Study of the issues arising in the community care of discharged hospital patients should help clarify the planning, preparation and support services for those in-patients who will be resettled into the community in the future.

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Discharge delays

DEAR SIRS

We report a recently completed study which examined discharge delays from the acute admission wards of a psychiatric hospital once the psychiatric condition for which the patient was admitted had been dealt with. In addition to the waste of resources implied, it raises questions on the ways in which this could affect the cost, quality of service, and patients' satisfaction about their care.

We conducted a questionnaire survey on four acute admission wards for the under 65s and three acute admission wards for the over 65s, over three months.

Sixty-six patients (30 under 65s and 36 over 65s) were identified to have spent extra time in hospital for non clinical reasons and the extra time spent by them was 3,727 days with an average of 49.7 days for under 65s and 62.1 days for the over 65s. During the 91 day study period, of the total 15,117 bed occupancy positions on the seven wards, 2,768 (18%) were occupied by patients awaiting discharge, despite being ready to leave hospital.

Of the various reasons for delays in discharge, accommodation problems ranked highest, with 73% (22/30) of under 65s falling in this group. Among the psychogeriatric patients, the accommodation problem was the sole cause of delay in only 11% (4/36); however, when those awaiting Part 111 accommodation (12/36) were also included, the figure rose to 44% (16/36). The second important factor was internal transfer to continuing care wards in the case of over 65 s (25%) and to rehabilitation wards for the under 65s. Although the proportion of patients in this category was less than those awaiting accommodation, the average length of extra time spent per person was substantially higher (122.2 days v. 36.8 days).

Legal problem (section 37/41) was causing delay in discharge in one patient (under 65) who had already spent an extra 108 days at the close of the study. Other reasons included awaiting transfer to other facilities (e.g. medical wards, reprovision programme) within and outside the health authority and those awaiting input from social services.

Our findings confirm the considerable problem posed for treatment teams by discharge delays, leading to occupancy of facilities in acute admission wards which are then unavailable for other patients who may require them. In the present climate of thinly spread resources, this limits the availability of acute beds which are already insufficient to meet the demands of the respective catchment areas. The implications of this waste of limited clinical resources are serious. The reasons for delayed discharge seem to point to major accommodation problems in the community and it emerges that there is a need to increase these resources. It may also be worthwhile to consider the provision of a 'Resettlement Officer' to liaise with the community and co-ordinate the effective use of available facilities. More detailed analysis should be undertaken in future, attempting to find out whether diagnostic categories have any influence in delays, staff attitudes in hospital and in other agencies, especially for patients with prolonged or multiple admissions. Findings of the present audit will be distributed to Social Services, Housing Agencies and Unit General Management, to help improve deficiencies in the existing services. The authors wish to repeat this audit on a regular basis to monitor any change in trends. A more systematic study may be required to focus on the exact nature of the difficulties in the context of available local resources. This will help plan future mental health services in the area.

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Out of hours admission

DEAR SIRS

We read with interest Gardner's study of out of hours admissions to a general psychiatric hospital (*Psychiatric Bulletin*, 1992, **16**, 357–358). The nature and volume of such admissions have important implications for staffing levels and service planning. When assessing their volume it is important to take into account the timing of the preceding referral.

Not all patients admitted out of hours have been referred out of hours. We wonder whether the author has data on the proportion of out of hours admissions in which the decision to admit was made during routine hours. Due to differences in working hours, duty rota and shift systems of medical and nursing staff, the time of referral is likely to be of greater importance to doctors, and the time of admission more important to nursing staff. Out of hours, medical staffing levels are reduced to a skeleton on-call team, and it is this team that is called upon to make the decision whether or not to admit a