SIMPLE GUIDE TO THE CARE ACT AND DELAYED TRANSFERS OF CARE (DTOC)

1. UNDERPINNING PRINCIPLES

Across the whole system, our common aims are to:

- Improve services for patients by avoiding situations where, particularly older people are put at risk by remaining in the acute sector when they no longer need acute care.
- Encourage systems to invest together in an extended range of services to prevent delays occurring in the first place.
- Reinforce partnership working between acute trusts and local authority social care departments.
- Drive a better system of discharge planning encouraging the development of proactive planning for discharge rather than the reactive last minute planning for discharge that still exists in many trusts.
- Whether reimbursing or not the system of notification is necessary for alerting community and social services to the likely need for services post-acute discharge and the forward planning for discharge through expected dates of discharge.

2. THE CARE ACT

The Delayed Discharge Act of 2003 was replaced by the Care Act 2014. One of the aims of the Care Act is to ensure that people do not remain in hospital when they no longer require care that can only be provided in an acute trust. The arrangements for discharging patients who are likely to have on-going care and support needs have been designed to encourage acute trusts to plan for discharge in advance of the patient no longer requiring acute care.

The current requirements are described in Annex G of the Care and Support Statutory Guidance which can be found at https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation. The annex is short and worth reading in full. The changes made by the Care Act are small in number and are:

- Every day of the week now counts, including weekends and all Bank Holidays.
- The terms ‘Assessment Notice’ and ‘Discharge Notice’ are used instead of Sections 2 and 5 notices.
- Fining is no longer mandatory.
• The patient’s NHS number must be included in Notifications, as must the name and contact details of the person at the hospital liaising with the local authority.

3. REPORTING – SITREPS

Counting delays

From April 2004 there has been a separate, but linked, requirement to return a weekly/monthly report, as a part of the wider system reporting (SitReps). This has identified all delays in transferring patients from acute settings since 2003 and from non-acute settings since 2006. It specifically excludes acute to acute transfers and internal acute trust delays.

There are three broad categories:

• reasons related to social care;
• reasons related to health care (non-acute);
• reasons related to delays in both health and social care.

All categories must be counted for the SITREP.

For social care delays, reimbursement is no longer mandatory and it is up to the discretion of local systems whether they want to charge or instead use the resources in a different way to support effective discharge. The latter two categories of delay are not reimbursable but they also need to be counted.

Categories of Delay

There are 9 sub-categories for each of the 3 types of delay leading to detailed information if collected correctly about reasons for delay. (See the SitRep guidance at http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/Monthly-Sitreps-Definitions-DTOC-v1.08.pdf).

There are clear definitions for all the categories in the guidance and some systems have further subdivisions – and this is up to local discretion. Appendix 1 offers an example of sub-categorisation that will be helpful in ensuring that delays are counted consistently across the country.

SITREP Reporting

The delayed transfer information by code is input via UNIFY onto the report. The requirement is to return this monthly and it must include all health, joint and social care delays. It is common for reporting frequency to increase to weekly from October through to April, and sometimes daily, although this is not done through UNIFY currently. This has led to shortcutting of the above process in some systems as there has not been a robust validation process. This can lead to disagreements about numbers that have impacted negatively on local partnership behaviours. Best practice is that systems should be in agreement with any numbers that are being nationally reported.
There is a requirement that the SitRep return is validated, agreed and signed by the trust and social care. This should be at Executive Director-level in the acute trust and the Director of Adult Social Care-level in the local authority. Delegation is acceptable as long as there is a process for escalation if there are any disputes. The validation process should also sign off delays for other councils. This is commonly delegated to managers from the trust and the local authority who have responsibility for the discharge of patients within their remit.

In many systems reporting higher numbers of delays, a more in-depth review of patients has shown that there were things that had not happened that were in the acute trust’s control and that might have had a positive impact on delays. We recommend that it is good practice to collect information on delays that are internal to the trust and understand the reasons why. Whilst they are not reportable DTOCs, solutions are commonly in the grasp of the acute trust. Attached at appendix 1 is a list of sub-categorisation of DTOCs and internal waits that are not reportable.

4. PROCESSES and TIMELINES

Notifications

Acute trusts are required to make two notifications to social service departments. The first notification, an ASSESSMENT NOTICE, gives notice of a patient’s possible need for services on discharge this should include:

- A prediction of the LOS i.e.: an expected/estimated or target discharge date (EDD).
- A sign that the possibility of the need for NHS Continuing Care has been considered (see national continuing care framework). This is an area that can cause significant process delays in systems. It should be reviewed against the framework to ensure that full assessments of need are not being undertaken in the acute setting while people are still acutely ill or if there is still potential for improvement. Ideally, existing assessments of patients should be used rather than starting a new assessment process with additional professional involvement. Assessments should be undertaken by the team that knows the patient best.
- Using a discharge to assess model is one way of way ensuring that timely assessments are not happening in an acute setting. At any one time there are a number of people in an acute bed, whose acute medical episode is complete, but who still need further assessments or non-acute care. Rather than wait in hospital for further assessment of their long term needs, patients can be discharged from hospital into a more appropriate care setting. With a stay of up to six weeks, patients receive specialist treatment, support and assessment, with the aim of enabling them to return home or move to a more suitable care setting.
- The patient must be aware of the referral and have consented to it. If the patient lacks capacity and it is considered in best interests of the patient that a notification is sent, the family or carers should be made aware.
- Full demographics including the NHS number are required on the Notification
Following this there is a second notification requirement – **DISCHARGE NOTIFICATION**. This gives notice of the date the person will definitely be ready for discharge.

