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Delayed transfers of older people from hospital: causes and policy implications

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Abstract

Health and social care agencies in the U.K. have been under pressure for some time to reduce delayed transfers of older people from hospital because they absorb scarce health service resources and incur a human cost through inappropriate placement. A local study based on an analysis of records and interviews with managers showed that delays reflect the complex needs of older people, and arise from financing and organisational problems at both the planning and implementation stages of a discharge. Family resistance may also be a factor. Budgetary constraints result in delays in confirming public support for some clients. Shortages of professional staff and care assistants limit the provision of domiciliary packages. The contraction of the residential sector has reduced the availability of beds and increased the cost of care home placements. Scope exists for expediting administrative aspects of transfers by coordinating health and social services. More recent legislation that imposes fines on social service departments for delayed transfers does not address underlying causes.

(163 words)

Key words Older people. Delayed transfers. Domiciliary care. Residential care.

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1. Introduction

The concept of delayed transfer from hospital has received wide attention in the UK. It refers to the situation where patients deemed to be medically well enough for discharge are unable to leave because arrangements for the continuing care they need have not been finalised [1]. Delayed transfers are particularly associated with older patients with complex needs. It has been estimated that delays in this group cost the British National Health Service (NHS) about £170 million (225 million Euros) a year, the equivalent of 1.7 million hospital beds. Over a third of people affected have delays of more than one month [2]. With rising demand for hospital care alongside a declining number of beds, (as exemplified by lengthy waiting lists for elective surgery), there is strong pressure to increase patient throughput by eliminating delayed transfers. Moreover, there are compelling health reasons for seeking to reduce unnecessary extensions to hospital stays. There is evidence that older people remaining in hospital are both less likely to gain further independence and are more vulnerable to hospital borne infections [3]. The problem of delayed transfers is not confined to the UK but is also encountered in other countries, including Israel, Sweden, Norway, New Zealand and the USA [4].

In the UK, care of older people involves primary and secondary health services, which are provided free at the point of delivery, and social services, which are available dependent upon assessed need and subsidised according to a client's ability to pay. Patients can only be discharged from hospital when appropriate care packages have been agreed by all involved. This means gaining approval of medical and social service professionals, the patient and his/her significant others. Two thirds of social services spending is used to fund care for infirm people over 75 years of age either in residential settings or in their own home. Most of this care is provided by a plethora of independent small or medium sized care homes, or by care agencies who recruit nurses and assistants to deliver home-based health and personal services. Both care homes and domiciliary agencies must register with

the National Care Standards Authority and submit to annual inspections for quality assurance purposes.

In circumstances where patients are assessed to require continuing health and social care after discharge from hospital, several procedures must be completed in order to effect their transfer, and delays may arise at each stage. First, patients' physical and psychological needs must be assessed in relation to their domestic circumstances by healthcare professionals (primarily occupational therapists and psychiatric nurses) in order to determine whether home care is feasible from a medical perspective, and, if so, what aids and adaptations are required, or whether long term residential care is indicated. Some patients may be deemed in need of specialised health care, for example, for continuing rehabilitation after stroke, in which case residential care in appropriate NHS facilities may be recommended or a day hospital placement may be sought. Second, social care needs for personal care and household tasks must be assessed by care managers. This process involves both consideration of the availability of informal care by family and friends and patients' financial circumstances, and hence their eligibility for public support.

Once decisions on destination and support have been made, appropriate domiciliary or long term care providers must be found, in accordance with the client's individual needs and preferences and available resources. Delays can occur at this stage because desired placements or domiciliary care services are not available, or because necessary equipment cannot be provided to enable transfer home. Family issues can cause further delays at any point in the process, for example if a patient or their close relatives reject the outcome of the care plan, or if disagreements arise about the best care strategy. When older people are mentally infirm, delays also occur pending court protection orders that enable care managers to act on behalf of their clients.

National level analyses of delayed transfers have identified broad causes of the problem [5]. They mainly attribute delays to the problems of coordinating actions between health and social care agencies. Concerns have been expressed, however, about the unreliability of data at this aggregated level [1,4,5]. We used local databases to explore the nature and extent of delayed transfers of older people in one primary care trust area (an administrative area for the provision of primary health and social services) in south-east England. The objective of the study was to provide a detailed analysis of local conditions to inform workforce planning and service development in such a way that the delayed transfer problem could be addressed. To this end we sought to identify bottlenecks in the discharge system through a review of case records, and to compare the findings from this exercise with the perceptions of health and social care managers working in the field.

