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A Realistic Evaluation of Fines for Hospital Discharges: Incorporating the History of Programme Evaluations in the Analysis

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Many programmes, especially those implemented over a considerable period and across many local institutions have the habit of self-transformation. They bend because of differences in local conditions, funding contingencies, political impetus, staff turnover, policy fashions and so on. Above all they change because from the start they meet with varying success. Unsuccessful programmes may continue to die a slow death or they may be revived and remodelled. Successes may remain successful, or they may over-reach themselves, or they may just become 'part of the furniture'. Even more perplexing is the possibility that all of these transformations may occur simultaneously in different localities and institutions.

This condition, which sociologists rather grandly term: 'morphogenesis in adaptive systems', can wreak havoc in evaluation research. Evaluation is always space and time limited, so that effectively the researcher is left to investigate part of the programme process in part of the institutional apparatus. From multisite and longitudinal evaluations to the incorporation of evaluators as an ongoing feature of programme design and implementation, the apprehension of the 'programme reality' is always limited. Furthermore, the ever-decreasing time-frame between the requirements of policy analysis

and policy development makes it common for evaluations to be undertaken before programmes have run their course.

Viewed in this light, evaluations are always 'case studies'. This paper considers how to incorporate some of the history of programme transformation into an evaluative case study in such a way that evidence from that study can speak for intervention more generally. To illustrate this process, an evaluation of the Community Care (Delayed Discharges etc.) Act 2003, an English policy designed to financially penalise social services for hospital delayed discharges (Department of Health, 2003a) is used as a vehicle for methodological exposition. This study performed a theory-driven evaluation, incorporating the realist logic to evaluate the effectiveness of this reimbursement policy, a prime example of the self-transformation of programmes that are designed nationally to be implemented locally.

The article starts explaining what delayed discharges are and how they came to be a policy priority in the English National Health Service (NHS). The following section introduces the realist methodology and the evaluation presented in this article. Finally, the results are explained over two sections that follow the main components of realist evaluation analysis: context and outcome patterns (including mechanisms), focusing on how the history of programme evaluations was incorporated in the analysis process. This article aims to contribute to the development of the realist evaluation strategy by introducing programme's transformations as key evidence when trying to understand how complex interventions work in particular contexts.

Realist Evaluation of Fines for Hospital Discharges: Background and Methodology

The use of financial incentives to influence behaviour has been extensively analysed in the literature of multiple disciplines. Within health care, in the last decade, attention focused on the way in which incentives could improve efficiency in publicly funded health systems. In hospital care, financial incentives are a common management tool to reduce patients' length of stay. The constant fight to confront all obstacles to early discharge theories made it only a matter of time before the generation of specific incentives for social services patients' delays (phenomenon also referred with the loaded term 'bed-blocking'). In 2001, the English government expressed its intention to eliminate widespread bed-blocking with the allocation of a significant NHS and social care budget increase (Department of Health, 2001). This increase in funding was accompanied by the introduction of cross-charging to deal with bed-blocking inspired by previous experiences in Scandinavian countries (Department of Health, 2002). The Community Care (Delayed Discharges, etc.) Act 2003 was the first exclusive policy response to the problem of delayed discharges in the form of statutory law in England. It introduced, among other initiatives, financial penalties for local authority social services departments unable to discharge patients from hospitals within set timescales. Social services are given a minimum of two days to assess and arrange services. Then, once the hospital decides that the patient is ready to leave, social services are given 24 hours to organize the patient's discharge. If the patient is not discharged on the third day, the local authority must pay the

hospital £100 per day (£120 in south-east England). The basic assumption is that local authorities would be prompted to assess and transfer patients quickly out of hospital because of the threat of fines.

