

promoting access to White Rose research papers



Universities of Leeds, Sheffield and York
<http://eprints.whiterose.ac.uk/>

This is an author produced version of a paper published in **Clinical Medicine**

White Rose Research Online URL for this paper:

<http://eprints.whiterose.ac.uk/id/eprint/77331>

Paper:

Manzano-Santaella, A (2012) *Measuring and costing delayed discharges: conceptual and methodological challenges*. *Clinical Medicine*, 12 (4). 308 - 309.
ISSN 1470-2118

<http://dx.doi.org/10.7861/clinmedicine.12-4-308>

Author: Dr Ana Manzano-Santaella, School of Sociology & Social Policy, University of Leeds.
Correspondence: a.manzano-santaella@leeds.ac.uk

Title: Measuring and costing delayed discharges: conceptual and methodological challenges

Western societies are experiencing challenging economic times and the UK NHS is faced for the first time in decades with budget reductions. In the last few years, media reports of people staying in acute care for too long have proliferated. 'Bed-blocking' is the loaded term used to describe patients whose discharge from hospital is not timed with the speed desired by the institution. Synonymous expressions used in different countries and across time have similar meanings despite the contextual differences. 'Delayed discharges' is the recommended politically correct expression in the UK at the time of writing. In the 1990s, when the drive for efficiency embedded healthcare institutions, economists established that to maximise productivity in hospitals, patients had to flow through acute care at an average speed. Any deviance from this average is considered a decreased in efficiency and a misuse of public resources. Four interrelated issues challenge this economic theory and research studies like the Hendy et al¹. which is published in this months' issue illustrates most of them.

- 1) Diagnosing and caring for acute patients is a complex process because of the unexpected and often difficult to control contingencies, stemming not only from the illness itself, but also from a host of organisational sources as well as from biographical and life-style sources pertaining to patients, their relatives and staff². This complexity is at the centre of acute care and it does not escape the clinical decisions to establish that patients are 'medically fit' to leave the hospital. This does not mean that patients are no longer sick rather their medical condition does not require the technology, expertise, observation, costs etc provided in acute hospitals. Difficulties with the concept 'medically fit' and how this can affect delayed discharges research are evidenced in the Hendy et al study when they wrote: 'If a patient became unwell after being declared medically fit, periods of being medically fit were summated'. The authors did not interpret this as patients, either being wrongly deemed 'medically fit' or accepting that 'medically fit' is a dynamic concept that fluctuates especially in acute emergencies and admissions. Instead, the authors recorded 'fit days' and 'non-fit days' without explaining the reasons for this fluctuation and still counting 'non-fit days' as delays.
- 2) There are methodological difficulties in establishing objective definitions of delays and single causality agents. Research studies often rely on expert panels who determine when and why specific delays occur. Panel's composition affects outcomes (seniority, generalists or specialists, presence of therapists and social care representatives, etc), and so do panel consensus strategies and frequency in which multi-disciplinary meetings occur. In the UK, there is a legally binding³ definition of 'safe to transfer' that must also be followed also for research purposes: Patients are 'safe to discharge' when the following stages are all simultaneously addressed:
 - a. A clinical decision has been made that a patient is ready for transfer; and
 - b. A multidisciplinary team decision has been made that a patient is ready for transfer; and

c. The patient is safe to discharge/transfer⁴.

Disagreements about when patients are safe to transfer due to different institutional understandings are common and medical records cannot be the only documents to analyse when exploring reasons for delay (social services and therapy records should also be analysed). Research on the causes for delayed discharges frequently focuses on social services delays and underestimates internal clinical and hospital organisational factors which account for a significant proportion of delayed discharges⁵.

- 3) Economic theories of efficiency do not equate to clinical theories of efficient management of illness. Despite the official choice to use length of stay as a measure for efficiency, the clinical evidence between shorter stays and quality of care is not straightforward. Traditionally, much of the literature explains that health outcomes are not affected by shorter stays and that extended stays are linked to increase morbidity. However, some authors⁶ expose the lack of causation between longer length of stay and poorer health outcomes. Delayed transfers of care are particularly associated with older patients with complex needs and geriatric medicine often purposely decelerates the process of discharge to achieve better long-term results⁷. Gains made in the efficiency of treating the acute care patients faster may even be made at the expense of pushing a larger fraction of the patients into permanent care.
- 4) Short-term institutional savings do not equate to long-term decreased public expenditure. This is the case also for patients admitted in A&E or Acute Admissions Units like the one researched in Hendy et al. To equate delays with 'cost per patient for the ward' does not take into consideration that patients flow through health and social care institutions at different time streams depending on their illness and social complexities⁸. Calculations using single short-term measures are a guessing exercise that disregard increased expenditure for other public institutions (or themselves!) for earlier discharge: increased number of re-admissions, increased use of primary healthcare and social care services and the cost to families and carers. Furthermore, in the UK, reducing hospital-based NHS care relocates services free care at the point of delivery to community services, which are means-tested and incur charges for the population.

Delayed discharge is a contested concept⁹ that can lead researchers through dangerous theoretical and methodological pathways. Patients are 'delayed' in hospital for multiple complex reasons (waiting for tests, second opinions, therapy, community care services, transfer to other social or health institutions, etc). Hospital productivity theories promote single public hospitals institutions to treat more patients within the context of a large reduction in their physical infrastructure (number of beds available being constantly reduced). The conceptual subjectivity of who, when, why and for how long people stay in hospital for longer than expected embeds research, practice and legislation on delayed discharges. For the single institution, speeding up production beyond critical levels can also lead to poorer care and increase risks for patients. For countries that subsidise health and social care, financial gains of reducing length of stay overlook the long-term outcomes for overall public expenditure and for the patient.

¹ Hendy P, Patel JH, Kordbacheh T, Laskar , Harbord M. In depth analysis of delays to patient discharge: a metropolitan teaching hospital experience. Clinical Medicine 2012

² Strauss A, Fagerhaugh S, Suczek B, Wiener C. *Social Organization of Medical Work*. Chicago: The University of Chicago Press, 1985

³ Department of Health. *The Community Care (Delayed Discharges Etc.) Act (Qualifying Services) (England) Regulations 2003*. Statutory Instrument 2003 No. 1196. London: Stationary Office, 2003

⁴ Department of Health. *SITREPS Definitions and Guidance 2003-2004*. Version 1 from 29 September 2003. London: Department of Health, 2003

⁵ Clarke A, Rosen R. Length of stay: how short should hospital care be? *Eur J Public Health* 2001; 11: 166–70

⁶ Glasby J, Littlechild R, Pryce K. Show me the way to go home: a narrative review of the literature on delayed hospital discharges and older people. *Br J Soc Work* 2004; 34:1189–97

⁷ Millard PH, McLean SI, eds. *Modelling Hospital Resource Use: a Different Approach to the Planning and Control of Health Care Systems*. London: Royal Society of Medicine Press, 1994

⁸ Harrison G, Ivatts S, Millard P. Mathematical modelling: how and why. *Br J Health Care Manag* 2003; 9:144–50

⁹ Manzano-Santaella, A From “bed-blocking” to delayed discharges. Precursors and interpretations of a contested concept’. *Health Services Manag Res J* 2010; 23: 121-127