The Longest Wait to Leave

Tackling the delayed discharges that help to drive corridor care

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Contents

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Executive Summary

In this report we look at how today, discharge delays are a significant driver of corridor care, blocking the flow of patients through hospital and causing ripple effects throughout the system. This follows an Age UK report in autumn 2025 focused more narrowly on corridor care itself.

Reversing the trend of delayed discharge must be a system priority if we are to overcome delays further upstream, such as those leading to corridor care, reduce pressures right across the hospital and improve patient care for those most at risk of delay-related harm: that is, sadly, our older population.

Delayed discharges are a huge problem for any older person impacted and for the health and care system as a whole. On a typical day, around 13,000 people are medically fit to go home but are stuck in hospital – the definition of a delayed discharge. Since 2021 this number has grown by 70%. Delayed discharges happen for a number of reasons, including waiting for an in-hospital assessment or because some form of intermediate or social care support is needed in the community but unavailable. Those affected are overwhelmingly older.

In 2025/26, 6.75 million bed days were lost to discharge delays of seven days or more. In four years (2021/22-2025/26) this number has more than doubled. The financial cost of these delays is staggering - estimates from June 2026 were that delayed discharges cost the NHS upwards of £229 million in a single month. The annual cost in 2025/26 was estimated to be £2.66 billion.

An inadequate number of hospital beds is another factor that helps to drive corridor care. Since 2010/11, the total number of beds in NHS hospitals has declined by 11.3%, while over the same period the number of emergency admissions from Type 1 A&Es has increased by more than a third (36%).

A lack of sufficient beds plus the incidence of delayed discharges result in people having to wait ever longer in A&E departments. This disproportionately affects older people as they are more likely to be admitted from A&E and to have complex needs and frailty. Shockingly, 30% of all 90+ year olds arriving in A&E wait 12 hours or longer.

In March 2022, 12 hour waits from decision to admit to admission were 22,506; by December that year they exceeded 50,000 for the first time ever. By March 2023 they were still almost double the previous year (39,687), with delayed discharges spiking at the same time. It is likely that one of the major reasons for the sharp deterioration from March 2022 was that the special arrangements for funding social care on discharge that were put in place during the pandemic came to an end. Since then, record highs for 12 hour waits and delays have become the norm.

There is a postcode lottery: in 2025/26 there was a difference of nearly 20% between the NHS region with lowest proportion of people stuck in hospital and the region with the highest (44% vs 63%). However, only one NHS region achieved more than half (56%) of people medically fit for discharge leaving hospital on a typical day (East of England). Delayed discharges are clearly therefore a system problem.

The Government must recognise the serious harm being visited on older people due to delays in hospital and take action to reduce it. These harms start in A&E with 12+ hour waits; continue through their time on the ward with excessive length of stay; and are compounded at exit by delayed discharges. However, we are not doomed to live with these problems forever: the solutions are well known – indeed some of them were articulated by one Andy Burnham more than a decade ago, so we are confident that with political will and policy attention they can in fact be ameliorated and ultimately solved. It's what older people badly need and we all deserve.

Recommendations

Age UK calls on the Government to:

- End the funding disputes between the NHS and local authorities over who pays for an older person who needs social care and other forms of support following discharge. There are different ways of achieving this, for example, through reform of the Better Care Fund or by establishing a specific joint fund. During the pandemic something akin to the latter was established and worked well.

- Face up to the need to increase the number of hospital beds. Much can be done to free up beds through better discharge planning and by preventing avoidable admissions, but the truth is that we currently have fewer beds per head of population than we need.

- Strengthen community capacity to help older people to get home, recover and stay well. This requires, among other things, enabling every older person to be assessed at home within 24 hours of discharge; the NHS being far more strategic and intentional in commissioning effective VCFSE organisations to help older people go home and settle, especially those living alone; and supporting the unpaid carers who will be caring for older people when they get home. Success will also depend on increasing the availability of intermediate care and reablement and ultimately, of course, on reforming social care and expanding its capacity.

- Turbo-charge a peer learning programme for hospitals to help them to minimise in-hospital discharge delays, caused by factors such as waiting for assessments, for discharge letters to be signed and medication and transport home to be organised. Planning discharge at the earliest opportunity and working closely with community services are other important factors. Some hospitals are more efficient than others in these respects and their good practice needs sharing to support improvement across the board.

- Strengthen data collection: Trusts should be required to collect and publish their numbers of 12+ hour waits and delayed discharges, alongside the ages of those affected. This would increase transparency and accountability, recognising who is most affected and inform the policy changes required to drive better practice.

In addition, we repeat our calls from our first report on corridor care for Government to:

- Produce a funded operational plan to reduce the incidence of long A&E waits and end corridor care, with specific deadlines and milestones.

- Give explicit accountability for reducing long A&E waits and ending corridor care to a Minister in the Department of Health and Social Care, requiring them to report on progress to Parliament every six months.

Finally, we strongly recommend that the term 'bed blockers' is consigned to the past because it is victim-blaming and ageist. As this report shows, the problem is with the system not the person.

Introduction

"If frail, older people are left without everyday support at home, they will be at greater risk of going into hospital and getting stuck there. And, if our hospitals become full, A&E will start to struggle and waiting times for everyone will get worse….. With the wards full, pressure is backing up through A&E leaving patients waiting on trolleys or held in the backs of ambulances queueing outside……. If we leave things as they are, we are looking at a future where hospitals become more and more full of older people. That is not a positive vision of the ageing society."

Andy Burnham, 23rd February 2015[1]

In October last year, Age UK reported on the scandal of emergency department crowding and dangerous long waits in hospitals, resulting in unsafe care delivered in inappropriate spaces ("corridor care").[2] We highlighted the shocking rise in long (12+ hour) waits following a decision to admit a patient to a hospital bed and called for a national strategy to tackle these challenges.

In this report, we explore how discharge delays are also driving this phenomenon, impeding the flow of patients through hospital and causing ripple effects throughout the system. We argue that reversing the trend of delayed discharge must be a system priority if we are to overcome delays further upstream, reduce pressure in hospitals and improve patient care for those most at risk of delay-related harm – that is, older people.

A wide coalition of experts are calling for a stronger focus on hospital discharge policy to tackle hospital crowding, delay-related harm, corridor care and elective recovery performance. Yet despite the overwhelming evidence of its importance, national policy to tackle discharge delays seemingly remains stranded[3], with the most recent figures being some of the worst on record. At the same time The Royal College of Emergency Medicine (RCEM) estimates that more than 250 A&E patients are dying each week because they waited more than 12 hours to be either discharged or admitted.[4] These are possibly tens of thousands of deaths that could have been avoided[5,6.] The gravity of this situation is hard to overstate.

In four years, discharge delays have increased by 70%, with a seven-fold increase in long delays of 21 days or more.[11] Discharge delays have a knock-on effect across the whole hospital, creating a bottleneck that impacts flow from ambulances into A&E and from A&E to hospital ward admission. If bed capacity is taken up by patients who do not have a medical need to be in the hospital these are the same beds to which people in A&E cannot be admitted. Delayed transfers of care can be the result of stalled processes within the NHS, social care, and across both sectors. They occur for a range of reasons and reveal long-standing dysfunction at the interfaces within and between services. A significant proportion of delays also occur within the NHS.

In this report we examine how delayed discharges contribute to long waits in A&E; what is causing them; and what this means for the older people caught in the middle. We will also examine how this challenge can be tackled, why we need to give much greater priority to this issue in debates about tackling 'corridor care', and highlight places that have started to make a positive change – showing that these are problems that are within our power to solve.

- In 2025/26, more than half (57%) of people who could be discharged on a typical day were still stuck in hospital.
- This means over 13,000 people every day are still in hospital despite being medically well enough to leave, the vast majority older people.
- Since 2021, this number has grown by nearly 70%.
- In 2025/26 6.75 million bed days were lost to discharge delays of seven days or more.
- In June 2026, delayed discharges cost the NHS £239 million. For 2025/26 the total cost was £2.66 billion.

