



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

Discharging older patients from hospital

Key facts

62%

of hospital bed days occupied by older patients (those aged 65 or over) in 2014-15

18%

increase in emergency admissions of older people between 2010-11 and 2014-15 (12% increase for whole population)

£820m

our estimate of the gross cost to the NHS of older patients in hospital beds who are no longer in need of acute treatment

- 1.15 million** bed days lost to reported delayed transfers of care in acute hospitals during 2015 (up 31% since 2013)
- 2.7 million** our estimate of hospital bed days occupied by older patients no longer in need of acute treatment
- 11.9 days** average length of inpatient stay for older patients in 2014-15 (based on emergency admissions only)
- 5%** percentage of muscle strength that older people can lose per day of treatment in a hospital bed
- 54%** hospitals in our survey who told us that discharge planning is not started soon enough to minimise delays for most older patients

Summary

1 Unnecessary delay in discharging older patients (those aged 65 and over) from hospital is a known and long-standing issue.¹ For older people in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Older people can quickly lose mobility and the ability to do everyday tasks such as bathing and dressing. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the National Health Service (NHS) and local government.

2 Older people are cared for in hospital by the NHS, but once discharged some may need short- or long-term support from their local authority or community health services. This may involve living at home with some support or living in a care home. NHS community healthcare and short-term care to increase people's independence provided by local authorities are free. Local authorities have to apply a financial means test and an eligibility test based on levels of need for other types of care.

3 The number of older people in England is increasing rapidly, by 20% between 2004 and 2014, and with a projected increase of 20% over the decade to 2024. Hospitals have also experienced increases in the number of emergency admissions of older patients, by 18% between 2010-11 and 2014-15. Older patients now account for 62% of total bed days spent in hospital.

4 With the increase in numbers of older patients, it is critical for health and social care providers to work together to minimise the length of time that such patients spend in hospital. This will be through a combination of admitting only those older people who really need treatment in hospital, and minimising delays for those who are admitted. It is important that, in line with the aims of NHS guidance, patients are not discharged from hospital before they are clinically ready.

5 The only official data relating to delays in discharging patients from hospital are NHS England's 'delayed transfers of care' data. We estimate that 85% of patients captured by this measure of delay are aged 65 and over. According to official figures, the number of bed days in acute hospitals recorded as delayed in 2015 has risen by 270,000 days (31%) in the past two years to 1.15 million bed days in 2015 (around 3% of total bed days).

¹ Throughout this report, by 'hospital', we mean acute hospitals which focus on the treatment of a patient's immediate medical care needs as opposed to community hospitals, which are more focused on rehabilitation.

Scope of our report

6 Our report examines how effectively the health and social care system is managing the discharge of older patients from hospital, in particular:

- the scale of delays that older patients experience in hospital (Part One);
- the extent to which health and social care providers are adopting good practice in discharging older patients (Part Two): and
- barriers to local health and social care systems working effectively (Part Three).

7 Older patients account for most delayed transfers of care, so this report focuses on patients aged 65 and over with an emergency admission, from the point when they are admitted to hospital through to when they are discharged. It complements our 2013 report on emergency admissions – which examined how well health and social care systems managed the demand for emergency services, thus it does not cover out-of-hospital services designed to avoid hospital admission.² It also does not cover mental health services in depth, including dedicated dementia care.

Key findings

8 **Rising demand for services, combined with restricted or reduced funding, is putting pressure on the capacity of local health and social care systems.** As set out in paragraph 3, the number of people aged 65 and over in England is increasing rapidly. The relative growth in numbers of older people is important. The number of older people with an emergency admission to hospital increased by 18% between 2010-11 and 2014-15 (compared with a 12% increase overall). In 2014-15, the percentage of older people admitted to hospital after attending accident and emergency (A&E) was 50% compared with 16% for those aged under 65. Although overall length of stay for older patients following an emergency admission has decreased from 12.9 to 11.9 days between 2010-11 and 2014-15 – suggesting improved efficiency – the overall number of bed days resulting from an emergency admission has still increased by 9% from 17.8 million to 19.4 million days. Put simply, without major change, these recent trends indicate that the more older people there are, the more pressure there will be on hospitals. While NHS spending has grown by 5% in real terms between 2010-11 and 2014-15, local authority spending on adult social care has reduced by 10% in real terms since 2009-10 (paragraphs 1.1, 2.5 and 3.3).

2 Comptroller and Auditor General, *Emergency Admissions to Hospital: managing the demand*, Session 2013-14, HC 739, National Audit Office, October 2013.

The scale of delays to older patients

9 The number of recorded delayed transfers of care has increased substantially over the past two years.

As set out in paragraph 5, the official data show a 31% increase in bed days taken up by patients with a delayed transfer in acute hospitals between 2013 and 2015. The main drivers for this increase are the number of days spent waiting for a package of home care (which more than doubled between 2013 and 2015, from 89,000 to 182,000) and waiting for a nursing home placement or availability (which increased by 63%) (paragraph 1.9).