Fines appeared to reduce delays in three countries (Sweden, Norway and Denmark) where they were implemented in the 1990s. In England, since implementation of the programme, the number of delays dropped nationally and, moreover, they seem to do so rapidly (McCoy et al, 2007a). The association of all these factors is potentially pleasing to policy-makers but the causal relationship between all of them is not clear. Evaluations of this programme theory exist from the Scandinavian implementation but also from different English sites. All these evaluations are small pieces of the puzzle that the Delayed Discharges Act represents. Each of them explains how the programme works from different perspectives. Some offer simple outcome measures concentrating on volume and time periods of discharge to measure efficiency. Others, using a greater range of methods, examine some of the organisational changes that occurred after implementation. The evaluation reported in this article took place in one locality and it followed a small group of patients in detail but it presents a new onset from the previous ones. It tries to fill the gap for an evaluation that could explain how the financial incentives achieved the proposed changes. By concentrating more specifically on the role that the fines played in the successful outcomes and unintended consequences of the programme, certain features of the fines become more attainable.

The empirical work was designed around unravelling the inner workings of the fines. Accepting that fines reduce delays, the question to answer is 'how and why does it happen?' To elucidate the internal dynamics of how programmes work, the main broad objectives of this research were:

- To produce an analysis of the process and context in which financial incentives are applied.
- To explore how the financial incentives reduce the number of delayed transfers of care.

The combination of underlying programme mechanisms and contexts generate outcome patterns that help answer the question 'why does the programme work in here?' The main research question becomes 'How do fines actually work to reduce delays?' The organised efforts to intervene (with fines) for the purposes of solving a problem (delayed discharges) are assessed with these evaluative questions (Chen, 1990).

Cultural, social, economic and organizational contexts influence how the patient group of the so-called 'bedblockers' 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'(Gallie, 1956). 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 (Author, 2010). This situation poses several evaluation and methodological challenges. El Ansari et al. (2001) explain the complexity of evaluating multi-agent programmes since 'its enquiries will exhibit similar features and will have different meanings for each and every participant group. Each constituency will want to ask different questions about whether, how and why it works' (p.223). The challenge of this evaluation thus was to grasp the complexity of a multi-agency programme that deals with objectives for two organisations (acute hospitals and social services departments) which, although they may have the same long-term goals, in practice have very diverse immediate aims. Judge et al. (1999) note that traditional evaluation approaches could fail to reflect the complexities of collaborative government, arguing instead for the adoption of methodologies based on models of 'realistic evaluation' (Pawson and Tilley, 1997) and 'theories of change' (Connell et al., 1995).

In the area of policy evaluation, Pawson and Tilley have developed a set of methodological principles to evaluate programmes following the realist strategy to research. These principles are based on the 'theory-driven' (Chen, 1990) or 'theory based' (Weiss, 1997) approaches but rooted in the tradition of scientific realism, concerning the nature and operation of causal forces in the social world. These are assessed through configurations of contexts, mechanisms and outcomes. The real (mechanisms), the causal (events which may or may not be observable) and the empirical (evidence of experiences

and observable events) are elicited with the objective of describing the relationship, if any, between them. The use of a realist research strategy seeks to unravel most of the complex relationships between national and local policy contexts and the organisational dynamics that characterise multi-agency initiatives.

The use of a case study approach helped unravel the complexities of this multi-agency initiative. Discharges of fourteen patients were followed in one hospital site in the North of England so as to identify flows and blockages in the programme. Multiple methods of data collection were performed in real-time, meaning that discharge planning activities were followed as they occurred, observing them and then asking the actors to comment on them. 73 participant observations, 39 qualitative interviews and documentary analysis constituted the main techniques used to capture programme implementation. For delayed discharges policy, an advantage of the case study approach is their ability to accommodate complex causal relations inherent to partnership programmes (Gray et al., 2003). Statistical sampling was discarded because a probabilistic sample could never be representative of the larger population of programme participants. The main reasons being that this policy only applies to a relatively small number of patients with 'unmet' social needs (McCoy et al., 2007a) and the complexity and interpretation of such a definition would make the probabilistic sampling impossible. In other words, random sampling could never identify the variation of programme participants because the intervention has unexpected processes that cannot be predicted *a priori* for statistical purposes.