Source: Age UK analysis of NHS England (2026). Acute discharge situation report. Data accessed: April 2025 to June 2026

Corridor care – where are we now?

In October 2025, we revealed that the number of people experiencing corridor care had grown 525-fold since 2015/16, reaching over half a million incidents in 2024/25. In 2025/26, this number increased again, reaching 570,957 incidents with a record 71,000 incidents in January 2026 alone. For comparison, in all of 2011/12, the earliest available full financial year, it was just 123 across the entire year.

Over 60% of all instances of corridor care are experienced by people aged over 65 years. 30% of all A&E attendances by people aged over 90 years result in waits in excess of 12 hours. Perhaps even more shocking is that in 2024/25, 100,000 people waited between one and three days in this position, with more than half of these people aged over 80 years. These waits are not only distressing but also a risk to life, with the Royal College of Emergency Medicine (RCEM) estimating that 15,860 excess deaths were associated with long waits in 2025, "an almost ten-fold increase in the number of excess deaths over a decade"[7].

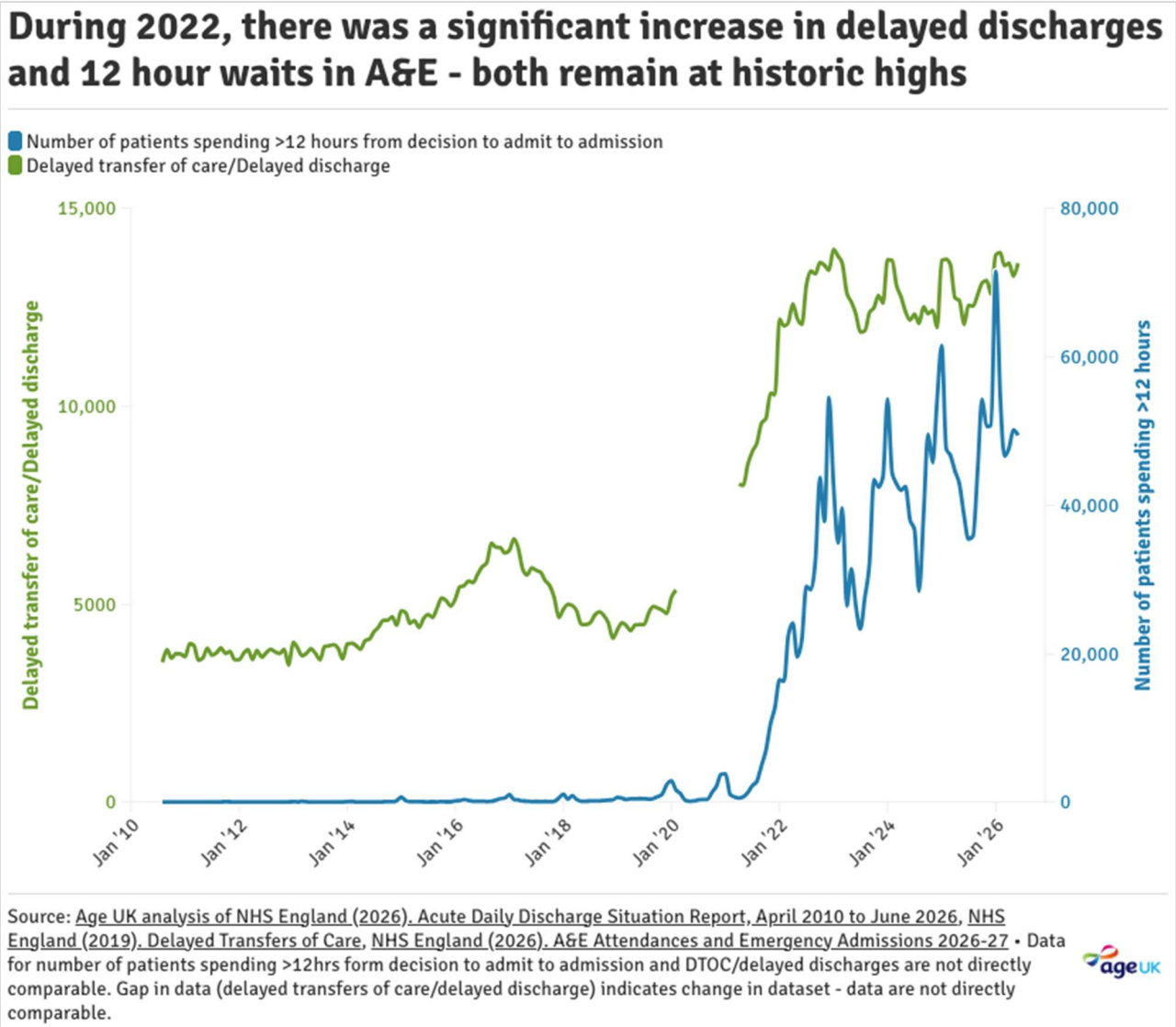
In the months following our report NHS England and the Department of Health and Social Care took a number of actions aimed at addressing corridor care. They invited the worse performing hospitals to a national event at which they were tasked to start planning how they will reduce their numbers in the coming months. This was followed by best practice guidance and the creation of a new definition of corridor care, with a commitment to collect and publish these statistics. This started in May 2026 and has revealed that on an average day there are 3,000 incidents of corridor care in England.[11]

However, there has so far been little sign of improvement. The rates of 12+ hour waits from a decision to admit someone to when they get a bed on a ward (how we have defined corridor care) continue to go up. They hit an all-time high of 71,000 in January 2026, and at the start of 2026/27, the numbers have all broken records for the respective months of April to June.[8] The Government has committed to "eradicating" corridor care by 2029, but there is clearly an awfully long way to go.

At the same time, the numbers of people delayed in hospital when medically fit for discharge are also going up. As we noted in our October 2025 report,[2] delays 'at the backdoor' of the hospital, as people wait to leave, are closely linked to long waits in A&E, because bed capacity is occupied by substantial numbers of people who do not have a medical need to be there.

The graph below tracks the pattern of delayed discharges and corridor care over time. Before 2020, the most comparable data was collected as "Delayed Transfers of Care" (DTOC), a data collection which stopped at the start of the pandemic. An equivalent restarted in 2021 as

“Discharge Delays” and, though not directly comparable, these figures do provide an indicative pattern of the volume of these delays.[11] The graph shows that Discharge Delays accelerate in a similar pattern to corridor care and that they have remained high since 2022.



The problem of delayed discharge

Delayed discharge occurs when someone who is “medically fit for discharge” – i.e. they no longer have a clinical need to be in an acute hospital bed – is unable to leave hospital. This could be for a number of different reasons, of which some are within and others beyond the hospital’s direct control.

For example, the delay may be because they are waiting for an in-hospital assessment or because they need some form of intermediate or social care support in the community. On a typical day, around 13,000 people are in this position [11] and these will be overwhelmingly older people, particularly those with the greatest health and care needs.

A National Audit Office report from 2016 estimated that 85% of discharge delays affect people over the age of 65 years[9] and a decade on there is no reason to suggest the percentage has since reduced. Older people are disproportionally affected by discharge delays because they

are more likely to experience a deterioration in physical or cognitive function after a period of acute illness, one that necessitates additional support on leaving hospital. This is because older adults are more likely to be living with multiple long-term conditions and to experience physical or cognitive frailty - all of which may get markedly worse if they become acutely unwell and need to stay in hospital for a spell.

Delays fuel a vicious cycle: an older person may have incurred harm enduring a long wait for an ambulance, a long wait in A&E, and then another long wait to exit the hospital. The result is that older people may need to be discharged with a higher level of support than would otherwise have been necessary. Ironically, this may trigger further delays because intensive support is more expensive and often harder to secure.