2. Method

The research was undertaken with the full cooperation of the primary health care trust and local social services departments. At the time of the study, they compiled joint lists on a weekly basis of the individuals who have been declared medically fit for discharge but remain hospitalised pending agreement from all parties regarding their transfer. This record was analysed over a 12 month period starting April 2001. It confirmed that delayed transfers were a continuing problem, but it gave no information about the causes. Detailed data covering two separate weeks were therefore obtained from patient records and analysed in order to investigate the underlying factors. The first sample week was randomly selected amongst weeks with approximately average numbers of patients experiencing delay. A second week was chosen from two that had unusually high levels of delay. Neither week coincided with the period when winter weather problems might be expected to affect hospitalisation. Data were extracted from patient files by an independent researcher and verified by a second. Information was recorded on a specially prepared and piloted pro-forma that was structured around the stages in the discharge process.

As background to the study of delayed transfers, population demographics, the number of older people (over 65 years), and hospitalisation records were analysed. In addition, qualitative data was collected through interviews with key informants. Operational issues were discussed with six middle level managers, three from each of health and social services. A semi-structured interview schedule was devised that asked respondents about service delivery issues in the context of delayed transfers. Data analysis involved triangulation across all sources to gain a full appreciation of underlying factors. Service users' perspectives were obtained from a local officer of Age Concern, which is a advocacy agency that represents the views of older people and their families.

3. Results

The study area had a population of 289,200 at the time of the analysis, with 46,272 (16%) of residents over the age of 65. Data on hospital admissions over the twelve month study period showed that 8,645 people over the age of 65 (18.7%) had attended hospital, 39% for day care, 28% for elective surgery, 30% as emergency admissions, 24% for other reasons. An estimated 7-10% of people using hospital services were already receiving care from social services. Approximately 2% of older people died during their hospital stay. Of those discharged, 83% returned to their original place of residence, 3% moved to other NHS facilities, and 14% went elsewhere (intermediate care, relatives or long term residential care).

A total of 125 people across the two study weeks were experiencing delays in transfer from hospital. The number of people affected by delays at each stage of the discharge process and the total and mean number of days these individuals had already been waiting for discharge are shown in Table 1 for each of the selected study weeks. The data are cross sectional and record discharge episodes in process, and the extent to which individual

clients may experience delays at more than one stage before the process is completed is not indicated. Inspection of the table shows similar patterns of delays across both the randomly selected “typical” week (Week 1) and the week with the unusually high number of delayed clients (Week 2).

Table 1 goes here

Causes of delays in the discharge process involving fewer than three clients in either study week were at the stage of health assessment (of all types), care manager assessments and provision of home aids and adaptations. Small numbers of clients were also delayed due to disputes over care plans and legal proceedings. The numbers of people experiencing delays for a particular reason is, however, not always a good guide to the significance of that factor because in some cases the average duration of delays could be lengthy, for example, clients who were in dispute about their care plans experienced mean delays of over 70 days.

The overall mean length of delay already experienced by clients at the time of the investigation was over four weeks (29 days). Mean delays of 21 or more days occurred in at least one of the study weeks at all stages of the discharge process except the care managers assessment, the installation of aids and adaptations in clients’ homes, and the assessment by domiciliary providers which is conducted in advance of agreeing the contract with social services.

Stages incurring the most serious delays were identified as those where three or more clients experienced delays of 21 or more days in either study week. Five stages met this criteria and together accounted for 3170 of 4029 (78.7%) of all days of delay across 97 of the 125 clients (77.6%). These stages and the number of people affected (mean number of days delayed) were:

- awaiting decision about social service funding, 37 people (40.7 days);
- seeking of care home placement: by social services, 14 people (37.4 days) or privately, 15 people (20.1 days);
- family delays, 14 people (27.8 days);
- domiciliary care unavailable, 8 people (29.3 days);
- no sub-acute NHS bed, 9 people (23.7 days).