The use of non-probability purposive sampling permits the selection of case studies based on the judgement about the extent to which they represent a population or a significant group of people (Blaikie, 2000). Cases were discussed with ward managers, discharge liaison officers and social services staff to make sure they would 'maximize variability so as to discover whether the program succeeds across a whole spectrum of sites' (Weiss, 1998: 164). In addition, general criteria for participant inclusion mirrored those set out in the Community Care (Delayed Discharges etc.) Act 2003. These are:

- Patients receiving acute care.
- Over 18 years of age.
- Referral to social services was formally issued

Of the 39 interviews, 13 were with patients, 12 with hospital staff and 14 with social services staff. The formal participant observations were divided in two settings: 37 multidisciplinary team meetings and 36 management meetings. Interview transcripts were transcribed verbatim and observations and other activities were also transcribed with added reflexive comments, which were an initial 'on site' attempt to codify data as possible mechanisms, context and outcomes.

Exploring Context: Born in the Nordic Countries, Borrowed in England

Programmes metamorphose. An idea is born, and then undergoes a series of changes in its form, sometimes small sometimes abrupt. Transformations

occur when programmes are transferred across different physical and temporal environments. In the case of the fines for delayed hospital discharges, the history of programme's transformation starts in the Scandinavian countries, it evolves in Whitehall corridors, and it changes again when it is implemented in excess of a hundred English local authorities with social services responsibilities and NHS hospitals with acute beds.

In the 1990's, three Nordic countries were pioneers in introducing programmes that enforced local authorities to pay a fee for patients in hospital who had finished their treatment but remained in there due to their social needs: Denmark (Colmorten et al., 2004), Sweden (Styrborn and Thorslund, 1993) and Norway (Health Committee, 2004). In all these three countries, the reimbursement reforms were deemed broadly successful by policy analysts. A sharp reduction of delayed discharges, bed closures and lower average length of stays were reported as the main outcomes of success.

Nevertheless, accounts were not always positive. All three reforms were accompanied by reports of decreasing quality of care (Twaddle, 1999; Colmorten et al., 2004; Harrison, 2004) and the reimbursement schemes were assessed as 'unduly expensive in the long run' (Fotaki and Boyd, 2005: 239).

These early Scandinavian experiences were claimed as a form of legitimisation by the British Government: fines worked in Sweden and Denmark and that was why the system was brought into England. This reimbursement scheme was fully implemented in 2004 and is still operational at the time of writing.

If you enter the social world's DNA, the inexorable transformation of this simple idea occurs. All programmes are implemented in the social world and this is a complex entity in constant flux. Rogers (2008) explained that complex problems tend to be those developed through networks and partnership governance. In the case of delayed transfers of care, the issue resides on the borders of both health and social systems. The Delayed Discharges Act is a policy solution based on partnership governance that confronts the challenge of a multi-faceted and multi-agency topic, including multiple factors outside the control of social services (Glasby et al., 2004). Shifting power relations, uneven capacities and political opportunities need to be taken into account when addressing how delayed discharges theories are shaped. For example, the successful discharge of patients in the community depends as much on the prompt availability of resources like publicly funded housing facilities or care homes, as on the inter-agency discharge planning procedures to manage the micro-characteristics of individual patients.

Another important factor to consider is that other programmes implemented simultaneously to the reimbursement scheme could have equal impact for acute patients. Although programmes are addressed to specific institutions, in real life they interact, overlap and intermix with some of the other institutional players. For instance, one initiative that directly interacted with the financial incentives programme theory is the English National Guidance on Choice Directive (Department of Health, 2007). This directive establishes the right for patients to select a care establishment of their choice. These two policies come into conflict when patients need to be admitted into care from hospital

beds. Their preferred establishment most probably will not have an instantly available vacancy, with the most popular homes having long waiting lists and, subsequently, delays occur.

Not only innovations outside the programme but those within the programme are as significant for the development of the theories of change implemented. The Delayed Discharges Act brought about multiple innovations, besides the fines, which cannot be artificially divided for the purposes of evaluation (Author, 2009). Financial incentives are never introduced in isolation. They are accompanied by a multitude of initiatives that can have as much power to change old practices. In addition to the cash injection applied to the health and social care systems, other designed organisational changes were introduced also aimed at reducing patients' length of stay, transforming discharge practices and improving quality of decision-making and care. All these innovations are interrelated and to evaluate one is to evaluate all of them. They have similar objectives and they generate similar outcomes. To untangle the intricate links that unite all of them is not only a difficult task, but most possibly an unattainable one.