"When I was ready for discharge, there was no doctor available in the whole hospital to sign off and prescribe medication to go home with, this meant an extra night in hospital, not just for me but also six other patients on the ward. Not acceptable."

When a patient who is medically fit for discharge remains in an acute bed they face an increased risk of complications in the form of hospital-acquired infections, physical deconditioning and declining mental health. For older people, especially those living with frailty, this can lead to functional decline and a loss of independence from which it can be very hard to recover. Every day a patient is delayed increases these risks – which may lead to worsening confusion (delirium), loss of mobility and reduced capacity for independence. It also heightens the likelihood of them needing more support for a full recovery.

The rise of delayed discharge: in numbers

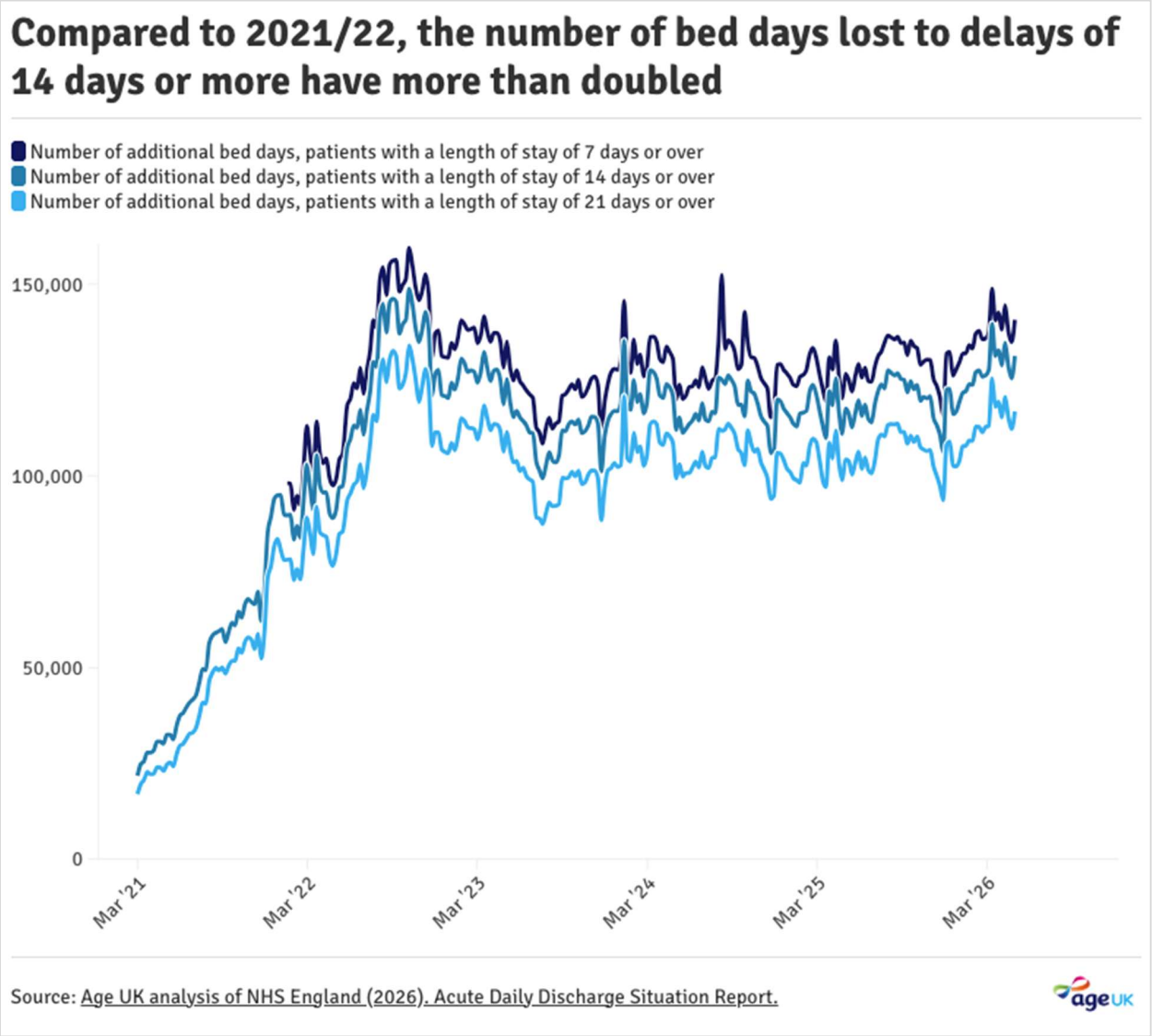
- Delayed discharges were historically recorded as "delayed transfers of care" (DTOC). This collection was stopped during the pandemic (2020).
- In the final annual report (2018/19), it was recorded that around **4,500** people on a typical day were still residing in hospital when medically fit for discharge or transfer. The total number of delayed days in 2018/19 was **1,665,725**[10].
- When publication of discharge delay data resumed, the total number for a typical day was **8,000** (April 2021). By the end of that financial year, it was **12,000** and has remained there or higher ever since[11].
- In 2025/26, on a typical day, **13,000** people remained hospital when medically fit for discharge**. 6,755,325** bed days were lost to discharge delays for people waiting 7 days or more in that year [11].

The cost of delays

In our report *The Longest Wait*, we used the total number of people who were waiting for more than 12 hours for a bed after the decision to admit had been taken as a core indicator of corridor care. In 2025/26 this number was 570,957, a new record high for a single financial year.[12] The number of beds in NHS hospitals is a leading cause of corridor care and delayed discharges play an outsized role in the number of beds available.

A standard NHS measure for discharge delays is the total number of *bed days* lost due to people being stuck in hospital, i.e. the number of days someone is using a hospital bed beyond

the date that they were assessed as being medically fit for discharge. This captures both the number of people affected by delays as well as the length of time a bed has been used. If we examine just those that have been delayed for *at least* seven days, in 2025/26, 6.75 million bed days were lost to discharge delays.[11] Since 2021/22 this number has more than doubled.



If we take the total bed base for England, there are approximately 128,000 beds, equating to 46.7 million bed days a year.[13] This means that over 1 in 7 (14.4%%) of the total bed base is being used by people who are medically fit to go home, with the proportion likely to be much higher in some places. The financial cost of these delays is staggering - estimates from June 2026 were that delayed discharges cost the NHS upwards of £229 million in a single month. In 2025/26, the cost was estimated at £2.66 billion[11].

View from the frontline:

"Of all the time that patients spend on our geriatric medicine wards, for 68.5% of that time they are receiving medical treatment, and around 31.5% is accounted for by delays. Looking at the data this way might suggest that we could save as many as 1/3 of our

beds if we were able to discharge everyone on the day they were identified as being medically ready!"

Consultant geriatrician

These estimates do not consider the alternative cost of providing health and care support to patients outside of the acute hospital setting if these patients were not delayed in hospital. However, neither does this analysis include wider costs, such as the opportunity cost of care foregone by not being able to admit other patients, and the creation of corridor care.

There is a significant cost from delay-related harm leading to deconditioning and increased time in hospital. "The impact of deconditioning sets in just 24 hours into a hospital admission, with a loss of 2-5% muscle power and 5% reduction in circulatory volume after 1 day of bed rest"[14]. In just the first seven days these numbers rise to 10% and 25% respectively.

