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## **Abstract**

The Department of Health has identified a high number of hospital delayed discharges in patients suffering from mental illness. Since 2006, the weekly monitoring of these delays is required for all non-acute and mental health trusts. This article explores the limitations of standardised definitions of 'safe to transfer' for mentally ill patients; the conundrum created by co-morbidity and legal requirements; and the constraints of current categories for delay established by this performance system are exposed.

Establishing when and why hospital discharges are delayed is not an easy task. It is embedded with subjectivity and complexity which increases in the context of the intricacy of mental illness and discharge pathways. Considering the constructed nature of delayed discharges, the limitations and over reliance on quantitative data collection must be taken into consideration in the case of quantitative itemisation of mental health needs for Payment by Results tariffs, or when using audit data to construct evidence-based systems of care for people with mental illnesses.

## **Introduction**

In England, concern over increased rates of delayed hospital discharges -often referred to by the media as ‘bed-blocking’- has been a feature of the Department of Health policy drivers over recent years. In 2003, following the apparent success of such a system in Scandinavia, England introduced a system of cross-charging (Department of Health, 2003a). This establishes a reimbursement policy to tackle the issue of people unable to leave hospital beds because they are waiting for community services. It placed a financial obligation on councils to reimburse acute hospitals (£100-120 per day) if social care assessments and services are the sole reason for delayed hospital discharges.

A significant number of patients admitted to mental health beds have their discharges delayed (National Audit Office, 2007). Although the scope for extending the reimbursement scheme to mental health beds was stated at the time; seven years later, this has not happened. Since 2006, however, weekly monitoring of delays became compulsory for all mental health beds. This article explores how the current monitoring system for delays encounters difficulties when applied to mental health beds. These findings are a starting point to take into consideration if fines are to be implemented for these beds, or in the case of quantitative itemisation of mental health needs for Payment by Results tariffs as announced in the latest White Paper (Department of Health, 2010).

## **Difficulties in Monitoring Mental Health Delayed Discharges**

Efficient access to social care is a key aspect of improving discharges from acute psychiatric beds but not the only one. Resources identified as fundamental include ‘total dependency psychiatric care, day hospitals, inpatient observation facilities and continuing care wards’ (Glasby and Lester, 2004: 753). Although the evidence on mental health delays is criticised for having significant limitations, these are, however, common methodological issues shared by all hospital delays research which relate to the conceptualisation of when, how and why patients are delayed (McDonagh et al., 2000).

In 2006, one of the innovations introduced in the reimbursement programme was extended to mental health beds: the weekly compulsory monitoring of delays through the collection of quantitative information in all non-acute and mental health NHS trusts. The same indicators used for general acute beds are being used across the country to monitor delays in non- mental health beds. Despite stakeholders identifying, for example, the need to differentiate between delays for working-age adults, older people, people with learning disabilities and children and adolescents when examining mental health beds (Department of Health, 2005), this has not yet taken effect. Another suggestion not implemented is the inclusion of patients on ‘Section 17 leave’, a population of great significance in the management of mental health beds. These are patients detained under Section 3 of the Mental Health Act 1983 (admitted in hospital for up to six months for treatment), who under section 17 are enabled to temporarily be transferred home (or to a care home) ‘on leave’

(Department of Health, 2008a). While patients are assessed regularly, these hospital beds can stand empty for several days or weeks.

When reimbursement was implemented, for the first time, hospitals were given a statutory standard definition of delays (Department of Health, 2003b). Decision-making was extended beyond consultants and “safe” transfers were not only defined within a medical model. In mental health beds, however, there is no standardised definition of patients ‘mentally safe or fit to discharge’. In fact, such a concept does not sit easily within patients suffering from mental illness. The words “safe” or ‘fit’ are too self-defining for this population because the nature of mental illness is the management of risk and hence unpredictability, fluctuation, rapid change, decline, etc. with some mental illnesses operating in cycles of relapse/recovery. Acute discharge plans aim to transfer patients to/with a service that is likely to maintain or improve a certain level of mental stability. Moreover, a large group of mental health conditions like dementia are chronic and irreversible, and others, like depression hinder recovery from physical illnesses (Godfrey et al., 2005). Unrecognised co-morbidity is also common in patients with mental health conditions (Watts et al., 2002).

