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BRIEFING PAPER

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Delayed transfers of care in the NHS

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A delayed transfer of care is where a patient is ready and safe to leave hospital care, but is unable to do so, and remains occupying a hospital bed.

In 2016/17 there were 2.3 million delayed transfer days in England, an average of around 6,200 per day. The average number of delayed days for 2016/17 was 25% higher than the previous year. It is estimated that delayed transfers cost NHS providers £173 million for the previous year, up 19% from 2015/16.

Much of this increase is attributed by commentators to pressures in social care related to, for example, patients waiting for a suitable home care package to be put in place or for a residential care home place to be found. Although the majority of delayed days are still attributable to the NHS, delays attributable to local authority social care have risen by 85% over the past two years.

Efforts made by the Government to reduce the number of delayed transfers of care focus largely around the Better Care Fund, a pooled budget between local authorities and the NHS to better integrate health and social care services.

As health is a devolved area, this briefing paper refers mostly to England. However, recent trends in Wales, Scotland and Northern Ireland are also examined, as well as local and regional performance in England.

1. Delayed transfers of care

1.1 Recent trends

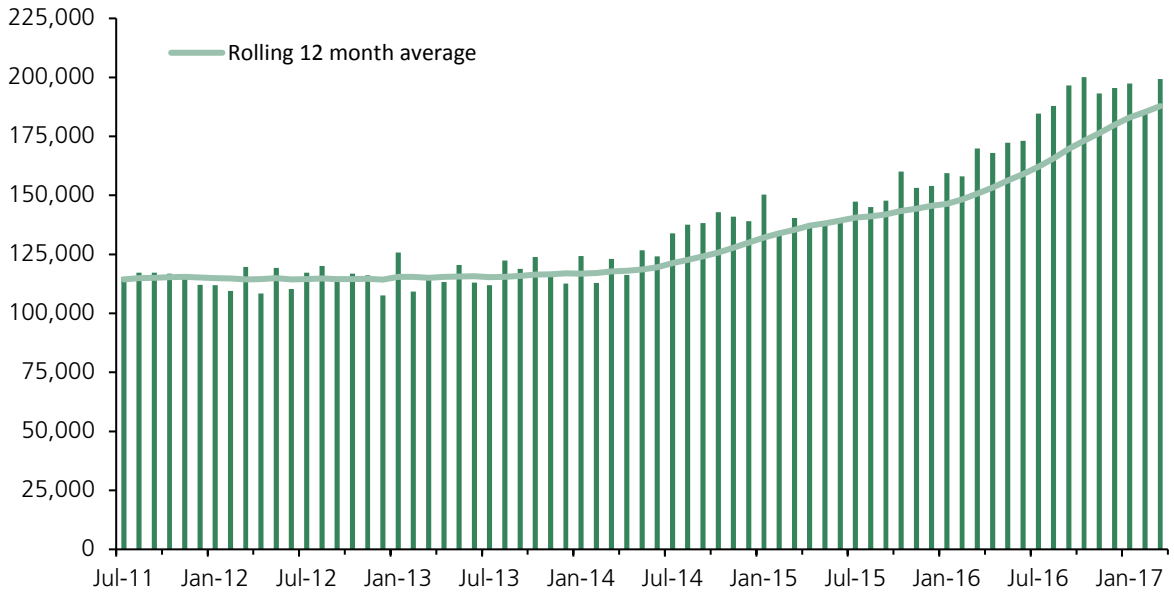
A delayed transfer of care occurs when a patient is ready and safe to depart from care and is still occupying a bed.

Delayed transfers of care, sometimes referred to as 'bed-blocking', occur when a patient is ready to depart from care and is still occupying a bed. According to NHS England, a patient is ready to depart when:

> a. A clinical decision has been made that patient is ready for transfer AND
>
> b. A multi-disciplinary team decision has been made that patient is ready for transfer, AND
>
> c. The patient is safe to discharge/transfer.[1]

In 2016/17 there were 2.3 million total delayed days in England with 1.3m of these attributable to the NHS, averaging around 6,200 delayed transfers of care per day with around 3,600 of these attributable to the NHS.

Chart 1: Monthly delayed transfers of care (days)



Source: NHS England

Chart 1 (above) shows the total number of delayed transfers of care days on a monthly basis in England. The 12 month average kept relatively consistent at around 115,000 until January 2014 when the total began to rise. The 12 month average for 2016/17 (188,000) is 25% higher than the 12 month average for 2015/16. The causes of this rise are further explored in section 2.