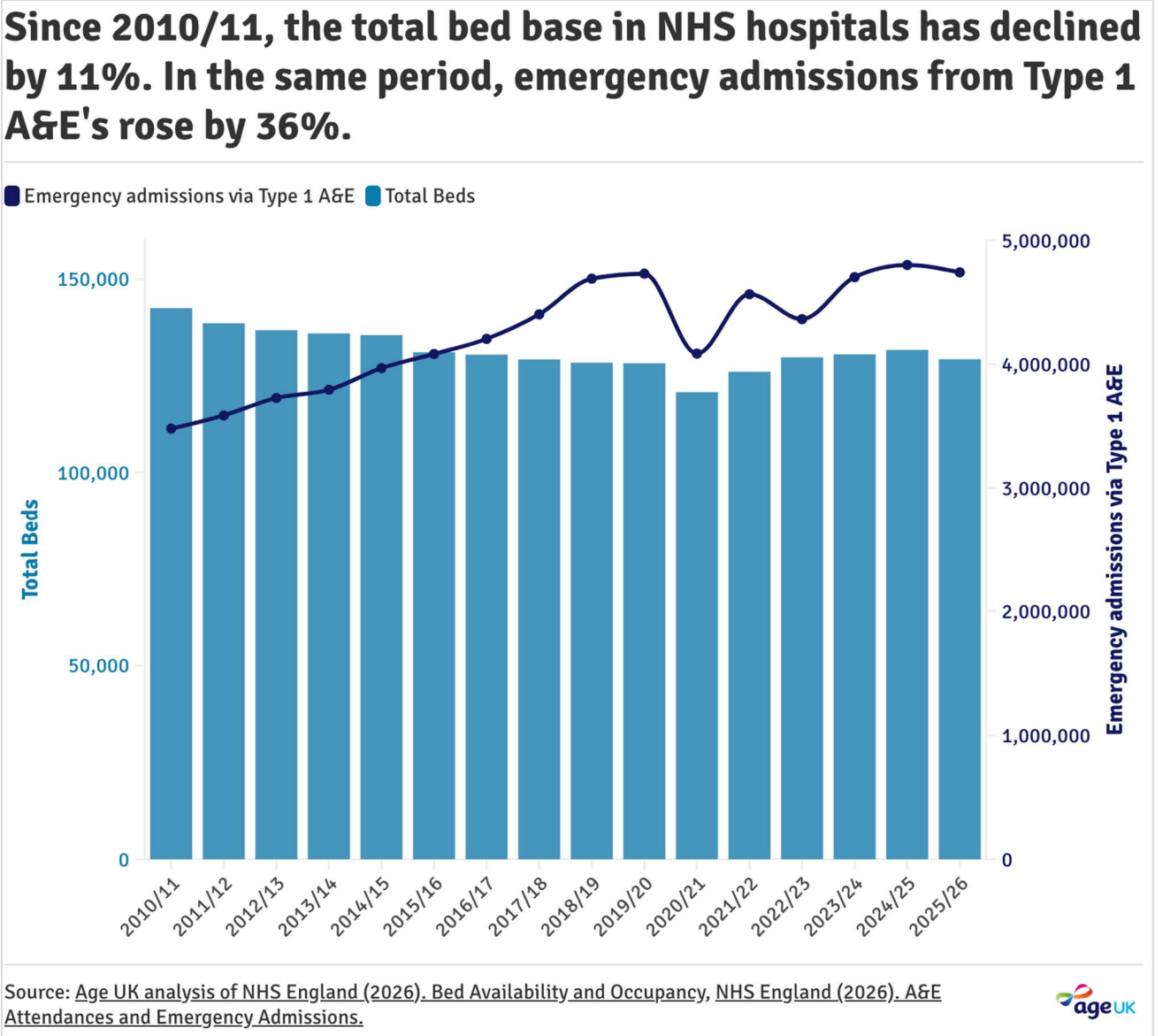
The longer an older person stays immobile in a hospital bed, the greater these impacts are likely to be, creating a need for more complex care and producing worse outcomes, stretching the costs out into the community and across both NHS and social care services.

At a personal level, the individual cost of these delays can be catastrophic, particularly for some of the most vulnerable older people living with frailty who, by definition, are at much higher risk of deterioration following even minor health shocks. In the most extreme cases delays may eventually result in a patient not being able to return home at all or even contribute to their death.

Not enough beds

For many years the NHS has been reducing the number of hospital beds[15] as the average length of stay in hospital decreased. However, hospital admissions have continued to rise. Consequently, bed occupancy in NHS hospitals routinely breaches what is regarded as safe capacity. In 2025/26, the average bed occupancy for adult general and acute beds was 94.5%[16] (well above the 'safe' threshold of 85%[17]). With this gradual reduction in the in-patient bed base across the NHS, and increased A&E attendances requiring hospital admission, high levels of activity are now seen in many hospitals all year round. High bed occupancy levels indicate that there is no slack in the system, meaning that even relatively[18] minor delays on the ward can have outsize effects upstream in A&E.

The consequences can be seen in the change in total beds when mapped against the number of emergency admissions from Type 1, or major, A&Es. A large proportion of people who come to A&E are discharged home, having had an injury patched up or concern checked and cleared. Around 28% of attendances are more serious and result in an admission, almost half (45%) of whom are older people[19]. As shown in the graph below, since 2010/11 the total number of beds has declined by 11%, while over the same period the number of emergency admissions from Type 1 A&Es has increased by a third (36%).[20]



At the same time, over 1 in 7 bed days are being used by people who have been assessed as medically ready for discharge, yet remain in hospital, further reducing the numbers of available beds.[11] Together, these factors create a 'perfect storm' that impacts A&Es and people waiting 12 hours and more to be admitted.

What is causing these delays?

A review of the weighting of discharge delay categories shows that there are multiple factors at play. This is because discharge decisions often sit at the interface of different services, both within and between health and social care. Recent analysis from the King's Fund identifies that the interface between health and social care too often functions as a 'no man's land', particularly at moments of transition such as hospital discharge, when people's support needs may well have changed so a different, probably greater, support package is now required for them.

Many of the most entrenched problems reflect a series of well known structural issues regarding funding, accountability and responsibility between the two services, or what one senior figure in social care described as 'a deep and fundamental divide'[21].

"Taken in with head injury. Kept on a trolley 48 hours. Finally admitted. When due to be sent to cottage hospital to recuperate she was kept in discharge lounge for 10 hours (NOT KNOWING WHERE SHE WAS DUE TO DEMENTIA). Transport didn't turn up. Taken back to ward. Transported next day after further 4 hours in discharge."

A particular challenge across this interface and frequently cited cause of delay is disagreements or lack of clarity about funding responsibilities. This can be for those in need of new or increased home-based care support, rehabilitation, a short-term interim care home placement, or a long-term change of accommodation (residential or nursing home) after discharge from hospital. This problem is more likely to affect older people because recovery from illness tends to be slower for them than for younger adults. After an acute illness their discharge support needs are likely to be higher. Short term rehabilitation may be required, and this can easily convert into longer term care or accommodation needs after a hospital stay.

Disputes about Continuing Healthcare (CHC), the funding mechanism for individuals leaving hospital with a primary health need, are another cause of delayed transfers of care. In principle, ICBs fund the entire health and social care costs for an eligible person, including personal care at home and accommodation in a care home as is required. However, the process is highly contested, with a recent report from the King's Fund identifying a rise in the proportion of people being turned down for NHS funding for their care after a reassessment, despite there being no change in the criteria for entitlement or improvement in their condition[22]. CHC has repeatedly hit the headlines for being unfair, highly rationed and a postcode lottery.

Length of delays and extended hospital stays

It is important to consider not only the overall number of delays but their length too. When the NHS and local authorities discharge someone from hospital they use four nationally defined discharge pathways known as The Discharge to Assess (D2A) model[23,24]. Pathway 3 relates to patients who need a complex care placement into long-term nursing or residential care homes. Data shows that around 65% to 70% of patients due to be discharged to a permanent care home face a delay[25]. Challenges can vary by geography; for example, in rural areas there may be shortages of care professionals.