Factors associated with delayed transfers that were raised by health and social care managers during interviews are shown in Table 2. The reasons most frequently perceived related to the availability of adequately trained home care assistants. There was also agreement amongst managers that major barriers were: shortages of health and social care professionals, including lack of provision of round-the–clock professional and care worker support for people returning to their own homes; funding limitations, both inadequate resources at the disposal of social services to provide domiciliary care, and the high cost of residential placements; and confusion of responsibilities between health and social care agencies giving rise to poor coordination. One manager from each of health and social services questioned the need for the multiple assessments undertaken by different professionals. Two managers thought provision of aids and adaptations in clients' homes was a source of delay, although this was not one of the more important reasons emerging from the record reviews.

Table 2 goes here

Family factors did not feature strongly in managers' views about the causes of delayed transfers although they appeared important in the quantitative analysis. Care managers raised the possibility that transfers home are delayed because of inadequate provision of support from informal (family) carers. The main issues raised during the interview with the

representative of Age Concern were the problems faced by older people in carer roles and the need to protect individuals' rights to choose.

4. Discussion

The process by which health and social care services are organised to support people with complex needs when they are discharged from hospital into the community involves a number of different stages, professionals and agencies. This study investigated the reasons for delays in this process in one district in England. Case records showed delays could occur at any stage in the discharge process but that the main bottlenecks were associated with gaining approval for public financing of social care services, securing placements in residential care homes, resolving family disputes over possible arrangements and arranging both NHS sub-acute beds or domiciliary care assistance. The sheer complexity and bureaucracy involved in the discharge process is an overriding concern and an important contributory factor to delays that occur. Significant benefits would arise from streamlining arrangements in terms of both reducing anxiety for people affected and their families and freeing up scarce hospital resources for other patients awaiting treatment.

The subjective perceptions of health and social care managers about the factors contributing to delayed transfers were largely in agreement with the objective data collected from patients' records. Managers emphasised problems with domiciliary care provision, including cover during nights and weekends, coordination problems between agencies and duplication of assessments. They also mentioned inadequate social service funding to meet client needs in the community as an important barrier. The records analysis showed waits in decisions regarding social service funding as the single most important reason for delays in discharge. It is likely that this is another manifestation of the shortage of financing mentioned by managers. Social services have fixed amounts of money that they apportion

on a monthly basis. Delays in approval of financing for eligible individuals tend to increase at times when pressure is placed on funds by rising numbers of claimants. At another level, concern exists that eligibility criteria differ between local authorities [6], and this is an issue that proposed reforms will seek to address [7].

Workforce issues were the basis of some of the systemic problems and capacity constraints that were observed. A national shortage of nurses and allied health professionals is well recognised [1] and resulted locally in delayed health assessments prior to discharge or insufficient community resources to support infirm older people in the community. In addition, a shortage of care assistants in the study area was an important cause of delayed transfer to domiciliary care. This may, however, be a local difficulty, and, in other parts of the country where the cost of living is lower, unemployment is higher and the population is less dispersed, care assistant positions may be easier to fill. More general concerns exist, however, over the training and skill levels of care workers. An area for cost-effective workforce development that has been recognised nationally is at the level of care assistants. Potential benefits may arise from workforce plans that identify new roles for care assistants within innovative service configurations and that provide an attractive career structure for care workers [8]. Increases in the numbers of such workers, and extensions to their areas of competency are viewed as means to release professional staff time and reduce constraints on the delivery of domiciliary care packages. Such developments are within the scope of the NHS Career Framework [9] which envisages specialist care assistant roles being developed.

Whilst staffing problems are also a continuing challenge for care home managers, delays in the placement of older people into long term residential care reflect the steady decline in the sector over the last decade [10] and the absence of vacancies at prices that either social service departments or private individuals are able to afford. Care home closures in the last decade have resulted from inadequate fee levels paid by local authorities and cost

pressures due to the national minimum wage and new regulations concerning quality standards of care [10]. In a tight market situation with small margins, it is unrealistic to presume that residential homes can afford to keep empty beds. Greater reliance on block (volume) contracts (rather than spot contracts) between social services and care homes could generate economies of scale and reduce some uncertainties for providers. However, they increase risks associated with variations in costs of care of clients, and they also reduce choice for patients themselves [11,12,13].