The Government's mandate to NHS England for 2017/18 set a target to reduce the national delayed transfers rate to 3.5% by September 2017.

[1] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

This is the proportion of available bed days lost to delayed transfers of care.[2]

The delayed transfers rate has not been below 3.5% since the fourth quarter of 2014/15. The most recent quarterly rate, for the fourth quarter of 2016/17, was 4.9%

Some commentators have questioned the quality of the recorded data on delayed transfers of care. In 2015, the King's Fund raised the following concerns:

> When we are considering delayed transfers of care we need to remember that there are some questions around the quality of the data, as we have previously argued. We aren't convinced that the reported numbers reflect the experience of delayed transfers across England. Currently, the data is only for patients aged over 18, it doesn't include acute-to-acute transfers and, following conversations with some NHS professionals, we feel there are variations in how local areas are reporting delays.[3]

In October 2015, NHS England published new delayed transfers of care guidance, including clearer definitions for NHS trusts to use when reporting figures.[4]

1.2 Risk to patients

Keeping patients in hospital longer than required can have a number of detrimental effects. Long stays can affect patient morale, mobility, and increase the risk of hospital-acquired infections.

Effects on mobility can be particularly felt by older patients. As Professor John Young noted in the *2014 National Audit of Intermediary Care*:

> A wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10% decline in muscle strength, hardly an advantage for people with frailty for whom muscle weakness is a defining characteristic.[5]

1.3 Cost to the NHS

Delayed transfers of care are also costly for hospital trusts. In addition to having to pay to provide places for patients who are ready to leave, these patients' presence can mean there are insufficient beds to carry out scheduled, elective procedures. Where insufficient beds mean elective procedures need to be cancelled, the hospital trust loses these as a source of income.

A survey of 50 NHS trusts by *The Guardian* in January 2015 found that at least 10% of beds were occupied by patients who were ready to be discharged. It also highlighted extreme examples, such as a patient at

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2 Department of Health, *The Government's mandate to NHS England for 2017-18*, March 2017, p20
3 The King's Fund, *Delayed transfers of care: join the queue*, 9 November 2015
4 NHS England, *Monthly Delayed Transfer of Care Situation Reports: Definitions and Guidance*, October 2015
5 NHS Benchmarking Network, *National Audit of Intermediate Care 2014 summary report*, November 2014

Addenbrooke's Hospital in Cambridge, who was still in hospital 72 days after being declared ready to be discharged.[6]

NHS providers' audited accounts for 2016/17 estimated that delayed transfers of care cost providers £173 million, up 19% from the 2015/16 estimate of £145 million. The NHS Improvement report on the audited accounts stated that the full cost associated with delayed transfers was likely to be much higher even than the NHS providers' estimated figure.[7]

1.4 Availability of hospital beds

Between 1987/88 and 2016/17, the average daily number of available hospital beds has reduced by 56% to 130,000. The largest reduction in bed numbers has been in specialist beds for people with learning disabilities, mental illness and for longer-term geriatric care. However, beds for general and acute hospital care have also declined by 43% over the period.[8]

The King's Fund's analysis of hospital bed data found that this reduction is part of a longer-term trend in England and in many other countries. Medical advances have reduced average patient length of stays, and there have been deliberate policy shifts towards treating and caring for patients outside of a hospital setting.[9]

As the table of European Economic Area countries shows (below), this trend is observable across Europe. Of the 22 countries that reported data for 2000 and 2014, only Poland and Norway saw an increase in the number of hospital beds per 1,000 population.

6 *The Guardian*, ''Bedblockers': the fit-to-leave patients deepening hospital crisis', 7 January 2015
7 NHS Improvement, *Performance of the NHS Provider Sector year ended 31 March 2017*, 16 June 2017
8 NHS England, *Bed Availability and Occupancy Data - Overnight*
9 The King's Fund, *The number of hospital beds*, 25 March 2015

