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Title

From Bed-Blocking to Delayed Discharges: Precursors and Interpretations of a Contested Concept

Abstract

Delayed hospital discharges have been identified as a problem for the English National Health Service and have prompted several policy and service development responses in the last decade. However, bed-blocking is an issue surrounded by rival interpretations on how and why hospital delays occur and the way in which they are measured. To better understand this contested concept, this article provides a brief description of the historical accounts that framed the emergence of delayed hospital discharges as a phenomenon.

Three key features of the bed-blocking concept are also analysed: the reduction of patients' length of stay to improve efficiency; the intrinsic methodological difficulties of measuring hospital delays; and the most common reasons for delayed discharges. A description of the characteristics of the patients frequently labelled as delayed discharge, their common traits and how these have been examined by previous research is also provided. Finally, this article argues that the presence of hospital delays in a health system tends to be considered as an indicator of two possible system inefficiencies: a failure in the discharge planning process, which generally blames social services departments for not ensuring timely services; or a shortage of alternative forms of care for this group of patients.

Introduction

Over the last thirty years, most western nations, influenced by neoliberal ideologies, embarked on healthcare reforms that are often characterised as ‘decentralisation’ and ‘devolution’. The shift of responsibility away from the state through the introduction of market forces extended to all aspects of governance. Throughout the development of British welfare policy, the state was responsible for finance, ownership and supply of healthcare and social care. Founded in 1948, the National Health Service (NHS) was seen as a triumph of socialist ideology, inspired by egalitarian ideas as it institutionalised the principle of allocating resources according to need. However, as in many other areas of welfare, as time went by, the NHS attracted criticisms typical to such large public organisations: inefficiency, slow to change and a waste of tax-payers money. Consequently, under the Conservative Government of the late 1980’s and early 1990’s, de-institutionalisation, privatisation of care homes and decentralisation were key strategies underlying health reforms which culminated in the introduction of the NHS and Community Care Act 1990.

The purchaser-provider system now operating in the NHS was a central part of this legislation. State provision for health and social care was targeted for replacement with a quasi- market oriented approach to welfare service delivery. Such a system is based on central government raising the funds for purchasing services, which are then distributed to agents who purchase these services on behalf of consumers. The construction of internal markets was based on the belief that healthcare in the purchaser-provider system would generate increased cost awareness and hence encourage more efficient use of

resources. Financial efficiency was to be achieved not with increased funds but through better performance management, delegating responsibility for the delivery of healthcare to local level.

Before the 1990 reforms, the state was a provider of social care for much of its population: funding, purchasing and providing care services. After the reorganisation, local authorities took on the characteristics of purchasers. The emergence of a management-oriented approach to community care planning meant that the state was supposed to enable social care, setting the emphasis on managing packages of care for people in the community rather than matching peoples' needs to services. Voluntary and private organisations (and families) undertook the provision of social care on behalf of the council, and social workers were given the role of 'care managers'.

The relocation of care from institutions to the community meant a transfer of the cost of care from the state to other social care actors: users, their carers and families, voluntary sector organisations and for-profit organisations. The early discharge of people from hospital or care institution also increased the financial burden upon social services departments and primary healthcare services. Furthermore, the constant development of initiatives that reduced hospital-based NHS care represented the relocation of free care at the point of delivery to community services, which are means-tested and incur charges for the population. In other words, the redefinition of some acute and continuing care as 'social care' had an economic consequence for the end users of services that should not be ignored.

The 1990 NHS and Community Care Act continued the historical division between health and social care. Eligibility criteria for free NHS continuing care and the appropriateness of discharging vulnerable patients from hospital became major political issues during the 1990s. Within this framework, in 1997, New Labour proposed 'The New NHS', a ten year plan for the NHS. While preserving many features of the internal market, this was intended to shift the focus of services from competition to cooperation. Government emphasis turned to 'integrated care' and 'partnerships'.¹ In this context, the old divisions between health and social care were identified as creating particular obstacles to the planning and delivery of 'seamless' services tailored to individual needs.²

In 2003, another initiative that attempted to reduce hospital based care was introduced: the Community Care (Delayed Discharges etc.) Act 2003.³ This policy meant that local authorities were made financially responsible for the accommodation costs (hotel services) that patients with social needs receive whilst in acute care. This figure was calculated in a daily tariff equal for all patients (£100 per day), with the exception of localities in the South East of England (£120 per day). As a consequence, administratively, social services departments were treated as purchasers of a service (acute care) for 'their clients', provided by the hospitals.