Hospitals do not work in isolation. Many different organisations besides social services departments, such as primary care trusts, independent and voluntary sector providers need to work in cooperation with acute hospitals to reduce delayed discharges. The contextual characteristics of individuals, institutional relationships and settings, and the wider macro-structural system will shape how fines work in each locality. Like in chameleons, programme

metamorphoses occur as self-defence mechanisms. Programme theory has an ability to blend in with its new surroundings as a form of survival. In the case of the Delayed Discharges Act, when the programme was first announced, the local health and social care managers met to re-define the nationally defined theories into local practices that were the most convenient for their services. In other words, the theories of change proposed by the national organisation (Department of Health) were organised locally by middle managers. Local implementation of national programmes involves adapting these to local circumstances. Consequently, when evaluating a programme locally, we have to draw a picture that captures 'the unique diversities and contrasts that mark local programs and to understand how and why programs deviate from initial plans and expectations' (Patton, 1987: 28). The importance of local circumstances in determining how barriers or facilitators of change operate in any setting should not be overseen and Figure 1 illustrates this.

[Figure 1 to be located here]

This figure includes a sample of the multiple levels of the nature of the Delayed Discharges programme identified in this evaluation. They are symbolised as different interconnected layers of the social reality of the programme where the multiple aspects affecting discharge processes and fines rest. The discharge options available are subordinate to the relationship between all the institutions involved. These levels are represented in Figure 1 as layers which resemble Layder's (1993) stratified model of society and they have numerous components and the relationships between all of these

intertwine. Components can interact within the same level but they can also interfere with components within other levels. For example, when evaluating the role of financial incentives, the link between these and the performance indicators (see meso-social phenomena layer in Figure 1) on which health and social care organisations were routinely assessed at the time of the fieldwork needed to be explored.

The theory of linking financial incentives to performance indicators builds on the economic theory of 'change the financial reward and the behaviour will be changed' (Fetter et al., 1976). Although 'delayed discharges' is a performance indicator managed by financial incentives, it is also embedded in a group of other performance indicators which are managed by another tool for target compliance: public reporting. In addition, fragmentation occurs between health and social care organisations themselves with different audit bodies and assessment tools for each agency. Data gathering for regulatory purposes is collected, managed and analysed by different institutions, which can potentially increase the recognised problems with data quality in healthcare regulation (Attride-Stirling et al., 2006).

In summary, there is a complexity within the performance indicators which shapes and potentially disguises the attribution of causality with regard to fines. The situation described above exemplifies some of the difficulties when evaluating the impact of one single measure like the fines. Figure 1 illustrates, however, how the whole programme depends on nested territorial levels of decision-making which become more complicated in the context of complex

overlapping networks. Consequently, the difficulty of evaluating this programme remained in the detailed interaction between the various agencies and the identification of the connections and outcomes of individual actors which are embedded in their own institutional, historical and political specificities. Not only because of the complexity that they represent but, most significant for this article, for the opportunities for self-transformation that every interaction offers.

Of course, this figure does not contain every single element that could affect hospital delayed discharges. Cilliers (2000) argues that any 'perfect' representation of complex systems must be as complex as the system itself, and this is an impossible task. In building representations of such 'open systems', we are forced to leave things out, and since the effects of these omissions are nonlinear, we cannot predict their magnitude. In other words, solutions to these problems would always be imperfect, and imperfection is also inevitable in their evaluations. In this study, priority was given to the aspects that interact more closely with the discharge planning processes that the fines try to modify in one particular context: one site (one acute hospital), one temporal section (2006-2007) and the elements that took special relevance in the discharge processes of fourteen patients. Therefore, if programmes are so defined by the context in which they are implemented, how can we learn transferable lessons from their contextualised evaluations?