	Hospital beds per 1,000 population, 2014	Percentage change on 2000
Austria	14.0	-9.1%
Belgium	13.6	-22.9%
Czech Republic	11.7	-20.6%
Denmark	5.3	-43.0%
Estonia	9.2	-33.1%
Finland	8.2	-34.2%
France	11.2	-20.5%
Germany	15.7	-7.8%
Greece	8.5	-11.2%
Hungary	12.2	-20.9%
Ireland	5.4	-47.8%
Lithuania	14.6	-18.8%
Latvia	10.3	-38.5%
Norway	8.4	+1.7%
Poland	12.2	+137.5%
Portugal	7.2	-11.5%
Slovakia	11.5	-24.1%
Slovenia	9.4	-17.2%
Spain	5.7	-19.9%
Sweden	5.3	-26.9%
Switzerland	9.3	-27.7%
United Kingdom	**5.5**	**-33.4%**

Source: OECD

It should be noted however, that even in the context of reducing numbers of hospital beds across Europe, only Sweden, Denmark and Ireland had a lower number of hospital beds than the UK relative to population in 2014. In addition, only Ireland, Denmark, Latvia and Finland saw the number of hospital beds fall by a larger percentage compared with 2000 figures.[10]

[10] OECD, *Hospital beds: Density per 1,000 population*, June 2014

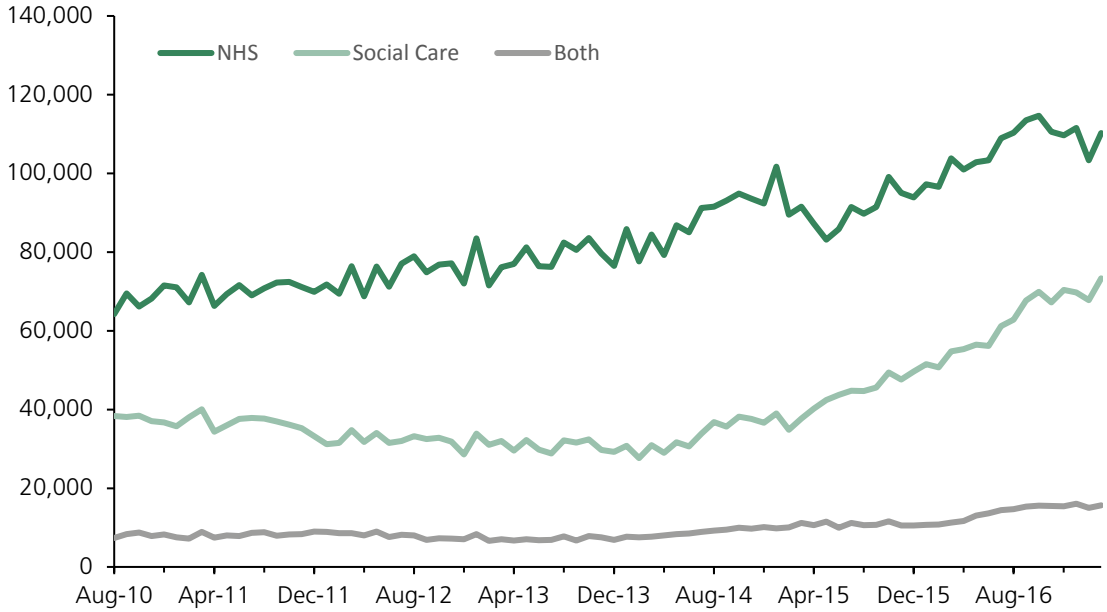
2. Causes of delayed transfers

Much of the recent debate around delayed transfers of care attributes rising numbers to pressures in social care. For example, in a July 2014 speech, the then Shadow Health Secretary Andy Burnham argued:

> Delayed discharges from hospital have hit record levels – up from 55,332 in August 2010 to 80,012 today.
>
> Why? Because of unsustainably severe cuts to social care.[11]

Chart 2 (below) shows the number of delayed days attributable to the NHS, local authority social care, or both. The number of days attributable to the NHS has risen relatively consistently since 2010, reaching a high point in October 2016.

Chart 2: Monthly delayed days by responsible organisation



Source: NHS England

The number of delayed days attributable to social care had been in decline until August 2013, after which the figure began to rise sharply. The total for 2016/17 is 38% higher than for 2015/16, and 85% higher than for 2014/15. A similar pattern can also be seen for delays attributable to both the NHS and social care.

When looking at the specific reasons for delayed transfers of care, notable increases in non-healthcare reasons over the past two years can be identified.