In this policy, the partnership ethos collided with the need for efficiency, which was constructed under a concept emblematic of that division: the problem of bed-blocking or delayed discharges. The phenomenon is deep-seated within the problematic

administrative, financial and professional division of health and social care. In order to investigate the rival interpretations affecting the topic of bed-blocking, three key features of the concept are described: the reduction of patients' length of stay as a management tool to improve efficiency; the intrinsic methodological difficulties of measuring hospital delays; and the most common reasons for delayed hospital discharges. Finally, the article closes with a description of the characteristics of the patients frequently labelled as delayed discharge, their common traits and how these have been examined by previous research.

'Bed-Blocking' or 'Delayed Discharge'? A Contested Concept

Cultural, social, economic and organisational contexts influence how the patient group of the so-called 'bed-blockers' could be defined. Nevertheless, there are rival conceptions and interpretations of this term which could thus be considered to come under the rubric of an 'essentially contested concept'.⁴ Bed-blocking is an internally complex term, open-ended and based on qualitative notions. Interpretations of the concept are disputed with particular lines of thought being sustained by different standpoints. In brief, the presence of delays in a health system may be considered as an indicator of two possible system inefficiencies: a failure in the discharge planning process, which generally blames social services for not ensuring timely services; or a shortage of alternative forms of care for this group of patients.

The term 'blocked bed' originated in the United Kingdom in the late 1950's and it was traditionally used to imply 'that regular patient or client through-put with regard to that particular bed has stopped'.⁵ Synonymous expressions like 'back-up', 'backlogs', 'long-stays', 'outliers' and 'delayed discharges' were used in the United States and Canada and have similar meanings despite the contextual differences. They all refer to the fact that average bed use is interrupted by patients who stay in hospital for longer than expected. Whatever the words used to describe this group of patients, similar terms were and still are applied not only to acute hospital beds but also to beds in psychiatric, geriatric and other health and social care institutions.

The beginning of the bed-blocking phenomenon cannot be separated from the changing role of hospitals in respect of geriatric patients. Originally, 'bed-blocking' concerns were driven by hospital clinicians becoming increasingly perturbed with their limited availability of beds. In the UK between 1961 and 1967, there was a 14 per cent rise in the elderly population but the number of hospital beds assigned for their use remained practically the same.⁶ Apparently, there was strong competition over hospital space which led to a desire on the part of some hospital doctors to exclude care of the elderly from major hospitals. Hall & Bytheway⁷ suggested that hospital doctors followed the prevailing 'acute ideology' in medicine and used phenomena like bed-blocking to restrict older people's entry to hospital.

Therefore, not surprisingly, early investigations into the 'bed-blocking' phenomenon relied on the opinion of consultants for the reasons why patients stayed in hospital longer

than necessary.^{8,9} Doctors' research tended to focus on the failure of social care to develop the services needed to facilitate discharges. For this reason, some authors¹⁰ argue that the concept of 'bed-blocking' is another example of the medical dominance that intrudes into policies and the daily administration of health institutions.

In the 1990's, with the drive for efficiency that dictated healthcare institutions, the term 'bed-blocking' was borrowed by health economists who used it as an example of the failure of efficient systems in hospitals. Indeed, in the debate over 'bed-blocking', economists tended to side with hospital doctors and blame inadequate local authority provision. In summary, reducing the boundaries of acute care had the potential to suit both cost conscious policy makers and the professional inclinations of many hospital doctors.

In 1994, Styrborn¹¹ argued that 'bed-blocking', despite its common use, was not to be accepted as a medical term but as an administrative concept that was part of an economic control system 'coined by health economists'. He explained that the term implied that the patient was situated in the wrong location in the spectrum of care. Later on, following a similar approach, Wimo, *et al.*¹² referred to the 'misplacement' of people who are situated at the 'wrong caring level' and this notion included the need for diverse care alternatives. Styrborn and Wimo *et al.*'s approach focuses on defining the bed-blocking problem as the need for a different place or site where patients could be located. Reasons for relocating patients range from administrative decisions and political policies to changes in patients' health status. Most importantly, this type of conceptual explanation

leads to solutions to the problem that are based on increasing the availability of 'locations', sites, or spaces for these patients.