Developing Mechanisms and Outcome Patterns in a Self-Transforming Programme

Programmes transform inexorably but mostly, quietly from their original design. Programmes change silently because previous similar interventions are frequently used as justification of why they will work. Modifications are, generally, overseen as contextually necessary or as improvements from original designs. In other words, changes in programme theory are considered (by both implementers and evaluators) only as necessary adaptations to the contextual differences of the sites where they are applied and not as key modifications that may affect the expected outcomes. It is not infrequent to picture programme theory as a shielded block of ideas that is created somewhere and later on transported, intact, from programme designers, to implementers and from these, once again, to programme practitioners. However, Bickman (1987: 6) explains how

‘often the objectives, goals, and theory underlying the program may be purposely ambiguous because of political concerns; that is, it may be kept intentionally vague in order to gain support from different groups’.

Consequently, programmes could have their theory explicitly described and, at the same time, ambiguously not described, leaving enough room for new theory generation. This view leads to the notion of a modifiable programme theory, which needs to be tracked down at different physical and temporal locations in the life of a programme.

In the case of the Delayed Discharges programme, it was tested in the 90s in three Scandinavian countries and then in England in the early 2000's over 164 acute trusts and their correspondent social services departments.

Therefore, each of those locally transformed programme theories are testing exercises from which lessons are learned. Each of the site evaluations are sources of information that also need to be considered. This study, located in only one acute trust and with data from only fourteen cases confronted the challenge to establish generalisation from a small number of case studies while evaluating a complex programme. It cannot, however, be considered a 'one-off' project because it is built from learning about previous studies. The present evaluation was not marooned in singular description because it used the knowledge gained from all the other studies. Consequently, the findings from this local implementation will state something about the broad programme theory ('fines work to reduce delayed discharges') as a general theory of change, thus, a number of transferable lessons can be learned from everybody and for everybody.

All the evaluations of the Community Care (Delayed Discharges etc.) Act 2003 published at the time of writing were taken into consideration in the analysis. Some of these were 'quantitative accounts' provided by the Department of Health, based on internal audits which showed a significant reduction in delayed discharges since the implementation of the programme. (Department of Health, 2004; Secretary of State for Health, 2006; Brindle, 2007). The Commission for Social Care Inspection (2004) performed two

evaluations on the effects of the reimbursement programme. The first evaluation looked at the initial months of implementation in seven local authorities, examining 151 case records and interviewing 70 people a few weeks after their discharge. Their second report (Commission for Social Care Inspection, 2005) was a follow-up exercise a year later in which they re-interviewed the same people as in 2004.

The UK Economic and Social Research Council funded an evaluation of the reimbursement programme based on the use of mixed-methods: a survey of all social services departments to determine level of reimbursement; analysis of weekly monitoring data on delayed discharges, and Hospital Episode Statistics data; and a qualitative case study in two London Boroughs interviewing key stakeholders (Godden et al., 2007; McCoy et al., 2007a, McCoy et al., 2007b; McCoy et al., 2007c). Before the announcement of the reimbursement programme, the Department of Health commissioned a study (Baumann et al., 2007) intending to fill the evidence gap regarding solutions to delays. This research analysed sites performing 'exceptionally well' with regards delayed discharges and it drew general knowledge from their practices. Six 'high performing' sites were selected, using a statistical model to shortlist authorities. Interviews were held with health and social services staff to identify key features of their sites. Based on organisational changes and outcomes, this study did not specifically concentrate on the innovations brought about by the reimbursement programme. It did, however, include characteristics of the local areas and examined existing local organisational arrangements.

Another study commissioned by the Department of Health was a longitudinal multi-site project carried out in three hospitals in England and two hospitals in Scotland (Godfrey et al., 2008). Two different approaches to tackling delayed discharges are compared in this research: the English reimbursement scheme and the Scottish Joint Action Planning adopted in 2002. Using a multi-method approach, researchers examined documents, observed meetings and practices and interviewed stakeholders, staff and service users and their carers. The contextual delimitations of discharge practices make comparative research of this type a difficult task. This study, however, incorporated views of frail elderly patients about their discharges and it also offered a comprehensive analysis of some of the innovations beside the fines brought in by the programme. Nevertheless, the authors expressed their difficulty in drawing 'any clear conclusions about the role played by the 'stick' of reimbursement i.e. fines imposed on the local authority for reimbursable delays' (Godfrey et al., 2008: 39).

