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Delayed transfers of care for older people: a wider perspective

Key points

- Delayed transfers of care (DTOC) in older patients, have been estimated to cost the NHS in England £820 million each year.
- The estimated cost of DTOC fails to reflect the impact on patient care needs when they are delayed in hospital.
- Failure to reflect the impact on patient care needs has led to the setting of blunt and potentially harmful policies.
- A new approach needs to move away from DTOC as a single index, to reflect the full implications across society.
- Until we reflect the full costs and benefits of prompt patient discharge, any policy to reduce DTOC may do more harm than good.

Abstract

Delayed transfers of care (DTOC), often unhelpfully referred to as ‘bed blocking’, has become a byword for waste and inefficiency in healthcare systems throughout the world. An estimated 2.7 million bed days are occupied each year in England by older people no longer in need of acute treatment, estimated to cost £820 million (2014/15) in inpatient care. Policy and media attention have often been drawn to this narrative of financial waste, resulting in policy setting that directly targets the level of DTOC, but has done little to put patient health first.

These figures and policies portray a misleading image of the delays as primarily of concern in terms of their financial burden on acute hospital care, with little consideration given to the quantification on patient health or wider societal impacts. In spite of the multi-factorial decision making process that occurs for each patient discharge, current evaluation frameworks and national policy setting fail to reflect the complexity of the process.

In this commentary we interrogate the current approach to the quantification of the DTOC impact, and explore how policies and evaluation methods can do more to reflect the true impact of the delays.

Introduction

Delayed transfers of care (DTOC) occur when a patient is ready for discharge from hospital, but is still occupying a bed[1], typically as they have nowhere identified as an acceptable discharge location. This term has become a byword for waste and inefficiency in healthcare systems throughout the world.

Criticism of the failure of health and care systems internationally to robustly address the issue of DTOC is not new. For example, in 1975 DTOC were characterised as *'a chain reaction: acute medical receiving beds are blocked because the acute medical beds to which patients should be transferred are blocked by patients who should be in geriatric beds; but these are blocked because there are too few local authority beds to receive patients discharged from geriatric wards'*[2].

Nevertheless, the perceived inefficiency of healthcare systems that is demonstrated by the existence of DTOC has endured, and continues to receive regular episodes of political and media attention. In the UK, this was typified during the 2010s when a rise in the rate of delays led to the publication of a National Audit Office (NAO) report[3], a Commons Briefing Paper[4], as well as considerable media interest[5]. Each of these emphasised the scale of the issue, reporting that up to 2.7 million hospital bed days were being used unnecessarily each year[3], primarily by older people with frailty, with the estimated cost burden reported between £173 million (2016/17)[4] and £820 million (2014/15)[3] depending on the characterisation of the resources used. A national target was subsequently set in 2017 that no more than 3.5% of all hospital bed days should be taken up by DTOC, building on existing policies such as the financial penalty to local authorities if the delay was attributed to social care.

The drive to discharge patients as soon as possible became more pronounced with the global covid-19 pandemic, with increased emphasis on prompt discharge to free up bed capacity and reduce the risk of in-hospital spread of the virus amongst older people, as a population at high risk of death. In August 2020 the UK Government made its intentions to move away from the previous system of recording and penalising DTOC clear, legislating a 'discharge to assess' model, whereby people ready for discharge receive any necessary assessments of function and social care need within their own home. This model is expected to continue after the pandemic, and has major implications for the organisation of health and social care across the UK[6].

However approached, the intuition behind policy interventions to minimise DTOC is clear. From a patient perspective, extended hospital stays can be associated with negative mental and physical health impacts[7]. From a health system perspective, the narrative of resources wasted on patients

who are inappropriately resident in hospital, and resource implications for clinical staff of providing unnecessary care, is well established[8].

With the recent national policy change relating to DTOC, emphasising the discharge to assess model, we have a valuable opportunity to re-assess the emphasis on rapid patient discharge over continued inpatient care beyond the point of being deemed suitable for discharge. To do so we must first reflect and address the apparent disconnect between the evidence used to set national DTOC policies and that used at a patient level to facilitate safe and reasonable discharges.