The highest *number* of delayed patients awaiting a specific service is typically tied to Pathway 1 (Home with new or increased short-term support) and Pathway 2 (Short-Term Bed-Based Care). Delays here are driven by severe capacity shortages or funding shortfalls in the community and social care sectors, complex legal and funding assessments (such as for NHS Continuing Healthcare) and, in a smaller number of cases, family disputes e.g. over the chosen care home.

View from the frontline:

"Delays particularly arise where there is a dispute about whether a patient has care needs which includes rehabilitation (so they would need intermediate care at home with physio, usually paid for by the NHS), or whether they have more straightforward care needs without rehab (and would therefore have reablement which is usually paid for by social services).

Sometimes the ward team needs to go backwards and forwards between teams to resolve care requests in this situation - which can cause unnecessary delays to care."

Consultant geriatrician

Delays in the hospital and in the community

Estimates vary, but there is broad consensus that at least one third (and perhaps up to half) of discharge delays are due to factors within the hospital (i.e. caused by interface processes within the NHS itself). For example, one study showed that 34% of delays for long-stay patients happen before the patient even hits a community pathway[26]. These are internal hospital and 'Care Transfer Hub' delays which may be caused by backlogs in completing medical reviews, finalising discharge summaries or securing required medications, among other factors.

Internal delays may also include waiting for a physiotherapist or occupational therapist to conclude their assessment; for a specialist nurse to review and consider the discharge plan; for the paperwork from these assessments to be completed and sent off; or for the Multi-Disciplinary Team overseeing an individual case to make an assessment and review of the discharge plan. Other delays might be due to a lack of available hospital transportation or waits for medications from the hospital pharmacy for the patient to take home with them.

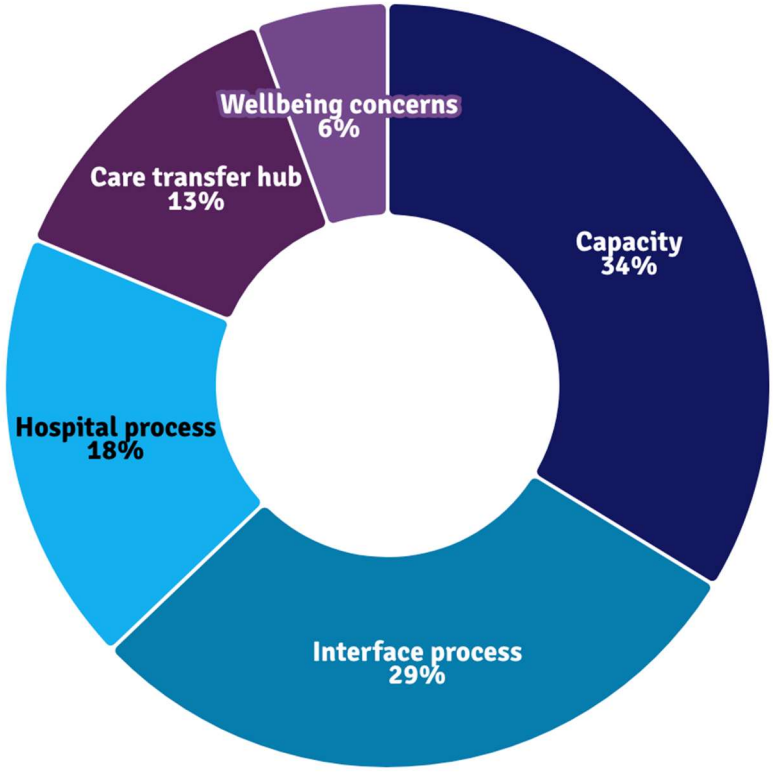
"My husband was delayed in hospital for over a week waiting for a care package to be put in place. I was told that the less care I agreed on the quicker discharge would be and he could come home. We were given no information on discharge about his health problems or follow up appointments and it left all the support down to me, his wife. I also have challenging health issues myself."

Delays beyond the hospital are often due to poor co-ordination and communication with local health or intermediate care services. A significant number can be attributed to there simply not being enough community services such as intermediate care (rehab) or reablement (short-term care). Although some reablement services may be delivered within social care settings, they are also often provided in community hospitals and specialised facilities.

Patients who are ready for discharge but who have complex needs - such as requiring mechanical ventilation, complex wound care, or specialised peg-feeding - often remain in hospital simply because the local primary care networks or social care services lack the specific clinical staff to support them at home e.g. Community-Registered Specialists. CQC's Annual report (2025) noted "a dramatic drop in district nurse numbers – with 50% fewer per person over 65 than there was 14 years ago".[27] This is an absolutely shocking state of affairs, given the crucial role these community based nurses play in supporting older people, and the reality of an ageing population.

"My father was due to leave hospital and had been allocated a rehabilitation slot nearby. But because he was on dialysis and his stay in hospital had been weeks, his dialysis slot in the community had been given to someone else. So Dad could not leave hospital as there were no slots locally. We were not informed that he had lost his slot. My father ended up dying a horrible death in hospital with no dignity or compassion for him or his family."

One third (34%) of people are getting stuck in hospitals due to capacity issues such as bed-based rehabilitation, reablement or recovery services not being available yet



Source: Age UK analysis of NHS England (2026). Acute daily discharge situation report. Data accessed: April 2025 to March 2026 • Not nationally representative - only represents NHS Trusts that have submitted data to NHS England.

Key to terms used on the chart:

- **Capacity** – availability of social care, rehab, care and nursing homes.
- **Interface process** – NHS Trusts and system partners discussing patients' onward care, related to both NHS and social care.
- **Hospital process** – Issues within the hospital's control, such as waits for reviews of need for supported discharge, referral to care transfer hubs or formal decision to discharge, awaiting medications, final tests, or transport.
- **Care transfer hub process** – Most commonly delays in identifying the appropriate destination or funding.
- **Wellbeing or safeguarding concerns** – Concerns from the patient or family about safety, or delays in assessing mental capacity.

The role of social care

Social care delays include patients awaiting social care assessments, the sourcing of care packages, or placement for longer-term care in residential or nursing homes. Evidence

suggests problems are not always caused by an absolute lack of capacity, but by how care is commissioned and co-ordinated, and by lack of funding. For example, home care providers have told us that there sometimes is capacity available locally but that the NHS is not willing, or does not feel able, to pay for it. Similarly, residential care providers sometimes report that they have vacant beds, but local authorities and Integrated Care Boards (ICBs) are underfunded and unable or unwilling to pay the price to secure them.

View from the frontline:

"My personal view is that there should be greater funding for home-based care arrangements and care home beds if we are going to be able to meet the demand of the growing proportion of older adults with increasing care needs. One important aspect here is the remuneration of care staff and difficulties identifying [professional] carers, particularly in remote or rural areas".

Consultant geriatrician

As we reported in *The Longest Wait*, problems concerning the sourcing of social care cause a significant proportion of discharge delays. In recent data (June 2026), 7.8% of delays for people who had a length of stay over 7 days were caused by the unavailability of home care services, both those waiting for it to be arranged (Interface Process) and waiting for it to become available (Capacity). The equivalent for nursing or residential care home placement was even higher, at 12.7%[11].

As noted above, challenges can often arise through a lack of clarity in funding responsibilities. During the COVID pandemic, a national discharge support fund was introduced to more seamlessly pay for a limited period of health and social care following a spell in hospital[28]. This removed some of the barriers and disputes that can hold up a transfer of care and enabled hospitals to free up capacity. The fund came to an end in March 2022, with ICBs expected to use their mainstream funding to continue similar arrangements beyond this date. Later in 2022, the Adult Social Care Discharge Fund was introduced, with funds distributed across both Local Authorities and ICBs, and further boosted in January 2023 in the face of winter pressures.

"She was delayed for a few days in hospital because they couldn't set up home care. We had asked to be informed when she was going to be released. That didn't happen.