Some of these evaluations were able to evaluate the theory in a variety of sites (spaces) or longitudinally (times) (See Figure 2). Others, like this one, can only reach a small amount of data in a specific location but it stills feeds from all the others evaluation schemes.

[Figure 2 to be located here]

Figure 2 was created to explain how this process of data accumulation occurs. It is mapped on two axes; these represent the coordinates 'time' and 'space' in which measurement in the form of evaluations or institutional audits (in grey rectangles) occur across diverse locations and at different times of programme implementation (in grey circles). The question here is how can all these previous enquiries be accommodated and brought to bear on the case under investigation; how can they be 'banked' to render the single study more generalisable? The answer is that the analytic strategy intends to work through programme complexity examining current and past data at different levels. Surfacing the local design of the programme theory is a first step that builds from the literature review on the problem (delayed discharges) and attempts to solve it; while performing at the same time, a detailed examination of the national policy, which included all available evaluations of the core programme theory. The assessment of the contextual framework of the research site informs the analysis of the structures influencing the programme and this helps the interpretation of the mechanisms used locally to avoid the fines. Then, these are compared with other similar mechanisms used elsewhere. Afterwards, secondary readjustments to all these working hypotheses are made to finally abstract some middle range propositions applicable to any future implementations of the same programme theory. This logic of analysis draws on the same methodological process of realist synthesis, attempting to explore the 'process of thinking through the tortuous pathways along which a successful intervention has to travel' (Pawson, 2006a: 170). In empirical work, however, "digging for nuggets" of knowledge as Pawson suggests (2006b:134) is not a prior fieldwork systematic search for

theories in the literature. It is a process embedded before, during and after the collection of new data in which historical fragments of evidence from other sites inform the construction of context, mechanisms and outcomes.

Strategies designed nationally are only 'suggestions' that can or cannot be followed when the programme is implemented in specific locations (Pawson and Tilley, 1997). Although the implementation evaluated here has unique local circumstances, this will be the case in any other location. The task embarked on is to explore how different contextual challenges enhance or weaken the basic programme theory. Assuming that fines work to reduce delayed discharges in some settings and not in others, to understand the behavioural patterns of the fines, the analysis strategy focused on contextual constraints of the programme mechanisms. The banking of the data extracted from contextual circumstances is illustrated in Figure 3, using the example of some of the key findings of this project.

[Figure 3 to be located here]

In the same way that realist synthesis reviews the same theory in comparative settings, (Pawson et al., 2005) previous evaluations were considered valuable sources of information and were inspected to develop the analysis. Evidential fragments of their findings were considered unit of analysis to be utilised within the logic of analysis. Then, they were interrogated to establish whether theories were confirmed, contradicted or modified. For example, in this evaluation, there was a case study with a long delayed discharge that the

fines could not resolve. Explanations for this 'blockage' were looked for in the contextual circumstances of the research site but also in those of the other evaluations. This case study, which experienced the longest delay in the sample had a significant micro-contextual characteristic. The patient was a young man who needed re-housing in a council property to be able to leave the hospital after a stroke. Subsequently, references to public housing structures were searched in all the research sites that have ever used fines to improve delayed discharges.

High property prices and lack of affordable and council housing are characteristics of the research site. This shortage of council housing and the limited involvement of the local housing department in the development of fast services for hospital patients framed the emergence of a key contextual feature of these implementations (which it was named Context 'housing needs'). The reimbursement programme was addressed to social services departments in local authorities which in England are totally independent from housing units. Compartmentalisation trends in public services divided these two institutions; they have different budgets and objectives and lack tradition in working together with regards hospital discharge. Prompt access to adequate housing was a national difficulty identified before programme implementation and the above cultural and organisational divides between housing departments, social services and the NHS were recognised by the Department of Health as limiting effective joint working for fast discharges. Besides, the need to secure a variety of housing options for discharging patients in many localities would have meant a significant increase in the

stock of affordable, supportive housing. The difficulties with these matters arrived back to the policy designers as they expressed in a later guidance (Department of Health, 2003b), when they accepted that social services departments could not take responsibility for these delays and excluded housing needs from reimbursement.