Transfer to long term residential care is a big life change for many older people and their families. From their perspectives, therefore, delays may provide much needed time to adjust to their changing circumstances, which have often been precipitated by a crisis admission to hospital. The importance of engaging relatives early in the care and discharge planning process is widely recognised amongst professionals [5]. In reality, however, practical and psychological considerations can mean that major changes cannot be speedily accepted by the people involved. A balance needs to be struck between reasonable delay from the point of view of clients, and unnecessary delays that impede access of others to acute hospital beds.

Since this study was undertaken, the government's assault on the problem of delayed transfers has intensified. In January 2004, new legislation came into effect that imposed fines of £120 (160 Euros) per day on social service departments which are unable to orchestrate discharge packages within 48 hours of an older person being declared fit to leave an NHS facility. Concerns have been expressed that this could reduce users' ability to exercise their right to choose their onward care [14], and these were echoed by Age Concern.

Long term initiatives envisaged by the NHS Plan [15] and the National Service Framework for Older People [16] are means by which the new legislative requirement can be met.

Intermediate care, or ‘step-down’ facilities provide temporary assistance to patients to bridge the gap between hospital and long term placement in users’ own homes, or in residential care. Nationally and locally there are examples of novel means to expedite transfers from hospital through hospital-at-home schemes, short term care home placements or dedicated multi-disciplinary community teams for particular groups of patients such as people who have suffered a stroke [17,18]. Such schemes can give patients and their families time to exercise informed choice about their future living arrangements.

Effective planning across health and social services is essential to ensure that human resources are used maximum benefit. Measures to facilitate joint working across health and social care agencies had been introduced by the National Plan [15] and became effective just prior to this study. Local difficulties encountered in adjusting to the new environment of cooperation were identified by both the case reviews and the managers and have also been documented by other investigators [19]. Recent public policy initiatives have continued to address organisational issues at the interface health and social care in order to foster more coordinated service delivery for older people with complex needs [7]. More recent proposals include single assessments, and local joint professional teams to coordinate person-centred care packages. No extra social care resources are incorporated in the emerging policy proposals, however, even though population projections indicate continuing increases in the number of people over the age of 65 years, and rising proportions of the oldest old (over 85 years) [10]. Instead it is expected that efficiency savings will have a positive impact on local service provision and that existing national policy initiatives will address problems with recruitment and retention of the healthcare workforce in the context of the expansion of the NHS [20].

This study has several limitations. The data on causes of delay were cross sectional, providing a snapshot of barriers at the time of the analysis. Longitudinal data collected by

observing patient journeys could have added an extra dimension but could not have been easily gathered because records were kept in several different places and coded by different criteria. Problems exhibited in the study area may not be generalisable to other parts of England, or to health care systems in other countries. This consideration, however, validates the purpose and methodology of this study which was to use local analyses to inform service development and planning in the study area. The work was impeded by the limited extent of local databases and record keeping which prevented more detailed analysis of the extent and nature of the varied issues that lay behind delays at different stages of the transfer process. Full understanding of local issues in the context of the complex needs of other people is required for effective planning and will only be possible with the development of robust databases [21], including outcomes information so that service development initiatives and new workforce configurations can be evaluated.

(3,320 words)

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Table 1: Extent and reasons for delayed transfer from hospital of people aged >65 years in two sample weeks from client records