In the recent years, the use of the adjective 'bed-blocker' to refer to patients has been considered inappropriate in the UK. It was argued that this term insinuated that patients themselves were responsible for their situation: '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'¹³. The term was considered politically incorrect, deemed offensive for patients and rejected by the Health Select Committee. Instead, the expressions 'delayed transfer of care' or 'delayed discharge' were proposed to replace it. In April 2001, the Department of Health issued a standard definition and introduced these new terms:

A delayed transfer occurs when a patient is ready for transfer from a general and acute hospital bed but is still occupying that bed. A patient is ready for transfer when: a clinical decision is made that the patient is ready for transfer; a multi-disciplinary team decision has been made that the patient is ready for transfer; and the patient is safe to discharge/transfer.¹⁴

Since then, the expression 'delayed discharges' has been widely adopted in the British governmental and research literature. Although it has been considered a 'more neutral term'¹⁵, the newly coined expression supports a clear theoretical position. It implies a shift from focusing on macro economic factors to micro organisational systems. The exclusive focus on the time component of the discharge process shifted the debate from

the availability and suitability of the next location (space), to the institutional process of discharge (time). Beds are not blocked but patients' discharges are delayed, which implies that somebody (generally, social services departments) should work at a faster pace to avoid those delays.

In addition, when redefining the need for relocation of patients into the need for speeding up the discharge process, attention is diverted not only from the availability of other forms of care but also from other significant aspects of the transitions between hospital and discharge destinations. Some of these issues are the long-term outcomes (for the state and for the patient) as a consequence of rapid discharges; the quality and adequacy of the new environment to which patients are transferred; the involvement of the individuals and their families in the discharge process. Although there are indications of the cost-effectiveness that discharge planning programmes offer when they result in decreased lengths of stay and readmission rates¹⁶, these calculations do not consider the expense of additional community services and specialist staff or the cost to families and carers.

Indeed, the speedy discharge of patients is not considered by all commentators as the best care model. 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 results.¹⁷ These authors explain that reduced stays cannot be used as measure for efficiency in all patients. Gains made in the efficiency of treating the acute care patients faster do not necessarily imply improvements in their long-term outcomes. These gains may even be made at the expense of pushing a larger

fraction of the patients into permanent care. In summary, the reduction of length of stay to improve hospital efficiency is a management choice that is not always supported by clinical evidence in all patients.

Reducing Length of Stay to Improve Hospital Efficiency

The phenomenon of 'delayed discharges' may thus be understood in the terms of organisational management choice. Healthcare planners, confronted with an increased number of potential users, choose to ensure a rapid patient flow as a new tool to improve efficiency. Millard & McLean¹⁷ used the analogy of a toy train to explain how an acute hospital works. The hospital was compared with a 24 hour train circling a track at constant speed. To improve the passenger carrying performance several choices were given:

- a) To add more carriages (i.e. more beds)
- b) To stop passengers getting on board (programmes to reduce admissions in the over 75's)
- c) To stop passengers staying overnight (increase day services like day surgery and other treatments)
- d) To persuade the passengers to get off the train earlier and continue their journey elsewhere (early discharge, intermediate care and transfer to social care homes).

Although in the UK, the number of hospital admissions keeps growing, the possibility of increasing the number of beds seems always omitted from the equation. Moreover, the

number of acute beds in England has been consistently reduced and solutions along the lines of b) c) and d) are the ones frequently used by the programmes implemented subsequent to the NHS plan.¹⁸ Other possible solutions outside the logic that the circular track represents are also rejected. The performance target is simplified to the fact that patients can only enter hospital if other patients leave and therefore, once patients are in, they should be processed out of the system as fast as possible. The reduction *ad absurdum* of this linear thinking is that no beds will eventually be needed to treat patients.¹⁹

When reduction of length of stay schemes are in place, two different categories of patients are generated: patients who need to enter or stay in hospital and patients who need to exit. The first are welcome, the latter are not welcome in hospital anymore. People change status as time goes by. The transformation from welcome to unwelcome patients, however, is not straightforward. There are important debatable concepts attached to this issue, such as who decides that patients should exit the hospital, how this decision is made and, in summary, when are patients' exits appropriate.²⁰ Those unwelcome patients are the so-called 'delayed discharges', a by-product of adopting economic theories that recommend decreasing length of stay to improve hospital efficiency.