As a result of the above contextual circumstances, the likelihood of the young man of this case study being allocated a suitable council property within a few days was much reduced. Critically, when other implementations were explored for this contextual characteristic, the Swedish fine scheme was accompanied by the increase of the housing alternatives available and the improvement of the quality housing facilities for older and disabled people (Minford, 2001). This bit of programme theory was considered key evidence in the consolidation of 'housing' as a key contextual circumstance that could enhance or disable the changing power of the fines. In Figure 3 this is represented with a long grey block arrow that connects both findings.

Because housing needs were excluded from the reimbursement programme, after implementation, in this research site hospital staff tended to be left on their own to deal with patients who needed re-housing, a role that social services used to take before the reimbursement policy. Hospital staff lacked knowledge of the procedures, contacts in the housing department and dedicated professionals to deal with patients with this type of needs and the likelihood of delays increased. Additionally, this finding speaks more generally for incentives theory and it identifies a well documented unintended consequence of financial incentives: 'Goal displacement'. This phenomenon

has been defined in the sociology of organisations for more than half a century, which recognises that the incentivisation of performance is likely to lead to decrease performance outside the domain incentivised. This has also been referred to as 'synecdoche' (Bevan and Hood, 2005); 'hitting the target but missing the point', 'tunnel vision' (Smith, 1993), 'parochialism' (Jacobs and Manzi, 2000); or 'what's measured is what matters' (Marshall et al., 2000).

In Figure 3, another important finding was itemised. Since the number of delayed discharges was significantly reduced following the implementation of the programme, it was assumed that mechanisms (whether planned or unplanned) followed and these generated the sharp reduction in the number of delays observed in quantitative data collections. As an initial exercise, the way in which delays were counted before and after programme implementation was explored. The introduction of the reimbursement programme was accompanied by a compulsory weekly census to count delays. The policy designers considered that rigorous management information systems would be necessary to make the reimbursement system work. Quantitative performance data which relate to hospital delays have to be collected daily by the acute hospital and then sent off weekly to the Department of Health. Therefore, a weekly census to count delays was enforced, as opposed to the one day quarterly census system used in the past. For many years, data for hospital delays was collected every three months using a 'one-day' census of hospital bed use.

Interestingly, the Swedish evidence that highlighted the success of the fines was collected using a monitoring system based on one day annual census. This annual collection is also used in Scotland but has been deemed more vulnerable to gaming activities with agencies trying to fast discharge patients in the weeks immediately prior to the one day of monitoring (Godfrey et al., 2008). In summary, the frequency of data monitoring is a mechanism that reduces delays. If social services are warned of a specific day (annually or every quarter) when nationally all patients waiting in hospital for social care are counted, then efforts to move patients concentrate on emptying hospitals on that day (Swedish and Scottish system). However, if patients are counted weekly a clearer picture of the problem will follow. The locality evaluated in this evaluation, like others around the country, as a consequence of this close monitoring, established a weekly management meeting, including hospital and social services senior staff, to discuss delays and fines before data are sent to the Department of Health. This type of interagency meetings is associated with hospital sites that have low figures of delayed discharges (Baumann et al., 2007). In parallel, in this research site local social services managers constituted another weekly meeting with the objective of accelerating funding decisions, when reimbursement was implemented.

A similar type of weekly funding allocation meeting is present in all three sites in the Godfrey et al. (2008) study. In those hospitals, like in the one analysed in this evaluation, the system for allocating the funding of the packages of care is rapid, with decisions made normally within a week. This mechanism seems to decrease the amount of delays caused by social services due to

waiting for their funding. Godden et al. (2007) concluded that waiting for funding scored as the smallest percentage of patients delayed because of social services reasons. This is significant because waiting for social services funding is one of the common reasons for delayed discharges identified in the research literature. Consequently, weekly allocation panels to speed up funding decisions appear to cause a reduction in delays because they formalise weekly systems to approve funding, which did not exist before the implementation of the fines, and consequently, the close and structured joint monitoring of delays by both agencies is a mechanism that reduced delays. Middle managers (as opposed to social workers) with their weekly involvement in meetings took formal control not only of the fines but of the discharges in an unprecedented way. In Figure 3, these pieces of evidence are presented in the form of a ladder of evidence, linked by small blocked grey arrows that end in the findings of this evaluation.