A neighbour, on the way to bed noticed a light on in the house. She and her husband went to investigate. Found her laying on her stone kitchen floor. She died from hyperthermia 3 days later in hospital. She never regained consciousness."

The March 2022 date is significant as there followed a significant jump in 12 hour waits in A&E, kick-starting the peaks we see in the graph on page 7. In March 2022, 12 hour waits from decision to admit to admission were 22,506; by December that year, they exceeded 50,000 for the first time ever. By March 2023, following the winter spike, they were still almost double the previous year (39,687). Delayed discharges had been climbing in the months up to March 2022, but the average number of people delayed accelerated, increasing by 12.3% by March 2023.

The various incarnations of discharge support funding have acted as a very useful, but severely time limited, sticking plaster to reduce the numbers of delayed discharges. Allocations typically end in March having enabled the system to cope better through winter than would otherwise have been the case. They are then often re-introduced the following autumn in the face of the

inevitable seasonal pressures kicking back in. Introduced at pace and allowing no real scope for long-term planning, these funds are often spent sub-optimally and, although pooled between the NHS and Local Authorities, they are typically spent separately[29].

"Previously, (just over a year ago) she was admitted with a blocked bowel. This was resolved, and she was ready to be discharged in 10 days. However, she needed two home visits a day afterwards, to help her during recovery. This just wasn't available. So she stayed in hospital for just over two weeks. This blocked a bed, and saw her condition deteriorate, because with only one physio session a week she took a lot longer to recover when she eventually got home. She eventually went home, with only one visit a day, rather than the required two. There really was a disconnect between NHS and Social Services. A complaint to the hospital patient liaison, and later the CEO, went unanswered".

This illustrates two key points about the problem of delayed discharges and how they can be tackled: 1) the inter-dependency between the NHS and social care; and 2) the persistent practical barriers to making them work well together. The introduction of the national discharge support fund provided some short-lived relief for some of the practical barriers and its removal has likely played a significant role in growing discharge delays and in turn corridor care. The Better Care Fund, on paper, acts to serve some of the same need, but disputes over who holds the budget and what care is in scope can limit its impact.

Road to recovery?

When someone is stuck in hospital they are not able to start their recovery. This should be the goal of every successful discharge – identifying what is necessary to help someone to return to the best possible state of health and daily living, and delivering the support to enable it. For some people at the end of life this can simply mean staying comfortable and being supported to die peacefully at home, if that's their place of choice.

When discharge to assess processes are carried out well and rapidly, a comprehensive assessment in the place where a person is recovering will provide a more accurate picture of their needs and will centre any care plan on what's most important to them. The fact that community services are often not resourced and set up to deliver this at pace is a major cause of many delayed discharges.

In some cases, older people can feel their discharge is pushed through regardless and we have come across a number of common issues:

- Feeling 'forced out' too soon and not having a voice in the process
- Patients and families facing unexpected bills for care and really struggling to make sense of how the funding system works
- Practicalities not being in place and care packages being inadequate
- Unsuitable/unsafe housing and this not being factored into discharge decisions
- Feeling a 'burden' ('bed blocker' language can often be used)
- Lack of attention to emotional and social issues
- Poor communication / lack of family and unpaid carer involvement.

One typical outcome from problems like these is that the older person comes back into hospital within a few days. In fact, fully a fifth of all emergency admissions of people over 75 occur within 30 days of a discharge from hospital[30]. A recent King's Fund report also stated that; "some 55% of homecare providers told us that hospital discharge paperwork does not reflect the person's needs and views, and 35% said most discharges they were involved in were not safe".

"Mum experienced a delay in hospital of around 5 days because of lack of communication, red tape between departments, and her house needing an assessment in order for her to return home. After she was discharged, I had to regularly visit mum to get her shopping, generally help her, and battle with the people who were meant to be looking after her."

The role of the voluntary sector in enabling safe and successful discharges

Older people and indeed their families often need very practical support, both on the day of discharge and in the days and week afterwards. This could include ensuring someone's house is warm during the winter; that there is food in the fridge, or that they have company and personal support to build their confidence and resilience as they recover. Help in the home, housing adaptations and welfare checks can further assist in making the recovery sustainable and in improving a person's morale and wellbeing. These are all classic roles for the VCFSE.

There are some outstanding examples of good practice in this respect within the VCFSE, and a strong evidence base to confirm the benefits in terms of improved outcomes for individuals and for the NHS, but frustratingly local NHS commissioners and NHS Trusts are not systematically taking advantage of the VCFSE services that are already available in their localities, or of others that could be if they signalled that they are required in their role as 'market shapers'. This is an important missed opportunity as this provision can quite often make the difference between a successful discharge and one that falls apart very quickly, resulting in a crisis re-admission – a disaster for any older person to whom this happens and a needless extra cost to the system.

Age UK Bolton: Preventing Admissions, Supporting Discharge and Enabling Recovery

Age UK Bolton's Home from Hospital service provides integrated admission avoidance, discharge and aftercare support, helping older people remain safe, independent and connected to their communities. Working alongside Bolton NHS Foundation Trust, North West Ambulance Service, Bolton Council and community partners, the service supports people before, during and after a hospital admission, preventing avoidable admissions, enabling safe discharge and supporting recovery at home.

By addressing practical, emotional and social challenges such as reduced mobility, loneliness, confidence, housing, transport and access to support, **the service helps older people regain independence while reducing pressure on health and care services**.

2025/26 Impact

- **2,493 older people supported** through the Admission Avoidance pathway
- **2,524 older people supported** through the Discharge & Aftercare pathway
- More than 25,000 support contacts delivered across both services
- Admission and readmission rates remained **consistently below 1%**, significantly lower than the Bolton benchmark of 8.4%, helping to avoid unnecessary hospital activity and associated NHS costs
- 100% of clients said they would recommend the service

Case Study – Rebuilding Confidence After a Fall

Following a fall and subsequent hospital admission, B, an 88-year-old widow living alone, returned home feeling anxious, isolated and lacking confidence. Reduced mobility and fear of falling again meant she was struggling to leave the house independently and was at risk of further deterioration and potential readmission.

Age UK Bolton provided practical and emotional support during the critical weeks following discharge. This included **welfare visits, escorted shopping trips to rebuild confidence, installation of a key safe to improve safety and access**, and support from the Information & Advice team to maximise income through a benefits check.

As B's confidence grew, she gradually began leaving the house again, re-established her daily routines and became less isolated. The support enabled her to recover safely at home, maintain her independence and avoid further crisis during a particularly vulnerable period.

"The contact and knowing I'd get help made me feel safe."

The service has become an integral part of Bolton's wider prevention, discharge and recovery pathway, supporting thousands of older people each year to avoid crisis, recover with dignity and confidence, and remain independent within their own homes for longer. In doing so, it helps **reduce pressure on acute services, improves hospital flow and delivers better outcomes** for older people across the borough.

Age UK Lancashire: Living Well Support Service

Reducing Discharge Delays and System Pressure

Age UK Lancashire's *Living Well Support Service (LWSS)* provides rapid, community-based support to adults following hospital discharge, illness, or crisis. The service enables safe and timely transitions home while reducing reliance on acute services. Working closely with Intermediate Care, LWSS operates a two-tier model: immediate, time-limited practical support (Tier 1) and follow-on guidance and longer-term assistance (Tier 2), ensuring continuity of care beyond discharge.

Activity and Responsiveness

During 2025, LWSS delivered support at scale, reaching over **12,770 individuals** through more than **59,000 contacts**. This included **1,900+ ward visits and 15,760 home visits**, demonstrating strong integration with hospital discharge pathways.

With staff embedded within hospital settings, the service responds rapidly to demand, achieving average response times of: 16 minutes for urgent referrals & 71 minutes for non-urgent requests. **This responsiveness directly supports patient flow and helps reduce discharge delays**.