The UK Government made the choice of selecting reduction in length of stay as a tool for efficiency, stating that it was one of its six dimensions of performance¹. Despite the official choice to use length of stay as a measure for efficiency, the causal relationship

between length of stay and quality of care is not straightforward. Traditionally, much of the literature in this area explains that health outcomes are not affected by shorter stays and that extended stays are linked to increase morbidity. However, authors like Clarke & Rosen²¹ expose the lack of evidence of the association between longer length of stay and poorer health outcomes. They explain how tensions between reducing stays in order to increase patients' throughput and maintaining the appropriateness of care are rarely appreciated by those keen to see stays reduced as a marker of efficiency.

In addition, reduction in the length of patients' stay has also the potential to increase the complexity of the discharge process.²² Healthcare work is frequently highly problematic due to the unexpected and often difficult to control contingencies, stemming not only from the illness itself, but also from a host of work and organisational sources as well as from biographical and life-style sources pertaining to patients, relatives and staff members.²³ The shortening of hospital stays could add to that complexity with the potential of more contingencies occurring due to the lack of time healthcare workers have to familiarise themselves with the patients' circumstances.

The Measurement of Delayed Discharges: Tensions and Challenges

The methodological literature studying delayed discharges raises serious questions related to core conceptual issues about what constitutes a hospital 'delay'. This lack of consensus is illustrated by four main tensions in the definition of 'delays':

- a) The first approach defines 'delay' as the time period established by a hospital discharge planner which is measured by the time difference between a patient being medically ready for discharge and the actual time of discharge.²⁴ Consequently, the resulting figure is a period of time defined subjectively by researchers, medical practitioners, health and social care staff or, in some cases, a panel of 'experts'. This approach is a more refined derivation of the traditional arbitrary approach used by consultants in the 1960s but it still seems to privilege opinion over evidence. Physicians' opinion tends to prevail upon other members of the multidisciplinary team and it is considered the 'gold standard'. Additionally variability in results occurs depending on physician seniority and whether the panel was made up of general practitioners or specialists.²⁵
- b) The second conceptual framework establishes that a hospital delay can be numerically quantified in an objective manner. In an attempt to overcome the subjectivity of the first approach, delays are defined with the construction of a mathematical norm. This statistical calculation is generally based on the individual length of stay for a particular age group, consultant and diagnosis which is greater than a standardised threshold for mean length of stay by the respective consultant and condition derived for the whole population. However, this type of single average measure relies on length of stay as an appropriate measure of performance. This has been disputed by some health analysts who argue that single averages of bed occupancy, bed emptiness and average length of stay do not represent hospital activity. Instead, they propose the use of mixed exponential distributions as a better

way of understanding bed usage. This means that patients flow through medical care following different time streams according to the complexity of their illnesses, psychological and social circumstances.²⁶ These types of criticism highlight also the use of mean duration of stay as misleading when dealing with geriatric or rehabilitation patients because a small number of patients with very long stays can skew the distribution.

- c) A variation of the single average system is the use of standard measurement instruments which list clinical reasons why a patient should stay in hospital and later on, these factors are scrutinised in the patients' medical records. Examples of these instruments are the Intensity-Severity-Discharge Review System with Adult Criteria²⁷, and the Oxford Bed Study Instrument.²⁸ However, McDonagh *et al.*²⁵ claimed that few of the existing tools have been tested for reliability and validity. The best validated tool, known as the Appropriateness Evaluation Protocol (AEP)²⁹, was originally developed in the United States and later adapted in Switzerland for use in Europe; but its validity and reliability for other European countries has also been questioned.³⁰ Although studies which used validated tools tend to be considered the most evidence-based, Vetter²⁰ found that all measurement tools are poor, lacked validity and reproducibility. They also tend to be applied retrospectively and, most significantly, they still rely on subjective interpretations of delays and take no account of local circumstances or the availability of alternative services to the hospital bed.³¹

d) The fourth approach is the one of authors highlighting the lack of consensus in defining delays and therefore, the difficulty in comparing research findings. They accept that establishment of who and when hospital patients are delayed is an essentially subjective task. They exhibit the methodological limitations of the decision criteria employed by discharge planners, clinical practitioners or researchers. For instance, Carter & Wade³² acknowledge how:

It is difficult to define precisely when a patient is 'ready for discharge' or 'no longer in need of our medical/ surgical expertise'. We simply relied on the opinion of the clinical team responsible for the patient; they no longer felt responsible for the patient's management. [...] it was not easy to establish the reason for delay. We simply relied upon clinical judgement, identifying the one factor that seemed most important, but in practice there were often several inter-related reasons'. (p. 319)

Styrborn & Thorslund³³ consider local circumstances as decisive for the definition of delays and for any attempted solutions; and they also refer to the importance of a consistent definition of the bed-blocker concept when comparing over time. Vetter²⁰ reinforces the above argument and deems the assessment of inappropriate bed usage as being 'beset by problems of lack of definition' and 'dominated by subjectivity'. Glasby *et al.*³¹ follow the same line and they also emphasise the importance of local contexts and history in different areas for the study of delayed discharges.

All the four tensions identified above face not only the problem of lack of a common definition of delay but also concerns about the accuracy of the related numerical data that

is collected for performance purposes. The Department of Health started collecting data on delayed discharges in 1997 but a standard definition of delayed discharges was only issued in 2001. Although this represents a step towards common measurement, it does not guarantee it. Definitions can also have ambiguous elements, be misinterpreted, misapplied or not followed. In 2003, the National Audit Office reported that only 27 per cent of hospitals surveyed were following the 2001 definition in full. Discrepancies between data reported by acute hospitals and data provided by primary care trusts were also noted.³⁴

Another significant difficulty with the way in which delayed discharges data is collected is the focus on acute and general beds and the exclusion of other non-acute, mental health and community bed.³⁵ Finally, with some exceptions, literature related to delayed discharges often fails to include patient and carer perspectives.³⁶

Most Common Reasons for Delayed Discharge

As previously explained, delayed discharges can be considered as an indicator of a shortage of alternative forms of care or they can be seen as a consequence of inefficiencies in the discharge planning process. Interestingly, the second standpoint dominated research on delays through the 1980's and 1990's with discharge planning receiving most of the attention. Research on the causes for delayed discharges concentrated on which organisation was to blame for the problem, social services or hospitals. This was a potential distraction that moved attention away from the macro

problems that created resource shortages or even the reasons why bed-blocking was constructed as a problem. Micro-level concerns drove research on assessing discharge planning procedures and schemes. Moreover, one of the limitations of research on discharge planning is that it does not normally spotlight the reasons for delays but the ways of improving internal organisational processes.

The origin of the bed-blocking phenomenon is in part responsible for the main assumptions embedding the research studying causes for delayed discharges. Clearly, the first doctors in the 1960s who conducted bed-blocking studies believed that some patients were staying in hospital longer than necessary, for reasons other than medical. Indeed, delays were generally perceived to be the responsibility of social services departments. This medical standpoint is present in the research on this topic mainly because it was driven and performed by the clinicians themselves. Typically, investigations concentrated on identifying predictors for delay (age, illness, etc) and costs generated by these patients' delays due to their social care needs. In the 1990's, with the introduction of health management theories and performance indicators as a form of governance, cost efficiency analysis drove research into clinical pathways and why patients, with or without social need, were delayed. The scrutiny of the internal clinical systems revealed that hospital organisational factors were the cause of a significant proportion of delayed discharges.³⁷ Patients waiting for results of investigations, consultants input, assessment from specialist health staff, transport or pharmacy were typical efficiency or provision failures.

Significantly, studies that examine delays from the social standpoint seem to also reproduce the historical divisions between health and social need. Roberts & Houghton³⁸ conceptualise delays as been caused by the hospital, social services or ‘delays beyond control of either agency’. In the research literature common reasons why delays are allocated to social services are: delays in allocating social workers, complexity of assessment criteria, delays in allocating funding. It seems that, in general, the research on causes for delays concentrates on who to blame instead of accepting the complex and multi-faceted nature of factors contributing to delayed transfer. This perspective is a continuation of the historical preoccupation of both social and health sectors, to focus on ‘who’ (should provide services, whose fault is it?, etc.) more than on ‘what’ they should provide.⁶

In the UK, between 2000 and 2004, only two literature reviews concentrated on studies of rate and cause of delayed discharges. Glasby *et al.*³¹ analysed 21 documents on reasons for delays between 1993 and 2003. They concluded that causes for delayed discharges are extremely diverse but they identified three main reasons for delays: a) internal hospital factors as a prime cause such as waiting for another opinion, a planned investigation or a decision from another consultant; b) lack of rehabilitation services; c) other factors, such as waiting for social care assessments or funding, issues related to patients and carers, or factors such as housing. Similarly, Hubbard *et al.*³⁹, in a review of studies published between 1984 and 2005, concluded that there was no conclusive evidence to demonstrate that delayed discharges were caused by problems in any one part of the care system, and they argued that a combination of factors contribute to the problem. Problems in health

and social care settings associated with delayed discharges identified were: lack of home support; unavailability of convalescent or rehabilitation facilities; delays in community care needs assessments or homecare packages.