All the above information informed the development of a mechanism to reduce delays that was secondary to the introduction of the fines which was called 'frequency of data monitoring'. The thread of fines generated several inter and intra-agency meetings that themselves (and not the fines) reduced delays. Since number of delays are now linked to fines, they are monitored and bargained daily. Social services managers are not only proactive in activating services for hospital patients but they also have a say in what patients are recorded as delays in the quantitative returns sent to the Department of Health. Instantly, the establishment of rigorous information

systems contributes to the numerical reduction of delayed discharges accounts.

In summary, the preliminary theory (fines reduce delays) was refined and a new theory on how fines operated was developed. This identified other mechanisms contemporaneous to the fines which are more or as likely to reduce delays. Some of these are summarised in Table 1 and further explained in Author, 2009.

[Table 1 to be located here]

Conclusion

The history of programmes' transformations is formed by a sequenced of opportunities for programmes to morph. Attempts to evaluate patterns of cause and effect in programme's theories should analyse those opportunities and identify them as part of the evaluation process. In this study, the application of a realist evaluation strategy provides the explanatory depth that such a complex multi-agency programme requires. This is highly relevant when evaluating policies that are designed nationally to be implemented locally and therefore, self-transforming inexorably. Since the influence of contextual factors needs to be taken into account because the same measure (in this evaluation, the fines) is never an exact replica and consequently, the same effect will not be produced.

The concept of policy context is central to this evaluation. It refers to the historical, political and legal settings, organisational structure, the character of markets, and the nature of issues related to the topic where programmes are implemented. Following the hypothesis that the nature of the issue to improve (delayed discharges in this case) and the institutional context largely determine the ways in which particular policy instruments evolve and, therefore operate. If that is the case, methods to evaluate these programmes should reflect those contextual differences. They should also be able to identify the elements of the 'programme amalgam' before claiming causality.

The evaluation used in this article as a vehicle for methodological explanation presented a new onset from the previous ones. It tried to fill the gap for an evaluation that could explain how the financial incentives achieved the proposed changes. By concentrating more specifically on the role that the fines played in the successful outcomes and unintended consequences of the programme, certain features of the fines become more attainable. But they did so with the contribution of all the other evaluations of the same programme to developing understanding on how fines work. The tendency of traditional evaluations to be 'rather self-contained assessments that do not build on learning from other disciplines or policy domains' (Blamey and Mackenzie, 2007: 448) is overcome with this approach. The evaluator builds on what other evaluators / researchers have already discovered about that same intervention.

In this evaluation, previous studies were inspected for evidence according to 'how it supports, weakens, modifies, supplements, reinterprets or refocuses' (Pawson, 2006a: 96) not only the preliminary theory (fines reduce delays) but also my own theory on how fines operated (other mechanisms contemporaneous to the fines reduce delays). Causal relationships were investigated to ascertain whether they could hold and which were the contexts that facilitated or prevented their association. These could be institutional (like the example of the generation of inter and intra-institutional meetings); individual contexts or those derived from the macrostructure where the programme is embedded (like the example of the public housing infrastructure explained above). All of these were 'cumulated' together and contrasted with contexts learned from other implementations of the same programme theory. This was the way of aggregating knowledge: moving from one specific case to general theories, back to the next case and once again to review the theories.

Social interventions are complex systems and they do not produce exact copycat programmes or copycat CMOs. When diverse research studies are brought into the analysis, concentrating on one programme theory but extracting evidence in the form of context-mechanism-outcomes, these will not materialize as duplicates that can be accumulated by easily pooling them together. The logic of this configurational puzzle uses aggregation and combination of the components, but also allows for emergence and for 'morphogenesis' (Archer, 1998).

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