[11] *Labour Press*, 'The choice on the NHS – Andy Burnham speech', 29 July 2014

Table 1: Reasons for delayed transfers of care, 2016/17

Reason for delay	Total delayed days	Change from previous year
Awaiting care package in own home	456,447	+45.3%
Awaiting further non-acute NHS care	386,028	+16.8%
Awaiting completion of assessment	380,832	+22.9%
Awaiting nursing home placement or availability	342,982	+39.6%
Patient or family choice	245,033	+5.8%
Awaiting residential home placement or availability	231,994	+22.9%
Awaiting public funding	81,327	+17.5%
Housing – patients not covered by NHS and Community Care Act	52,431	-1.0%
Awaiting community equipment and adaptations	52,121	+12.8%
Disputes	24,641	+18.9%

NHS England's delayed transfers of care figures for the past year (above table) show a marked rise in delays due to 'awaiting a care package in own home', up 45.3% in comparison with the previous year. There have also been increases of over 10% for 'awaiting completion of assessment', 'awaiting nursing home placement or availability', 'awaiting residential home placement or availability', 'awaiting public funding', and 'awaiting community equipment and adaptations'.

This rise in delays attributable to these categories seem to support the argument that the social care system is largely responsible for recent growth in delayed transfers of care, and is likely behind the growth in the last two years of delays attributable to local authorities.

It is important, however, to note that delays in these categories can be attributable either to local authority social services *or* to the NHS. For example, if a care package involves the services of a district nurse or physiotherapist, who is not in place when a patient is ready to be discharged, this delay is the responsibility of the NHS, not of social care. In 2016/17, 25% of care package delays were attributed to the NHS.

A 2014 report by Age UK also reported that social care-related delays were seeing patients experiencing longer waits than in previous years:

> Patients waiting to be transferred to a residential home in 2013/14 wait an average of 30 days, while someone who needs grab rails or ramps fitted at home waits 27.3 days - 11.5% longer than in 2010.

> People waiting for a social care package to be put together before they can go home are having to wait an average 28.6 days in total, 5% longer than in 2010.[12]

In its 2016 report on discharging older people from hospitals, the Public Accounts Committee found that NHS England had serious concerns about the impact of social care services on attempts to reduce the number of delayed transfers of care:

> NHS England believes the increasing pressure on adult social services will prevent significant progress being made in reducing the number of delayed discharges over the next five years. Local authority spending on adult social services has fallen by 10% in real terms between 2009–10 and 2014–15. This is putting pressure on local authorities to reduce fees which in turn puts pressure on care providers. The introduction of the national living wage is adding further to this pressure. Most home care and residential/nursing home care is provided by private sector organisations who face significant issues with the recruitment and retention of home care workers and nurses in nursing homes, depending on other factors such as local employment markets and whether there is full employment. In some areas care providers are charging higher prices to people funding their own care compared to local authorities who benefit from bulk discounts.[13]

Although much of the recent *rise* in the number of delayed transfers can be attributed to social care, the majority of delayed transfers overall for 2016/17 (57.7%) were attributable solely to the NHS.

Nigel Edwards, Chief Executive of the Nuffield Trust, cautioned against attributing responsibility solely to social care in a 2017 briefing on delayed transfers of care:

> We need to beware a narrative that fixing social care will fix the problems of the NHS. It won't, but it would help. Secondly, it cannot be assumed that alternatives to hospital will save large amounts of money unless far more radical changes to the system are made.[14]

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12 Age UK, *Nearly 2m NHS days lost from delayed discharge*, 11 June 2014
13 Committee of Public Accounts, *Discharging older people from acute hospitals*, 22 July 2016, HC 76 2016-17, conclusion 3
14 Nuffield Trust, *What's behind delayed transfers of care?*, February 2017

3. Reducing delayed transfers

3.1 Better Care Fund

The Better Care Fund (BCF) is the Government's primary funding mechanism specifically for the integration of health and social care. It was first announced in the 2013 Spending Round, with the aim of "delivering better, more joined-up services to older and disabled people, to keep them out of hospital and to avoid long hospital stays."[15]

The BCF is a pooled budget between the NHS and local authorities, which is intended to shift resources away from hospital care and towards care in the community and at home.

£3.9 billion was the minimum amount initially to be pooled for the 2016/17 BCF, with local areas able to pool more than their allocations should they so choose. As a result of additional pooling, the total BCF for 2016/17 was £5.8 billion. For 2017/18, the minimum mandatory amount for pooling is £5.1 billion.