10 The delayed transfers of care data substantially underestimate the range of delays that patients experience.

By definition, the official data only count delays that occur after clinicians and other professionals deem a patient to be ready for discharge. It does not count all patients who are no longer benefiting from acute care, or all the delays patients experience during their treatment. Based on our survey results, we estimate that the number of older patients in hospital who are no longer benefiting from acute care to be approximately 2.7 times the figure for reported delayed transfers of care. This amounts to around 2.7 million bed days a year. We also found inconsistencies in how hospitals count delayed transfers of care. Around one-third (37%) of local authorities in our survey said they never or only sometimes agreed the data with hospitals before it was reported. NHS England refreshed their existing guidance to clarify the rules and definitions for counting delayed transfers of care in October 2015 (paragraphs 1.7 to 1.11, 3.27 and 3.28).

11 The NHS spends around £820 million a year treating older patients who no longer need to be there.

We used the limited data available together with our survey results to estimate the gross annual cost to the NHS of treating older patients in hospital who no longer need to receive acute clinical care to be in the region of £820 million. This would assume that patients are moved out of hospital as soon as it is clinically safe to do so, consistent with the aims of NHS guidance. Shortcomings in the available data mean that it is not possible to estimate the scope for efficiency savings precisely. If these patients were treated in more appropriate settings at this stage in their care, hospitals could make more efficient use of beds, or relieve pressure on high bed occupancy rates. However, it may not be easy for hospitals to realise these costs as actual savings in the short term, as this would depend on their ability and appetite to close wards and reduce staffing. It may also reduce the need for new capacity in the future, allowing hospitals to avoid costs. This report highlights a range of short- and long-term issues that currently restrict the extent to which delays can be completely removed. Given demographic trends, the current inefficiency will only increase in scale and cost without a radical change in current trends in hospital admissions and discharge practice (paragraph 3.10).

12 Caring for older people who no longer need to be in hospital in other settings could result in additional annual costs of around £180 million for other parts of the health and social care system. Available data, particularly around what care this group of patients might need outside hospital, are very limited and do not support a precise estimation of transferred capacity and costs. Under a scenario of higher care needs, our best estimate is a public cost in the region of £180 million for providing care either at home or in a more appropriate care setting. This assumes that some additional costs would fall on individuals arranging and funding their own care with related capacity requirements; these costs are not quantified in the estimates. Due to data limitations, this estimate also does not include the impact of any potential increase or decrease in care needs, and therefore the duration of care, as a result of being discharged more quickly from hospital. Our cost estimates are sensitive to a number of assumptions, which are set out in Part Three and Appendix Two (paragraph 3.10).

Managing the discharge of older patients

13 Health and social care providers have made limited progress in adopting recommended good practice. Good-practice principles are that: hospitals should identify patients' needs as quickly as possible to determine whether hospital is the best place to meet them; health and social care staff should work together to maintain the momentum of treatment and discharge planning; and staff should assess and rehabilitate patients in their home wherever possible (paragraphs 2.2 to 2.5). We found:

- **Early identification of needs**

More hospitals had frailty units (specialist units that assess and treat older people's needs at an early stage): 55% of hospitals that we surveyed compared with 29% in an audit published in April 2015. However, capacity in these units was often limited. Only a minority of hospitals (42%) were undertaking early geriatric assessments. The proportion of older patients admitted from A&E varied from 37% to 61%, suggesting there is scope to improve how hospitals manage admissions (paragraphs 2.7 to 2.8).

- **Maintaining momentum**

Most hospitals had elements of good practice in place (for example, 95% had reviews of patients' progress by senior clinicians at least every day). However, they had made limited progress in other areas (for example, only 39% set expected discharge dates linked to criteria for discharge for all or most older patients). Some 54% of hospitals in our survey told us that discharge planning did not start soon enough to minimise delays for most older patients. We identified difficulties with hospital staff maintaining knowledge of out-of-hospital services and a lack of shared understanding of what skills are needed for good discharge planning (paragraphs 2.9 to 2.12).

- **Assessment and rehabilitation at home**

Our survey showed 52% of hospitals had 'discharge to assess' schemes (now seen as the default model in NHS guidance, whereby assessments and care planning are done in the home rather than hospital). However, only 39% of schemes could be offered to all or most patients and around half of hospitals had arrangements in place to share patient assessments with other bodies. We identified particular issues with the management of the assessment for Continuing Healthcare (a package of on-going care that is arranged and funded solely by the NHS where the individual has been found to have a primary health need) (paragraphs 2.13 to 2.14).

The effectiveness of local health and social care systems

14 Workforce capacity issues in health and social care organisations are making it difficult to discharge older patients from hospital effectively. Across health and social care, providers and commissioners said that staff recruitment and retention were a significant cause of delays. Vacancy rates for nursing and home care staff were up to 16% in some regions, based on data for 2014 and 2015. In our survey, fewer than half of hospitals felt they had sufficient staff trained in the care of older patients (paragraphs 3.4 to 3.8).