The ‘safe to transfer’ definition for acute beds refers to ward-based multidisciplinary team agreements for discharge. In contrast, in mental health, it is the community-based teams who must work in conjunction with inpatient wards to plan effective discharges. This process is not only driven by good practice but often by the legal requirements of the Mental Health Act 1983, and amendments to that Act. Section 17 Leave of Absence or the more recent Community Treatment Orders impose an obligation on mental health services and local authorities to implement tailored care

programmes (the Care Programme Approach – CPA) for all patients considered for discharge from psychiatric hospitals. According to the CPA, patients retained under Section 2 or Section 3 should be reviewed and there must be involvement of community mental health workers prior to discharge or home leave (Department of Health, 2008b).

## **Monitoring Reasons for Delays**

Reasons for delay are monitored in ten categories which identify the agency (either the NHS or social services) responsible for this situation. Only one category can be selected.

### **1. Awaiting completion of assessment**

Historically, hospitals referred patients to social services departments for an assessment of social care need, but often there was a significant delay before the social worker could visit (National Audit Office, 2000). In the case of patients with mental illnesses, it is often crucial for community mental health teams to be involved in discharges. The complexity of the cases often meshes together health and social care needs and theoretical simplistic divisions become impossible in practice.

Current mental health legislation determines assessment and discharge procedures, particularly for formal patients. In addition, the Mental Capacity Act 2005 can affect the timescales and process of discharge practice for people with mental health problems. If a person has been assessed as lacking capacity to make the specific decision about admission to a care home, and has no family or friends whom it is

appropriate or practicable to consult, an Independent Mental Capacity Advocate (IMCA) must be appointed to safeguard their best interests. Although this process can be long and has the potential to delay the discharge planning process, it is fundamental that it is respected to avoid the marginalisation of people with dementia and their exclusion from decision making processes about their own future (Boyle, 2008).

## **2. Awaiting public funding**

Another common reason for social services delays is that patients stay on wards waiting for public funding of their care home placement (Bryan et al., 2006). At the point of writing, social care, unlike healthcare is means-tested. The most acutely ill patients are admitted to NHS inpatient units, and are, therefore, more likely to need specialist mental health services on discharge, including continuing healthcare. Others may be assessed as needing only social care. Placements fully funded by social services will be primarily for people with moderate dementia, with little or no associated behavioural issues.

People with NHS continuing healthcare needs are defined as those whose health needs are 'primary'. This is a highly contested policy area; citizens have legally challenged decisions of refused funding with significant successes (Luxton, 2003). The continuing care funding system attempts to define when needs are primarily in the health rather than social domain and, in practice, this artificial distinction means that often people with dementia are not recognised as having chronic healthcare needs unless they exhibit "challenging behaviour" or complex co-morbidities. Those

patients whose mental health needs are assessed as entitled to be met by continuing healthcare are mostly transferred to dementia nursing homes but the provision of these is varied throughout the country. If there is appropriate capacity in the local care homes, delays will not occur. If there is no capacity in the independent sector homes, delays are attributed to the NHS.

### **3. Delays due to waits for NHS non-acute care.**

Reimbursement regulations exclude from the fines scheme those people with intermediate care or rehabilitation needs. Intermediate care needs (Cowpe, 2005) are not always clear when people are referred to social services and more significantly, people suffering from mental illness, specifically older people, often do not meet services' criteria for rehabilitation. There is often a common assumption in acute care that people with dementia cannot benefit from rehabilitation (Godfrey et al., 2005).