Supporting Safe Discharge and Recovery

LWSS plays a critical role in addressing non-clinical barriers to discharge, including low confidence, lack of practical support, and social isolation. The service delivered: 12,000+ instances of advice, emotional support, and health-related guidance & 14,400+ referrals to over 370 partner organisations This ensures individuals can access the wider support needed to recover, regain independence, and remain safely at home.

Who the Service Supports

LWSS primarily supports older and higher-risk populations, with: 87% aged 65+ and 61% living alone. Many individuals have complex needs and long-term conditions, closely aligning with cohorts most at risk of delayed discharge. The service also contributes to reducing health inequalities, **supporting nearly 4,000 people in deprived communities** and delivering targeted interventions linked to NHS Core20Plus5 priorities.

System Impact

- Between October 2025 and January 2026, **LWSS prevented 99 hospital admissions & 1,080 bed days**
- This delivered **£335,667 net savings and a 903% return on investment**, demonstrating a highly cost-effective intervention.

Outcomes and Experience

User outcomes and satisfaction are strong, with: 68% reporting improved wellbeing & 99% recommending the service

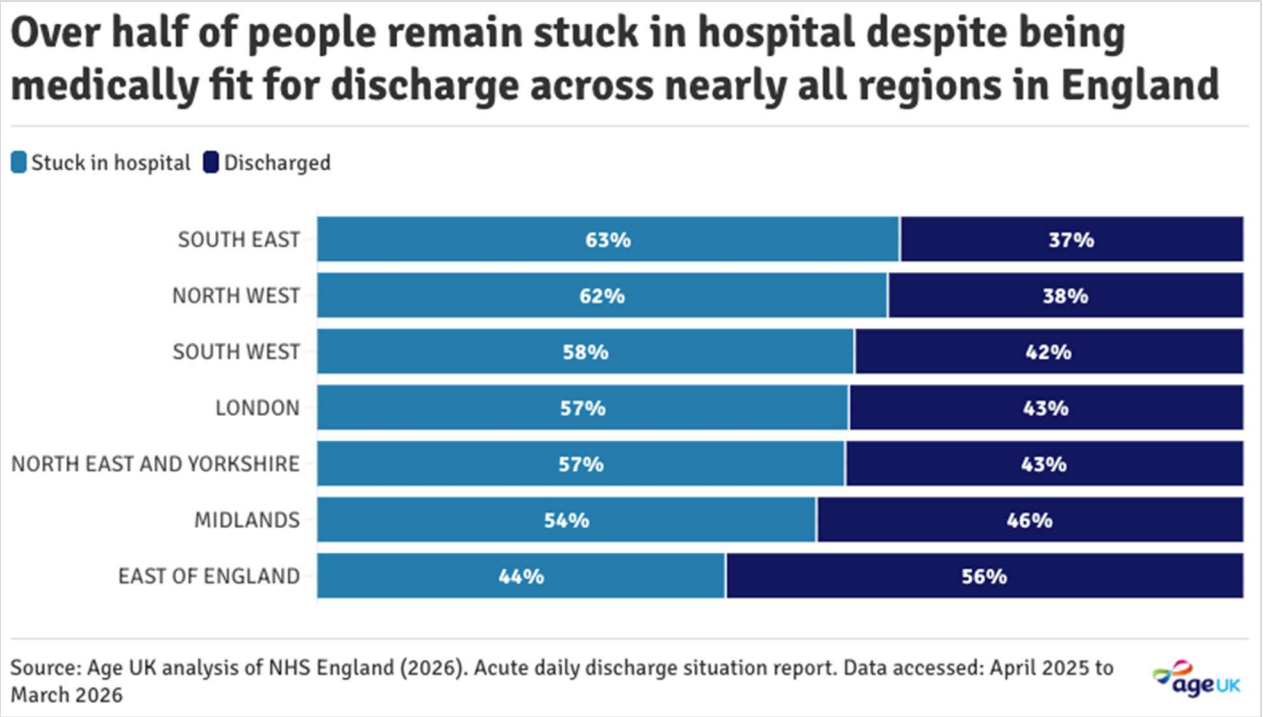
Through its holistic, coordinated approach, often involving multiple services per individual, LWSS ensures people are not only discharged promptly but are supported to remain well, safe, and independent at home.

Another post-code lottery

In our follow-up reporting on corridor care in January 2026 we revealed the wide variation between hospitals in performance on 12+ hour waits in A&E. 25 acute NHS Trusts[31] (just over 20%) accounted for half all incidents of 12+ hour waits for a bed. This led to NHS England making specific demands on the worst performing sites.

Trends in the numbers of delayed discharges paint a similar picture. In recent data (June 2026) 32 NHS Trusts (just over 25%) account for half of the total number of delayed discharges. This means that in these 32 Trusts alone, and in a single month, 206,000 bed days were lost to delayed discharge, at a cost of £116 million. The total for England was 408,533 and £229 million respectively[11].

In 2025/26 we can see this high degree of variation across the NHS regions. There is a difference of nearly 20% between the region with the lowest proportion of people stuck in hospital and the region with the highest proportion (44% vs 63%). Nationally, only one region achieves over half (56%) of people medically fit for discharge leaving hospital on a typical day (East of England).



The policy context

In response to campaigning calls, NHSE recently introduced a formal definition and metric for tracking corridor care[32] and agreed to collect and publish this data to monitor improvement efforts. However, in the flurry of associated guidance and policy announcements, the significance of discharge delays in tackling these challenges appears to have been lost. No new funding measures have been announced to tackle delayed discharges – including no increase in hospital beds or increases in social care and intermediate care capacity.

The Urgent and Emergency Care Plan 2025/26[33] acknowledges the wider impact of delayed hospital discharges on performance in urgent and emergency services and system-wide pressures, but the solutions identified do not major on them. Subsequent guidance on the Model Emergency Department, the Model Acute Pathway and a clinical decision-making framework for urgent community care focus on admissions avoidance and not the challenge of patient flow, impeded by delayed discharge.

Increasing the numbers of older people who are able to go home from A&E the same day is an important priority, but these approaches are failing to address the harm that is happening now to older people - in corridors, on wards and out into the community.

Multiple experts have commented that emergency care policy has diffused attention and resources. A metric on length of delays in the new hospital league tables is intended to increase the scrutiny of NHS Trust performance, but the new NHS planning framework does not address the fundamental frictions[34]. Social care is virtually invisible in the framework– yet, as this report has demonstrated, in practice it plays an enormous role in what happens to older people after they leave hospital. In fact in general, increasing access to social care is not generally acknowledged in NHS documents as a fundamental block to improving delayed discharge and in turn, corridor care – an extraordinary oversight.

The revised Better Care Fund (BCF) policy framework (published 17 Feb 2026)[35] identifies new arrangements, including asking health and wellbeing boards, ICBs and local authorities to more closely align plans for integrating health and social care services. However, in reality, the BCF remains in a phase of reform, reflecting uncertainties concerning the implementation of Neighbourhood Health. The Care Quality Commission (CQC), among others, has warned that the entire national strategy of moving care rapidly from hospitals into community health hubs is heavily at risk.[36] The problem is that community-nursing, GPs, and intermediate care teams are all under such acute structural strain that they cannot always safely absorb the complex, high-acuity patients who are being discharged.

> *"Instead of a simple target drawing attention to overall emergency care performance, we have many targets distracting from the key goal to ensure rapid treatment of emergency patients. The strategy assumes that many diffused activities will achieve progress when only a clear choice to improve access to beds will deliver anything notable. Lots of activity is preferred to lots of improvement."* Dr Steven Black, Data Scientist and expert in A&E data and performance (HSJ op ed, 1 June, 2026)

The Hospital discharge and community support statutory guidance[37] was published in March 2022 and last updated in January 2024. It details a duty for NHS and local authority bodies to co-operate and says "Health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they no longer require care". The statistics and stories shared throughout this report suggests the system is a very long way from meeting these duties.

