the inclusion/exclusion criteria in Appendix B and categorised using the criteria outlined in the National Service Framework for Older People (Department of Health, 2001a):

A1 Systematic reviews which include at least one Randomised Control Trial (RCT) (eg Systematic Reviews from Cochrane or Centre for Reviews and Dissemination)

A2 Other systematic and high quality reviews which synthesise references

B1 Individual RCTs

B2 Individual non-randomised, experimental/intervention studies

B3 Individual well-designed non-experimental studies, controlled statistically if appropriate; includes studies using case control, longitudinal, cohort, matched pairs, or cross-sectional random sample methodologies, and well-designed qualitative studies; well-designed analytical studies including secondary analysis

C1 Descriptive and other research or evaluation not in B (eg convenience samples)

C2 Case studies and examples of good practice

D Summary review articles and discussions of relevant literature and conference proceedings not otherwise classified

P Professional opinion based on clinical evidence, or reports of committees

U User opinion from Older People's Reference Group or similar

C Carer opinion from Carers' Focus Group or similar

Data have then been extracted using the pro-forma in Appendix C, which is based on the criteria for assessing the quality of qualitative research proposed by Mays *et al* (2001).

With one exception, all documents identified for inclusion in this review have been collected and analysed in the above report. The only document which we have been unable to locate is a document focusing on health authorities' perspectives on community care published by the National Association of Health Authorities and Trusts (NAHAT) in the mid-1990s (NAHAT, 1995). This was not identified during our database search, but a reference in Victor *et al* (2000) appeared to suggest that this source may contain a rate of delayed hospital discharge. Without viewing the document concerned it is not possible to establish whether or not it should be included in this review. However, we have been unable to locate this document, either through the British Library or through the NHS Confederation (the successor body to NAHAT). Despite this, an electronic abstract does not suggest that this document would meet out inclusion criteria (see Appendix B).

Appendix B: Search Strategies and Exclusion/Inclusion Criteria

We have searched each of the databases in Appendix A using key word searches relating to delayed hospital discharge and older people. The exact terms have depended on the individual databases concerned and rely upon our specialist library service having a detailed knowledge of each database included in this study. However, as an example of our approach, we set out terms that have been employed in a search of the Health Management Information Consortium (HMIC) database. HMIC comprises the databases of the King's Fund Library and Information Service and the Department of Health Library (both ongoing) as well as the Nuffield Institute for Health's library database (HELMIS) up until 1998. The HMIC database is particularly strong in identifying grey material and has good coverage of both health and social care literature.

Sample search terms for older people and hospital discharge:

Term 1 - Discharge

Keywords:

- Discharge*
- Hospital discharge*
- Patient discharge*
- Patient early discharge*
- Transfers of care*

Descriptors

- Discharge
- Discharge-
- Discharge-arrangements
- Discharge-letters
- Discharge-planning
- Discharge-policy
- Hospital-discharge
- Patient-discharge
- Patient-early-discharge

Term 2 - Elderly

Keywords:

- Elderly*
- Geriatric*
- Old*

Descriptors:

- Elder
- Elderly
- Elderly-
- Elderly-men
- Elderly-patients
- Elderly-people
- Elderly-persons
- Elderly-women
- Geriatric
- Geriatric-patients
- Geriatrics
- Geriatrics-
- Old
- Old-age
- Older
- Older-people
- Older-women
- Elderly disabled people (de)
- Elderly-mental-infirm-people (de)
- Elderly-mentally-ill-patients (de)

Term 3 - Delays

Keywords:

- Delay*
- Inappropriate*
- Bed block*
- Blocked bed*
- Bed management*

Descriptors:

- Delays
- Delays-
- Bed-blocking
- Blocked bed
- Bed management

Inclusion/Exclusion Criteria

The literature search has focused on documents that explore the rate and causes of delayed hospital discharge for older people in the UK.

Specifically excluded will be:

- Material published and/or based on data collected prior to 1993 (the date of the implementation of the NHS and Community Care Act 1990).

- Local inspections where findings have been summarised in a national report.

- Articles reporting findings from studies already included in the review.

- Discharge from non-acute care or from accident and emergency departments.

- The discharge of people aged under 65 (unless a significant proportion of the sample are older people).

- Historical estimates of the rates of delayed discharge in official reports where there is a more up-to-date figure (for example, we have taken the latest Department of Health figures at the time of writing rather than each document with an annual estimate).

Appendix C: Assessing the Quality of Research – Pro Forma

Article number:
NSF Type:

Authors and Year	
Brief summary	
Nature of comparator if applicable	
Theoretical basis if applicable	
Clarity of research question	
Design	
Setting	
Population/participants	
Sampling	
Thoroughness of data collection	
Rigour of data analysis	
Outcomes	
Main findings	
Policy/practice implications	

Rate of Delayed Discharge:
Causes of Delay **Individual:**
Organisational:
Structural/Social Policy:

Appendix D: Clinical Review Instruments

As an example of a clinical review instrument, the Oxford Bed Study Instrument is cited below:

The Oxford Bed Study Instrument

A patient is considered to have a positive reason for being in hospital if one of the following criteria is met:

- Has that day a life threatening condition that requires treatment or observation, including acute haematological disorders.
- Any invasive therapeutic or investigative procedure that day.
- Postoperative day for criterion 2 above.
- Requiring close medical monitoring by a doctor.
- Undergoing ventilation.
- Undergoing any form of intravenous therapy.
- Care of major surgical wound and drainage.
- Continuous monitoring of vital signs, including cardiac monitoring.
- Scheduled for any invasive therapeutic or investigative procedure or requiring preoperative evaluation.

(Anderson *et al*., 1988)

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