It is hoped that better integration of health and social care will mean fewer delayed transfers of care. One of the four national BCF conditions for 2017-19 is 'managing transfers of care', requiring local partners to agree a joint approach to funding, implementing and monitoring local plans.[16] The BCF is seen as a key tool in reaching the delayed transfer target rate of 3.5%, as set out in the Government mandate to the NHS for 2017/18.

The *2015 Spending Review and Autumn Statement* announced an increase to the BCF of £1.5bn by 2019-20. It also set out plans to integrate health and social care across the country by 2020, with a requirement for areas to have a plan in place for this by 2017.[17]

More information on the Better Care Fund can be found in the Commons Library briefing paper, *Health and Social Care Integration*.

3.2 Delayed discharge payments

Legislation has been in force since the passing of the *Community Care (Delayed Discharges etc.) Act 2003* to counter delayed transfers of care as a result of local authority care provisions not being in place. The 2003 Act was updated by the *Care Act 2014*.

Under the 2014 Act, the NHS is required to notify relevant local authorities of a patient's likely care and support needs, where the patient is unlikely to be safely discharged from hospital without arrangements for such support being put in place first. This is referred to as an assessment notice.

The NHS must also give local authorities at least 24 hours' notice of its intention to discharge the patient, referred to as a discharge notice.

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15 HM Treasury, *Spending Round 2013*, Cm 8639, June 2013, para 1.30
16 Department of Health & Department for Communities and Local Government, *2017-19 Integration and Better Care Fund Policy Framework*, March 2017, Annex A
17 HM Treasury, *Spending Review and Autumn Statement 2015*, November 2015

Once an assessment and a discharge notice have been received, and a local authority does not carry out an assessment or put in measures to meet a patient's care and support needs, the NHS body can claim reimbursement for each day a patient's discharge is delayed. [18]

This reimbursement can only be claimed if this is the sole reason for a delayed transfer of care. The rate of reimbursement is currently £155 per day in London or £130 elsewhere.[19]

[18] *Care Act 2014*, Schedule 3, paragraph 4
[19] *The Care and Support (Discharge of Hospital Patients) Regulations 2014*

4. Regional performance

In 2013, the King's Fund reported that NHS finance directors felt that numbers had been increasing in comparison with the previous year. This was prior to the significant increase in the reported number of delayed transfers of care (see sections 2 and 3).

The King's Fund proposed that this difference between perceptions of rising numbers of delayed days and the national statistics was due to varying local situations, with rising numbers of delays in some areas and not others.[20]

NHS England reports delayed transfers of care statistics by local authority and by NHS trust, allowing for analysis of local performance.

4.1 Local authorities

The table below shows the top and bottom 10 local authorities in terms of total delayed transfers of care, attributable to social care or to both NHS and social care.

Total delayed transfers of care (days), 2016/17 Delays attributable to social care or NHS and social care			
City Of London	76	Hampshire	55,131
Peterborough	118	Cumbria	38,336
Rutland	197	Birmingham	37,014
Darlington	200	Northamptonshire	26,705
Newcastle Upon Tyne	345	Essex	25,968
North Tyneside	406	Cornwall	24,211
Sunderland	461	Staffordshire	24,163
Barnsley	605	Oxfordshire	22,880
Wakefield	609	Suffolk	22,562
Rochdale	715	Kent	21,671

One problem with this metric as a measure of performance is that it is affected by the population size of a local authority. Looking instead at the number of delayed days per 100,000 population is a better comparative measure as to how local authorities are performing.[21]

[20] The King's Fund, *Are delayed transfers a growing problem?*, 14 February 2013
[21] Population data taken from NOMIS, *Population estimates – local authority based by single year of age*, 2015

Total delayed transfers of care (days) per 100,000 population, 2016/17			
Delays attributable to social care or NHS and social care			
Peterborough	61	Cumbria	7,698
Newcastle Upon Tyne	118	Trafford	5,114
Sunderland	166	Southampton	4,429
Wakefield	182	Cornwall	4,407
Darlington	190	Stockport	4,139
North Tyneside	200	Hampshire	4,075
County Durham	226	Tameside	4,061
Newham	245	Somerset	3,870
Barnsley	253	Northamptonshire	3,694
Northumberland	274	Stoke-on-Trent	3,483

Five of the best performing ten local authorities in 2016/17 were in the North East, although there are no other clear regional patterns visible in the above table. The performance of North East local authorities is apparent in chart 3 (below), which looks at regional data. The worst performing region, the West Midlands, has over four times as many delayed days attributable to social care (or NHS and social care) as the North East.