Local variations in the rate and reasons for delays seem to be a commonality across the UK. In 2002 the overall figures for delayed discharges revealed 'significant regional variation. London and the South are particularly affected, whereas the problem is generally less pronounced in the north of England'.³⁵ However, studies in the area of discharge planning and delayed discharges tend to ignore local historical and administrative contexts. Instead, patient's characteristics attract much more attention. These individual factors are explored in the following section.

Patients in Blocked Beds: Who Are They?

Whatever the term chosen to describe them, bed-blockers are people. They are hospital patients admitted into wards due to illness. These people may be considered problematic by the hospital because the administrative jungle of institutional responsibilities and specialisations categorised them as been in the wrong location at some specific time. If we, however, accept that delayed discharge is an administrative and not medical term, then the bed-blockers are likely to be different sort of 'people' depending on the locality and the hospital where they are admitted.

Significantly, Glasby *et al.*³¹ pointed out that causes for delay vary substantially from area to area as do the delayed discharges rates. Although some studies have examined the social care market situation, hospital factors and patients' characteristics, research on 'inappropriate' hospital stays has a tendency to focus on micro individual characteristics of patients. Studies generally aim to generate patients' profiles, analyse mainly demographic, socio-economic factors and clinical characteristics of patients like age, gender, living arrangements prior to hospitalisation, dependency for daily living activities, etc. However, attention on the individual characteristics of people with prolonged stays may attribute the institutional need for relocation to patient's circumstances. The objective of most research concentrating on population characteristics is to establish predictors of delay, regardless of how delay is conceptualised.

Consensus seems to be achieved in the literature identifying specific group of patients that generate more obstacles for a faster hospital discharge than the general population. This is the case for older people who seem to make more inappropriate use of hospital beds, demonstrating higher delay rates than the rest of the general population²⁵. These delays are generally caused by higher levels of hospital admissions in older people, increased disability and related social needs in that section of the population. Other identified groups who are often thought to block acute care beds more frequently include patients with chronic illnesses and people with mental health illness or cognitive impairments. This population seems to create more delays due to lack of appropriate community facilities that could meet their needs.⁴⁰

Although delayed discharges are generally stereotyped as older or/and disabled people because they statistically represent the bigger group of users of acute care, patients who are outside this bigger group may still block beds. Moreover, many short delays from the elderly population may be less costly than one single case of a younger person who stays in hospital for a long time. From those limitations, people labelled as delayed discharges are generally described as fragile, dependent persons who need help from others for their daily living activities. These patients often have a multiple medical conditions and symptoms after being listed as medically ready for discharge. However, although older people, those with multiple pathologies and those with some specific clinical conditions (such as neurological deficit and stroke) might be most at risk of delayed discharge, it is not a clinical condition *per se* which causes the delay but the ways in which organisations are managing or providing services to care for people with these clinical conditions.⁴⁰

Conclusion

The delayed discharges problem is a complex fabrication, consequent upon the institutional separation of health and social needs. In the most recent decades, with a renewed management drive, the main economic incentive used in public hospitals to reduce expenditure is to minimise hospital bed use by reducing the length of stay of the patients. As a consequence, keeping people in hospital longer than necessary was constructed as an indicator of poor public performance. The construction of measures to analyse this indicator is challenged though, by the conceptual subjectivity of who, when, why and for how long people stay in hospital for longer than expected.

The analysis of how delays are measured demonstrates a lack of consensus which affects many of the studies that sought to measure initiatives to ameliorate the problem. Rival conceptions and interpretations of this phenomenon are apparent and embedded in all investigations. Finally, the main concern in monitoring delayed discharges has been with who to blame and with the numbers rather than with the reasons why these occur.

However, the simplification for performance purposes of actors to blame does not reflect the real pathways of people who experience delays on discharge; and little attention is given to the local contextual circumstances that cause delays in specific localities.

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