The national policy perspective - the financial burden on the healthcare system

Setting national DTOC policy, such as targets on the proportion of total bed days and blanket discharge to assess policies (beyond covid-19 legislation), has typically been driven by a focus on the cost burden to the healthcare system of delays in discharge. Key policy documents, such as the NAO[3] and Commons Briefing Paper[4], place the estimation of the financial cost of delays at the centre of their assessment. This is conventionally achieved by multiplying the number of bed days recorded as delayed transfers[9], by a reference cost of an excess bed day[10]. The chosen reference cost is often an average of all excess bed days, used for remuneration purposes, typically around £300 per day[3, 10].

The implicit question in such estimates is ‘how much money that could be spent on caring for other patients is currently spent on those who are in hospital inappropriately?’, with the assumption that delayed patients require the ‘average’ level of care. This approach therefore conceptualises DTOC as an unqualified cost burden, falling on hospitals alone, and associated with no health impacts to the patient, positive or negative, nor resource implication on other sectors.

The patient level perspective – the patient pathway and opportunity cost

The process of discharging an older person back to their own home after an acute hospital admission is typically complex and nuanced. While the factors considered in discharge assessment are diverse[11] they will include at their core an assessment of the potential harm to the patient of staying in hospital, and the suitability of their discharge location. More broadly, the clinical team will be aware of the opportunity cost of the occupied bed and associated services, the value of which is inevitably greater when they are in short supply relative to the needs of the population, such as over winter.

This is recognised in both the historic conceptualisations of DTOC[2] and contemporary clinical guidance regarding discharge assessment[12], which reflect that patient-level decisions and broader factors that result in delayed discharges are part of a wide system of activities that go beyond the cost implications for the hospital. This indicates that any conceptualisation of a delayed transfer as a tally of hospital bed days used unnecessarily, or money spent on care that could be given to others, as is indicative of current Government decision making, is at best a partial solution[7].

A pragmatic framework – a possible route forward

We believe the fundamental inconsistency in how DTOC is considered at a national level and how it manifests at a patient level is a primary factor in the failure to achieve a national policy that aligns with what is in the best interests for the patient being delayed, and the wider healthcare system. Furthermore, the current shift to a blanket discharge to assess policy, rather than resolving the issue simply takes the extreme assumption that discharge is always the best option and that there is the supply side capacity to facilitate it.

There has been a consistent acknowledgment in national research and policy that patient delays have a broad impact. Examples of such are the NAO estimation of the cost to other sectors of reducing inpatient delayed discharge[3], and the reflection of patient wellbeing being a factor in the latest discharge to assess policy[6]. However, the lack of guidance on how best to quantify the complexity in order to support analysis of interventions has resulted in policies which consistently apply a broad-brush approach to DTOC[13]. Recent research has highlighted the many challenges in applying a multi-sectoral perspective in such policy areas[14].

To fully address the burden of DTOC we must incorporate the full costs to all stakeholders, including all care providers, alongside central government and, ultimately, wider society. Furthermore, the health and wellbeing impacts for the delayed patients must be intrinsic to the quantification of the merits of minimising DTOC, both negative and positive, as well as the knock on effects to those who cannot access services due to the lack of an available bed[8]. **Error! Reference source not found.** explores some of the factors that must be incorporated into the quantification of the health and resource use implications of DTOC if we are to bring the national policy and patient care decisions into closer alignment, highlighting the many ‘knock back’ and ‘knock forward’ factors that are currently missing from the quantification of DTOC’s impact.

[Figure 1 here]

The emergence of more advanced analytical methods, innovations in data reporting such as Patient Level Information and Costing System (PLICS) in the UK, extensive research into the patient and

system level implications of DTOC[7], and the unique opportunity presented by the covid-19 pandemic, all provide key catalysts to allow us to achieve such a goal. However, there are still many barriers to overcome, such as a need to improve social care data reporting.

Furthermore, the plethora of push and pull factors evident in the decision to discharge a patient, both system and patient side, and often working in conflicting direction, means that it is unlikely that any implementable framework will ever fully quantify or identify the optimal patient level decision. However, it is our contention that a conceptualisation of the impact of DTOC that goes beyond simple headline bed day tallies and estimates of total costs, and closer to the lived clinical and patient experience, is vital to ensure patients, both those delayed and those awaiting care, are best served.

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