15 System resilience groups are not yet effective. NHS England has established system resilience groups as the main local forums for planning and coordination of health and social care services. Although most system resilience group chairs felt they had the core elements in place to work effectively, there were mixed views about their effectiveness: only 53% of hospitals in our survey felt they were effective. Delayed transfers of care continue to rise across the country. We found health and social care organisations commissioning services jointly to tackle delays in discharging older patients. However, commissioners were not always making full use of levers to minimise delays: for example, more than half of local authorities in our survey said contracts with care home providers did not specify agreed response times for admitting or assessing patients (paragraphs 3.11 to 3.19).

16 Health and social care organisations are not sharing patient information effectively. Health and social care organisations now have a statutory duty to share patient information, but our survey findings showed that information is still not routinely shared. For example, only up to a quarter of hospitals said that they had sufficient access to primary, community and social care information for most older patients. We heard examples where lack of access to information could result in A&E clinicians being less able to undertake a full assessment and more likely to admit an older patient (paragraphs 3.20 to 3.22).

17 Financial incentives do not adequately incentivise early discharge of

patients. Hospitals have financial incentives to minimise the length of stay for emergency attendances and keep space free for elective procedures for patients. However, community health providers and local authorities are not incentivised financially to speed up receiving patients discharged from hospital. For example, we found the use of block contracts with no activity-based payment did not offer incentives for providers to increase their activity. In our case studies, we heard from a broad range of stakeholders that the main driver of day-to-day decisions on when to discharge patients from hospital remains patient care and safety, rather than financial considerations. There was general recognition across local systems that reducing the length of stay of older patients in hospital would reduce care needs, and ultimately costs, in the long term (paragraphs 3.23 to 3.25).

National assurance and support

18 There has been a lack of coordination in central government work aimed at improving discharge practice.

When discharge delays started to rise, the Department of Health (the Department) and Cabinet Office undertook work to understand the causes. During our fieldwork, we found a number of examples of joint working across national health and local government organisations. However, the landscape was complex with a range of teams, initiatives and good-practice guidance either directly or indirectly related to improving practice in discharging patients. In response to this complexity, the Department only started to coordinate activities formally in December 2015, when it established the Discharge Programme. The programme aims to coordinate action to address delays in discharging patients and develop a coherent, cross-system vision of 'what good patient flow and discharge looks like'. There is not yet a strong evidence base across all the elements of good practice recommended by national NHS bodies (paragraphs 2.3 and 3.29 to 3.31).

Conclusion on value for money

19 Making sure older patients stay in hospital no longer than necessary is a complex issue that requires a coordinated response across health and social care organisations. Unnecessary stays in hospital result in worse health outcomes for patients and waste already strained NHS hospital resources as well as increasing the long-term care needs, and costs, for social care and community healthcare. NHS data show the number of delayed transfers are increasing at an alarming rate but do not capture the full extent of older people who should not be in hospital. While there is a clear awareness of the need to discharge older people from hospital sooner, both at national and local level, there are currently far too many older people in hospitals who do not need to be there, at an estimated cost to the NHS of around £820 million. Without radical action to improve local practice and remove national barriers, this problem will get worse and add further strain to the financial sustainability of the NHS. Given the increase in delays and limited progress in reducing barriers to further improvements, performance does not represent value for money.

Recommendations

20 The Department, NHS England and NHS Improvement have work under way to better coordinate the central assurance and support for patient flow and discharge. We encourage the continuation of these initiatives. However, we do not consider incremental operational improvements alone will address the problem effectively. We recommend:

- a** The Department, NHS England and NHS Improvement, in conjunction with local government partners, should set out how they will break the trend of rising delays against the demographic challenge of growing numbers of older people, with a particular focus on minimising avoidable admissions and inappropriate lengths of stay, drawing on existing initiatives as much as possible.
- b** Working with the Discharge Programme Board, NHS England should develop measures that fully capture the number of older people who are no longer benefiting from acute care. This may involve changing the current definition of the delayed transfers of care metric together with the use of a range of other metrics relating to patient flow in hospital.
- c** Building on the initial work set out in this report, the Discharge Programme Board should coordinate work to fully understand the cost to hospitals of delayed patient discharge and the costs, where these fall on the public purse, of caring for these people in the community.
- d** Health and social care commissioners should incentivise known good practice (including the recently published NICE guideline) in patient flow and discharge planning and reduce, by targeted amounts, the number of older patients unnecessarily delayed in hospital. This should include use of the recently published Commissioning for Quality and Innovation (CQUIN) relating to discharged patients returning to their usual place of residence within seven days of admission.
- e** NHS England and NHS Improvement should seek to understand which contracting and payment mechanisms offer the best incentives for community health providers to increase activity when required.
- f** NHS England should evaluate the effectiveness of system resilience groups and consider how they can be strengthened to support whole-system strategic planning and ownership of the discharge process and fit clearly with other local networks and programmes.

- g** NHS England, working with local government, should set out how health and social care staff can better share information on the existing health and social care circumstances of older people in their care so they can take this fully into account when making decisions about admission, treatment, care and discharge.
- h** The Department and Health Education England, working with local government partners, should set out how they will support initiatives that improve the supply of care workers and hospital and community health staff, bearing in mind the local variability in staffing issues.