The response from the system underlines a fundamental misunderstanding of the problems. That community health and care services are not equipped and resourced to meet the needs of older people living with frailty. Both in terms of preventing crisis in the first place and in mobilising quickly to support people home from hospital. No where is this more apparent than in the Model Discharge Pathway[38] published in June 2026. Its stated purpose is to "set out the model needed to make timely, clinically-led discharge routine", yet it does little to describe the role of community services and lacks any focus on delivery. The model includes an appendix on people living with frailty as a group at greater risk of discharge delays, but again does not acknowledge that they are the *predominant* group affected.

It repeats the mistake of previous guidance on urgent and emergency care pathways: an almost singular focus on hospitals and too little focus on older people with frailty. If those failures are not urgently addressed, the serious harm to older people will simply continue.

What needs to happen now

We are calling for national leaders, both in Government and NHS England, to recognise the serious harm being visited on older people due to delays in hospital. These harms start in A&E with 12+ hour waits; continue through their time on the ward with excessive length of stay; and are compounded at the exit with delayed discharges. We believe that lessening these harms must be prioritised in efforts to recover urgent and emergency care performance.

The evidence is unequivocal; reducing delayed discharges frees up capacity that enables people to be admitted in a timely way. Together with increasing the bed base overall, this will help to unlock hospital flow and start to end long waits and corridor care. Ultimately, reducing delayed discharges and improving outcomes for older people will require a combination of measures, including increasing capacity in social and intermediate care, NHS capital investment to improve hospital infrastructure, and implementing best practice for patient discharge across all trusts and interface processes.

Of course, it is also crucial that any improvements to flow, and any reduction in discharge delays, is achieved by improving patient care and supporting recovery, not 'exporting harm' by discharging patients prematurely.

"Discharged home after a fall, with four fractures and no social care or other support commissioned. There was an expectation that her son would care for her – but he lives at a distance and had not been part of any discharge conversation. When he arrived at her home he had no idea what to do and was worried by her condition so he called 111. The paramedic who attended was shocked and said his mother should never have been discharged. She was readmitted".

However, we know that there are places that are doing the right things and achieving really good results, having addressed immediate challenges while building towards the more proactive, person-centred care that both drives better outcomes and better value for public money.

Eliminating Corridor Care at Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust faced pressures familiar across the NHS: high bed occupancy, rising admissions, discharge delays and increasing emergency department attendances.

Why Change Was Needed

The experience of patients provided a powerful case for improvement. One patient described spending the night on a trolley in a corridor, saying it “wasn’t dignified” and that they “felt forgotten”. The Trust also recognised the associated risks to patient safety and staff morale.

A Whole-System Approach

As an integrated acute and community provider, supported by a strong integrated care partnership, Walsall Healthcare was able to look beyond the hospital walls. The Trust focused on building capacity, capability and connectedness across the whole system, rather than relying on a single solution.

Strong executive support, a culture of improvement and well-established trusted relationships across the system were key enablers. The Trust’s approach was grounded in a clear belief: corridor care is not inevitable.

Targeted Interventions

The Trust implemented a set of targeted interventions designed to improve urgent and emergency care performance, reduce avoidable admissions and support timely discharge and admission avoidance pathways.

- Expanded community capacity and capability to provide credible alternatives to conveyance and hospital admission.
- Strengthened urgent and emergency triage and care co-ordination across the system.
- Focused on front-door discharge, supported by extended senior clinical decision-maker input.
- Built capacity in same-day emergency care services outside the main emergency department footprint.
- Introduced daily specialty in-reach to the emergency department.
- Aligned diagnostic capacity more closely with demand.
- Managed more patients through outpatient hot clinics, preserving beds for those with higher-acuity needs.
- Promoted a home-first approach, with social workers embedded in front-door teams and access to 24-hour domiciliary care to support admission avoidance and discharge.
- Established a fully integrated transfer of care hub on the acute site, with joint funding to support rapid decision-making and same-day discharge once patients no longer met criteria to reside.

Impact

These interventions delivered sustainable improvements in five key performance areas:

- four-hour emergency department performance;
- emergency department triage;
- ambulance offloading;
- 12-hour waits in the emergency department; and
- decision-to-admit time.

They also improved hospital flow and length of stay, enabling more patients to spend their time in appropriate clinical areas receiving the right care.

Walsall's experience shows the value of a whole-system approach focused on what matters most to patients and staff. By combining community alternatives, front-door decision-making, same-day care, specialist input and home-first discharge support, the Trust reduced reliance on corridor care and created more sustainable improvements in urgent and emergency care.

The core message of this report is therefore that significant improvement is highly possible, as long as the system recognises the scope of the challenge; who is most affected; and the actions that will make a real difference.

View from the frontline:

"At an individual ward level, there is a lot that clinical teams can do in practical terms to reduce discharge planning delays. Predominantly this tackles those patients with internal delays but it would include things like:

- *Proactive early discharge planning from day 1 (planning discharge and care needs alongside medical care)*
- *Daily multi-disciplinary working, including medical, nursing, physiotherapy, occupational therapy and discharge planning team staff. We used to have input on the ward from a social worker however this role has devolved to the discharge planning nurses who act more as a liaison between the ward clinical teams and the social services teams*
- *Proactive chasing up of paperwork and systems to help identify where patients are in the discharge planning process*
- *Active involvement of patients and families in discharge planning decisions"*

Consultant geriatrician

Recommendations

The figures and underlying trends presented in this report speak for themselves: delayed discharges among older people are another crisis hiding in plain sight to add to the one we have already identified with corridor care. However, as with corridor care, we are confident that with the right policies and political attention it is crisis that can be overcome, because there is wide agreement among experts about the potential solutions.

To give older people the best chance of making a full recovery, as well as improving 'patient flow' in hospitals to help eradicate corridor care and long waits, Age UK calls on the Government to:

- End the funding disputes between the NHS and local authorities over who pays for an older person who needs social care and other forms of support following discharge. There are different ways of achieving this, for example, through reform of the Better Care Fund or by establishing a specific joint fund. During the pandemic something akin to the latter was established and worked well.

- Face up to the need to increase the number of hospital beds. Much can be done to free up beds through better discharge planning and by preventing avoidable admissions, but the truth is that we currently have fewer beds per head of population than we need.

- Strengthen community capacity to help older people to get home, recover and stay well. This requires, among other things, enabling every older person to be assessed at home within 24 hours of discharge; the NHS being far more strategic and intentional in commissioning effective VCFSE organisations to help older people go home and settle, especially those living alone; and supporting the unpaid carers who will be caring for older people when they get home. Success will also depend on increasing the availability of intermediate care and reablement and ultimately, of course, on reforming social care and expanding its capacity.

- Turbo-charge a peer learning programme for hospitals to help them to minimise in-hospital discharge delays, caused by factors such as waiting assessments, for discharge letters to be signed and medication and transport home to be organised. Planning discharge at the earliest opportunity and working closely with community services are other important factors. Some hospitals are more efficient than others in these respects and their good practice needs sharing to support improvement across the board.

- Strengthen data collection: Trusts should be required to collect and publish their numbers of 12+ hour waits and delayed discharges, alongside the ages of those affected. This would increase transparency and accountability, recognising who is most affected and inform the policy changes required to drive better practice.

In addition, we repeat our calls from our first report on corridor care for Government to:

- Produce a funded operational plan to reduce the incidence of long A&E waits and end corridor care, with specific deadlines and milestones.

- Give explicit accountability for reducing long A&E waits and ending corridor care to a Minister in the Department of Health and Social Care, requiring them to report on progress to Parliament every six months.

Finally, we strongly recommend that the term 'bed blockers' is consigned to the past because it is victim-blaming and ageist. As this report shows, the problem is with the system not the person.

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