Improved intermediate care 'which is accessible to people with dementia and which meets their needs' is one of the priority objectives of the NHS Dementia Strategy (Department of Health, 2009: 53). New initiatives to facilitate faster discharges like homecare re-ablement services (Glendinning and Newbrunner, 2008) - a short-term intervention that aims to maximise independent living skills and reduce long-term homecare needs- have to confront key challenges. It can take time for care workers to develop a therapeutic relationship with users of the service which impacts on the nature and timeframe of the interventions required. There is also national recognition that improved dementia care training is necessary in all areas of service delivery. The change of provider at the end of the re-ablement period is also a considerable issue



when trust and continuity are key to the recovery process in patients with mental illnesses.

#### **4. Awaiting care home placements**

Sometimes social services funding has been released for a care home placement but patients still wait in wards because their families are seeking a suitable home or they are waiting for a vacancy in their home of choice (National Audit Office, 2000). This code is only used if people are going directly from the wards into care. However, since reimbursement, acute general patients needing long-term care and requiring social services funding are routinely offered interim accommodation (Department of Health, 2003a). The idea is that patients should be transferred into temporary care home placements to wait for the service of choice. If the interim bed is rejected, the reason for delay shifts to 'patient or family choice' which is classified as an NHS delay and consequently is not reimbursable.

Temporary transfers have been considered as the solution for delayed discharges (Crotty et al., 2005) but this practice is criticised for not taking into consideration long-term effects in patients and overall cost of care (Coleman, 2003). Populations most at risk for transitional care problems include older people with co-morbidity, dementia, depression, or other mental health disorders. In the case of patients with mental health conditions, particularly those with dementia, temporary transfers are considered not to be in the best interest of the patient because of increased risk of confusion. Consequently, it is very rare that interim transfers could be safely used for

mental health patients and yet this is the mechanism most frequently used to either discharge or to avoid fines in acute general patients.

## **5. Awaiting domiciliary care package**

Discharges can be delayed because domiciliary care packages needed for safe discharges cannot be arranged in time (National Audit Office, 2000). Reimbursement, however, conceptualised community care services needed to maintain independence to live at home after hospital discharge as ‘intermediate care services’. These services are now free of charge for up to six weeks and, they are categorised as a health need and therefore, excluded from the fines.

Apart from family or friends, domiciliary care is the most important service involved in supporting mentally ill people in their own homes. For mental health patients, there can be difficulties in accessing homecare in some areas, but an added problem is the complexity of putting packages together. Current practices of homecare agencies (mostly independent providers) are particularly problematic for people with mental health conditions. Interventions have strict time limitations and do not provide consistency of worker to develop the relationship between individuals and care workers (Rothera et al., 2008).

Approaches to facilitating home-based support such as Direct Payments, designed to help care users get tailored services with cash payments (for example, to employ a live-in carer), indicate low rates of take up among older people and even lower in those suffering from dementia, ‘who find the system of direct payments confusing and

onerous. Complications include having to manage on- employer's national insurance, holiday and sick pay (National Audit Office, 2007). Nationally, there is a lack of reliable and flexible specialist homecare services for people with dementia (Department of Health, 2009). Inadequate care increases the risk of relapse or deterioration and potentially readmission. Delays in this category will be related again to the lack of specialised services for people with mental health illnesses.

## **6. Waiting for community-based equipment and adaptations**

Increasingly, the needs of people with mental health problems and their carers are supported by housing-related services like assistive technology and telecare. The use of assistive technology to meet social care needs is a fundamental option (and another recommendation of the NHS Dementia Strategy) to prolong independent living and a reliance on more intensive services. For example 'quiet care' (a passive system based on alert sensors within the house establishing patterns of behaviour and then tracking the anomalies), smoke alarms, wander alerts and flood alarms can effectively contribute to robust packages of care.

Assistive technology can enable people with dementia to remain independent (Woolham, 2005). However, this equipment is as yet not always issued through the Community (or Joint) Equipment stores, typically accessed by hospital therapists. Although there needs to be more practice use of assistive technology in care assessment and planning, this is still not part of mainstream care for these patients and this may lead to delays in discharge planning or to the underuse of telecare equipment because of the more complex access pathway to these resources.