Chart 3: Total delayed transfers of care (days) per 100,000 population, 2016/17

Source: NHS England; NOMIS 2015 population estimates

4.2 NHS Trusts

Data for NHS trusts cannot be analysed in the same way, as some trusts do not submit data month-to-month. In addition, there have been a number of mergers of NHS trusts over the time period, so it is not possible to compare like with like for the previous two years.

It is, however, possible to look at the most recent figures for March 2017. For this month, there were 17 NHS trusts with no delayed transfers of care attributable to the NHS or both the NHS and social

care. The 10 trusts with the highest numbers of delayed transfers are set out in the table below.

NHS Trusts with the highest total delayed transfers of care, March 2017	
Sheffield Teaching Hospitals NHS Foundation Trust	3,658
Oxford University Hospitals NHS Foundation Trust	3,384
University Hospitals Of North Midlands NHS Trust	2,130
University Hospitals Coventry And Warwickshire NHS Trust	2,077
Royal Devon And Exeter NHS Foundation Trust	2,071
Brighton And Sussex University Hospitals NHS Trust	1,983
Kettering General Hospital NHS Foundation Trust	1,943
University Hospital Southampton NHS Foundation Trust	1,860
Frimley Health NHS Foundation Trust	1,754
Gloucestershire Hospitals NHS Foundation Trust	1,714

As with local authorities, it should be noted that number of total delayed days will be affected to some extent by the size of the NHS trust, and it has limitations, therefore, as a measure of relative performance.

4.3 Local variation

Variation between local areas was highlighted as a key area of concern in the 2016 Public Accounts Committee's report on discharging older people from hospitals:

> There is unacceptable variation in local performance on discharging older patients. As an indication of the variation across different areas, for the hospitals within the Committee member's constituencies, the number of officially recorded delayed transfers of care in 2015–16 ranged from 10 days in Northumbria to nearly 18,000 days in Lincolnshire. The Department agrees that there is unacceptable variation in the performance of local areas on discharge delays. It told us that there are 65 local authority areas (out of 152) whose current levels of delay have improved from their levels of two years ago. Out of the remaining 87, there are also 22 areas with rates of delay that are at least three times worse than the group of 65 authorities which have improved.[22]

To help improve the performance of some of the worst local areas for delayed transfers of care, the Chancellor, Philip Hammond, announced additional targeted funding in his Spring Budget 2017 speech:

> While there are many excellent examples of best practice around the country, at the other end of the scale, just 24 local authorities are responsible for over half of all delayed discharges to social care.
>
> So, alongside additional funding, the Health and Communities Secretaries will announce measures to identify and support authorities which are struggling, and to ensure more joined up working with the NHS.[23]

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22 Committee of Public Accounts, *Discharging older people from acute hospitals*, 22 July 2016, HC 76 2016-17, conclusion 2

23 HM Treasury, *Spring Budget 2017: Philip Hammond's speech*, March 2017

5. Devolved nations

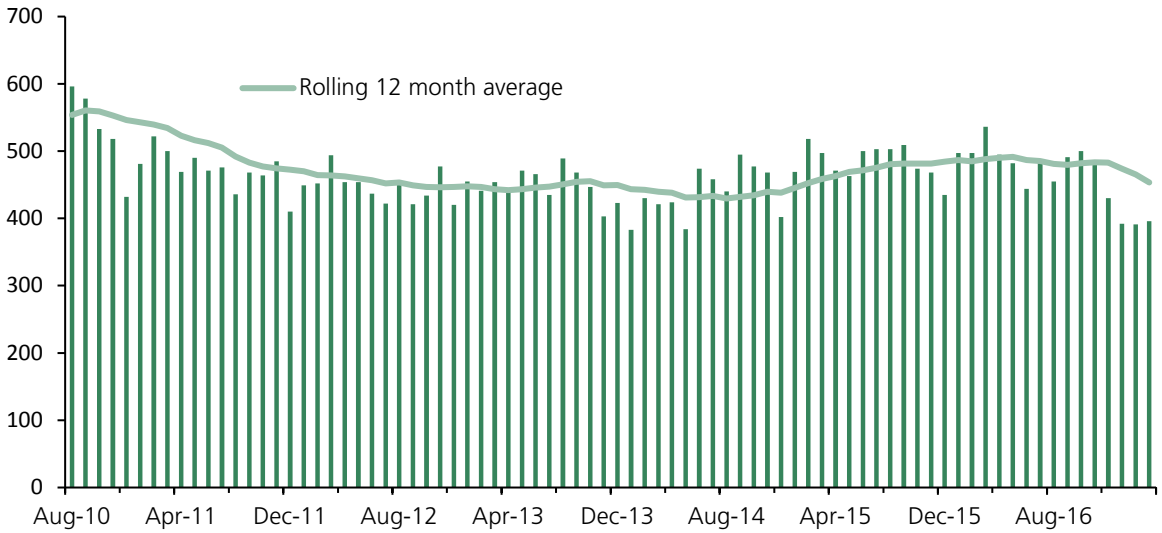
The devolved nature of the NHS in the UK means there are different challenges facing each nation regarding delayed transfers of care. This section sets out some of the trends in each country.