Reasons for delayed transfer from hospital	Week 1: Number of people delayed (%of total)		Week 1: Total number of days of delay (%of total)		Week 1: Mean number of days of delay	Week 2: Number of people delayed (%of total)		Week 2: Total number of days of delay (%of total)		Week 2: Mean number of days of delay
Health assessment delays in hospital:										
Await occupational therapy assessment	1	(1.9)	21	(1.4)	21.0	1	(1.4)	21	(0.8)	21.0
Await health needs assessment (medical)	1	(1.9)	13	(0.9)	13.0	2	(2.7)	77	(3.1)	38.5
Await psychiatric assessment	1	(1.9)	21	(1.4)	21.0	0	(0)	0	(0)	0
Total	**3**	**(5.8)**	**55**	**(3.7)**	**18.3**	**3**	**(4.1)**	**98**	**(3.9)**	32.7
Social Service assessment delays in hospital:										
Await care manager assessment of care needs and financial eligibility	3	(5.8)	13	(0.9)	6.6	0	(0)	0	(0)	0
Await decision regarding funding eligibility	11	(21.2)	584	(38.9)	53.1	26	(35.6)	921	(35.6)	35.0
Total	**14**	**(26.9)**	**604**	**(40.2)**	**43.1**	**26**	**(35.6)**	**921**	**(35.6)**	**35.0**
Delays in activating domiciliary care:										
Await aids and adaptations in home	1	(1.9)	6	(0.4)	6.0	2	(2.7)	26	(0.1)	13.0
Await domiciliary service provider assessment	7	(13.5)	123	(8.2)	17.6	0	(0)	0	(0)	0
Domiciliary care hours unavailable	3	(5.8)	133	(8.8)	44.3	5	(6.8)	102	(4.0)	20.4
No day centre place available, eg for rehabilitation as part of the domiciliary package	2	(3.8)	112	(7.5)	56.0	3	(4.1)	178	(7.1)	59.3
Total	**13**	**(25.0)**	**374**	**(24.9)**	**28.8**	**10**	**(13.7)**	**306**	**(12.1)**	**30.6**
Delays in activating residential care:										
Social services funding agreed, seeking placement	4	(7.6)	82	(5.5)	20.5	10	(13.7)	442	(17.5)	44.2
Private funding, seeking placement	6	(11.5)	74	(4.9)	12.3	9	(12.3)	228	(9.0)	25.3
Total	**10**	**(19.2)**	**156**	**(10.4)**	**15.6**	**19**	**(26.0)**	**670**	**(26.5)**	**35.3**
Delays in activating NHS care:										
No NHS bed available, eg in rehabilitation unit	3	(5.8)	55	(3.7)	18.3	6	(8.2)	159	(6.3)	26.5
Total	**3**	**(5.8)**	**55**	**(3.7)**	**18.3**	**6**	**(8.2)**	**159**	**(6.3)**	**26.5**
Family/ social delays:										
Refuse outcome of care plan	1	(1.9)	73	(4.9)	73.0	2	(2.7)	142	(5.6)	71.0
Other family delays,eg on liquidating housing equity	8	(15.0)	186	(12.4)	23.3	6	(8.2)	204	(8.1)	34.0
Await court protection order/ guardianship (for mentally infirm)	0	(0)	0	(0)	0	1	(1.4)	26	(1.3)	26.0
Total	**9**	**(17.3)**	**259**	**(17.2)**	**28.7**	**9**	**(12.3)**	**372**	**(14.7)**	**41.3**
Total	**52**	**(100)**	**1503**	**(100)**	**28.9**	**73**	**(100)**	**2526**	**(100)**	**34.6**

Table 2: Reasons for delayed transfers as perceived by health managers (n=3) and social care managers (n=3)

Reasons perceived	Number of health managers mentioning	Number of social services managers mentioning	Additional comments
Difficulties associated with domiciliary care assistants: - inadequate supply - variable quality/ inadequate training - no experience with mentally infirm	 2 1 1	 3 2 2	- Care assistants cannot give medicines - No provision for laundry at home - Wages of care workers too low relative to cost of living - Too many middle managers
Lack of professionals in the community	1	2	-Occupational therapists, - Physiotherapists (particularly neurology specialists) - Care managers
Social services constraints including inadequate funds	2	3	- Social services "culture of regulation and restriction" - No funds for people with moderate needs "you have to be nearly dead to qualify for help" - Lack of affordable care home placements/ many homes will not accept social services rates - Mentally ill are more expensive
Too many assessments	1	1	- Cause of much lost time: need single assessments
Lack of round-the-clock cover in the community (care assistants and professionals)	2	2	
Getting aids and adaptations to clients' homes	1	1	
Inadequate carer respite arrangements	2	2	
Confusion of responsibilities between health and social services	3	2	- "duplication of records" - "walls between social and medical care" - "protection of professional boundaries"
Family resistance	1	1	- Disagreements over home sales to finance care - Gap between financing legislation and peoples' expectations