## **7. Delays caused by patient / family choice**

This code includes patients / families who, for example, insist on a placement in a home with no foreseeable vacancies. According to the reimbursement regulations, as long as patients are offered an appropriate interim placement, and the patient or their family are causing an unreasonable delay, social services are not liable for reimbursement and delays are attributed to the NHS (Department of Health, 2003a).

In the case of people suffering from mental illness, the inability of social services to offer interim beds makes them more difficult to discharge or for social services to avoid the fines through this code. Frequently, patients with mental health conditions are unable to make informed choices about suitable long-term care services because of their lack of capacity associated with their illness. For instance, dementia is the key factor prompting the admission of elderly people to care homes (Moriarty and Webb, 2000), and carers or family wishes may be contrary to the patient's best interest.

## **8. Delays caused by disputes between statutory agencies**

Delays cannot be recorded as the responsibility of both agencies – one or other of the agencies have to be identified as accountable for patients' delayed discharges. In the case of people with mental health problems, disputes between secondary care, social services and acute hospitals. For example, patients can be assessed as able to return home by hospital staff but community mental health workers might dispute this decision. Home circumstances can be supported by a precarious package of care but

mental illness can deteriorate in these conditions (i.e. recurrent acute bouts of depression with subsequent increased risk of self-neglect) with care placements being a better option. Superficially, it would seem that patients can be supported at home but at the likely expense of their mental health deteriorating. To establish one agency as having sole responsibility for complex discharges can jeopardise the working practices of the multiple agencies involved in the effective and safe discharge of people with mental health illnesses.

### **9. Delays in patients not eligible for social services funded community care, for example, asylum seekers or single homeless people**

Effective hospital discharge is problematic if patients have no home to return to. In the mental health sector, delayed discharges of younger adults are often the result of a lack of alternative accommodation and the current reimbursement scheme does not directly tackle these delays. Cultural and organisational divides between housing departments, social services and health were recognised as limiting effective discharges before reimbursement (Department of Health, 2003a). In many localities, to secure a variety of housing options for patients would mean an increase in the stock of affordable, supportive housing. Critically, the Swedish scheme which inspired the British reimbursement was accompanied by the increase and improvement of housing alternatives (Minford, 2001).

Homeless or people living in temporary accommodation have higher rates of (and more severe) mental illness than the general population. Discharge difficulties lie in the lack of specialist temporary and affordable accommodation and inadequate

discharge arrangements from inpatient care can lead to repeat homelessness and further mental health problems (Department of Health, 2007). Homeless people may lose contact with mental health services if they leave inpatient units without accommodation and support. Officers can help to look for adequate accommodation or to improve/ adapt the accommodation used prior to admission but their intervention is limited by the lack of specialist resources and framed by bureaucratic systems that are not designed for the speed that hospital discharges require.

## **Conclusion**

An exploration of the performance indicators designed for delays in acute beds reveals that mental health conditions cannot be categorised in a simplistic or linear way. The choice of one exclusive category is quickly confronted with the complexity embedding patients' intricate circumstances and those of the institutions, programmes and legislation that try to approach them.

To establish that a delay is the sole responsibility of social care agencies is to assume that their input could be easily separated from that of the other disciplines. This relates conceptually to a model of health that is not dynamic but linear, where there is clear and sequential demarcation between physical, mental and social circumstances. Although there is a need for close monitoring and rigorous analysis of mental health delayed discharges, the over reliance on quantitative data underestimates the complexity of mental health conditions, the current legal framework and the shortage of specialised services for this population. These limitations must be taken into consideration when market mechanisms (case-mix systems like Payment by Results

or performance-based financial incentives) are applied to people suffering from mental illness.

## Key Points

- Close monitoring and rigorous analysis of mental health delayed discharges is needed.
- Mental health conditions cannot be categorised in a simplistic manner for performance monitoring purposes.
- Over reliance on delays quantitative data underestimates the complexity of mental health conditions, the current legal framework and the shortage of specialised services for this population.
- These limitations must be taken into consideration in the itemisation of mental health needs for Payment by Results tariffs.

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