It should be noted, however, that figures between nations are not directly comparable due to differences in definitions and differences in data reporting.

5.1 Wales

The data for Wales looks at number of people experiencing delayed transfers of care in a month, rather than the number of delayed days. This method does not differentiate between delays of a day and much longer delays.

Chart 4: Number of people experiencing delayed transfers of care, monthly



Source: StatWales

Total delayed transfers had been in decline in Wales from the mid-2000s until around 2011, from which point numbers remained relatively consistent. The total for 2016/17 (5,443) is the lowest annual figure since 2013/14, and the quarterly figure for Q4 2016/17 is the lowest quarterly figure on record.

In terms of causes, the most significant increase has been for reasons of selection of care home, which rose by 13.9% in 2016/17 compared with the previous year.[24] The most significant decrease has been for 'all healthcare' reasons, which saw a fall of 21.1%.

[24] There was a larger increase (50%) in 'principal reason not agreed'. However this has been excluded due to the small numbers involved.

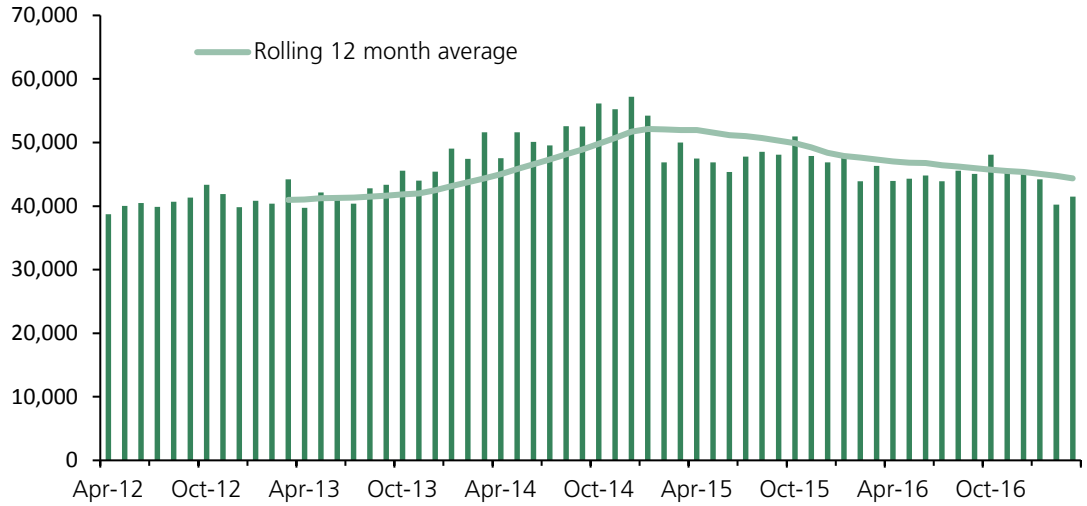
5.2 Scotland

Data for NHS Scotland looks at delayed discharges from acute hospital settings, not delayed transfers of care. This is significant as it means delay reasons such as awaiting further non-acute NHS care - the second largest reason in England - will not be counted as a patient is not being discharged from hospital.

Chart 5 (below), shows that the number of delayed discharge days was rising until the end of 2014, and thereafter began to decline. The figure of delayed discharge days for 2016/17 (532,000) was 6% lower than the previous year, and the lowest annual figure since 2012/13.

Legislation introduced in 2014- the *Public Bodies (Joint Working) (Scotland) Act*, requiring health boards and local authorities to integrate - came fully into force in April 2016. This duty of integration may be partially responsible for the fall in delayed discharges since 2014.

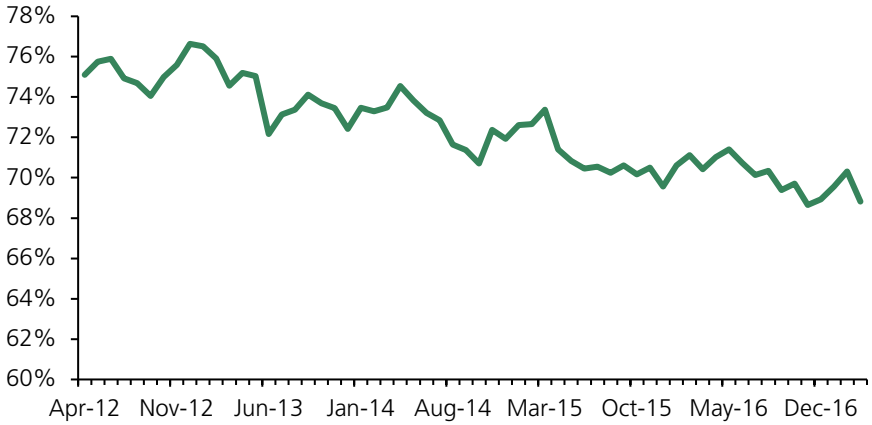
Chart 5: Monthly delayed discharges (days)



Source: ISD Scotland

Chart 6 (below) shows the proportion of delayed discharges experienced by those aged over 75. This age group has consistently experienced the majority of delayed discharges, although the proportion has been steadily decreasing since 2012/13. In that year, those over 75 experienced 75.4% of delayed discharges, and by 2016/17 the figure was down to 69.9%.

Chart 6: % delayed discharges (days) experienced by patients aged 75+



A new method of recording reasons for delays was implemented in July 2016. Between July 2016 and March 2017, 36.7% of patients experienced delays whilst awaiting completion of care arrangements, and 24.0% whilst awaiting care place availability.

5.3 Northern Ireland

There is no regularly published data related to delayed transfers of care in Northern Ireland.

A 2011 report by the Joint Improvement team, a partnership including the Scottish Government, NHS Scotland and the Convention of Scottish Local Authorities, published a report into the integration of health and social care. The report highlighted the positive example of Northern Ireland's integrated health and social care system to better manage delayed discharges:

> Performance in Northern Ireland has often been held up as exemplary. A member of the group visited Belfast to discuss the issues with them. While there is much to admire – and a single, unified health and social care system might help alleviate many of the issues – it is again difficult to make comparisons because of the different data collected. In Northern Ireland delays are only counted from acute hospitals, indeed a list of only 17 hospitals. Mental health and learning disability specialties are excluded.
>
> However, there are very tight targets to be achieved.
>
> - 90% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support.
>
> A discharge is defined as complex when it can only take place following the implementation of significant (7 hours +) home based or other community based service (including residential or nursing home services).
>
> - All other patients will be discharged from hospital within six hours of being declared medically fit.

> This includes all patients involving reactivation of an existing care package, the need for non-complex care packages, or equipment provision.
>
> These targets are generally achieved with a compliance rate of around 95%. However, most patients are transferred to intermediate care beds or post-acute settings at which point there is no on-going data collected on the patients. In other words the vast majority of delays in Scotland would not be registered in Northern Ireland.[25]

A 2013 report by the King's Fund also argued that the integrated Northern Irish system provided real benefits in managing delayed discharges from hospital.[26] However, a 2016 NI Audit Office report found that delayed discharges were still a significant problem:

> While we found positive examples of integration between health and social care services in their approach to emergency care, significant obstacles still impede a truly joined-up approach to avoiding unnecessary hospital admissions and facilitating timely discharges. We found that many patients who are ready to be discharged remain in hospital because of difficulties at the interface between health and social care organisations.[27]

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25 Joint Improvement Team, *Delayed Discharge – Report of the Expert Group*, 2011

26 The King's Fund, *Integrated care in Northern Ireland, Scotland and Wales: Lessons for England*, July 2013, p16

27 Northern Ireland Audit Office, *Managing Emergency Hospital Admissions*, November 2016, para 4.19

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