**Timescales**

The timescales laid down for services to be put in place are:

- **MINIMUM** of three days from the day the assessment notification is sent or the day after the proposed discharge date, whichever is the later. See the timeline attached at Appendix 2
- A notification sent after 14.00 is counted from the next day.

If the agreed care is not ready after these timescales have lapsed, the person is regarded as a validated delayed discharge and the days of delay are counted from this point. The reason for the delay may change during the time a person is delayed. If this happens, the recorded reason for the delay should also be changed and reported by reason for each day in the monthly report. One patient may have days in different categories, e.g. waiting for assessment, followed by days waiting for provision of care.

If the hospital is proactive in sending the notifications, the person will go home on the day they no longer require acute care. There will be a small number of cases where there are safety concerns linked to safeguarding issues when the MDT agree that it is not safe for them to go. The aim of the MDT should be to try and have everything in place for the day when the person no longer requires acute medical or nursing care.

**Short Stays**

Local agreements have been made for acute assessment and short stays (2 midnights or less) where people are not in hospital long enough for the process to be helpful. The need for rapid communication and decision-making should allow appropriate care to be put in place quickly in this instance. There needs to be evidence that a process was followed and that agreement by both health and social care to adapting the process. If the person then stays longer the proper notification process must be commenced.

**Withdrawal/Cancellation of Notifications**

There is a requirement to withdraw/cancel notifications if the person’s condition changes meaning that the original EDD is no longer valid. This has been an area of confusion, and it is not permissible for any member of the MDT to withdraw the notification with no involvement of the clinically responsible doctor.

The process for cancellation should be designed to eliminate paperwork for the wards and have a requirement to ensure that a senior member of the medical team, including a consultant or specialty registrar, has agreed that the change is clinically necessary. (In many systems therapists, nurses and others change the date when the medical team has not agreed the need for change, which is not correct).

The ‘challenge’ question that should be used is, ‘Can what the patient needs only be carried out in an acute setting?’ If it can be done safely and appropriately elsewhere, then the hospital can make provision for the medical need to be met outside the acute setting and the person is still fit for discharge. This situation often relates to on-going rehabilitation, which should ideally should be undertaken in the patients’ own environment.
(home) supported by intermediate tier services. If the patient is awaiting tests or results these can often be undertaken as an out-patient.

Occasionally the person’s condition changes radically e.g. they have a stroke, or falls and fractures. If this happens, the entire notification process should start again.
Recording

If there is a timed trail of communication the process does not have to be a paper one. Electronic systems for communicating the notifications have been developed in many systems and work well.

Agreeing Numbers of Delayed People and Bed Days

Counting should not become the be all and end all of the process. The focus should be on what needs to happen to ensure that the person can be discharged in a timely fashion whilst ensuring they understand what is happening and being planned. They, their family and carers should be involved and informed at every stage. The challenge question at this point is, 'If what the patient needs were available at this moment would they be discharged?'

Appendix 2 shows the timeline that describes when the person can be reported as a delayed transfer of care. There is a requirement to agree monthly with social services the total number of days that patients have been delayed in a month and the numbers at a point in time (the last Thursday of the month). Most systems do this at least weekly to ensure that the information is correct and agreed. They use the exercise to ensure that intractable delays are escalated in a timely way.

Medically Fit for Discharge/Medically Optimised

A number of new terms such as ‘medically fit for discharge’ have become a common and have led to two different figures being reported daily from systems. The ‘medically fit for discharge’ figure is that for the number of patients that the acute trust reports do not need to be in an acute bed. This figure is usually much higher than the DTOC figure, particularly in systems where all DTOC patients may not be being reported due to misunderstandings about what should be reported. In

Definition: ‘When the consultant (or deputy) judges that a hospital in-patient no longer requires acute inpatient care.’

- ‘Medically fit for discharge’ or ‘medical optimised’ is that point at which care and assessment can safely be continued in a non-acute setting. It is a decision that balances the acute care requirements of the patient, the typical desire of individuals to return to their home environment at the earliest opportunity, the potential harm associated with staying in hospital and the needs of other more acutely ill patients. Too often, early discharge is seen as ‘freeing up a bed’ rather than acting in a patient’s best interests to move them swiftly to a safer, more familiar environment that will encourage supported self-management, speed recuperation and recovery, and have them feel better. We must make every effort to shift understanding. The term ‘medically fit for discharge’ should be dependent on answering the following questions.
  - Does the patient’s care need to be on an acute hospital site? OR
  - If community/intermediate services or reablement/nursing home phoned up today, would the patient be stable to go (if capacity were available)? OR
If I saw the patient today on call, would I try to get them straight home again with any support they needed?

- Medically fit for discharge status is NOT related to whether all the assessments been completed or equipment delivered, nor whether the patient back to a baseline level of function.
- It should be a date and time specific; this will focus efforts and allow performance against plan to be measured more accurately. Consultants (and deputies) should be encouraged to default to 08.00 or 09.00 and variance from the default should be explained e.g. 10.00 because needs X-ray on day of discharge).
- EDD (expected date of discharge) can be interpreted as either the date of medical optimisation or the best guess of when the system will have the patient ready to go home. It should be the former so that it drives to the system to meet the medical needs of the patient.
- All staff must understand that there is recognition that patients may still have ongoing care and assessment needs (e.g. therapy or social care assessment), but that these needs can and should be met in the community.

5. GOOD PRACTICE

Medically Fit

In some systems social care has said that they will not accept notifications until the person is medically fit, which has prevented this forward planning. This goes against both the spirit and the letter of the Care Act and its guidance, and is potentially risky for patients, given the evidence of physical decompensation from excessive acute stay.

Below is a definition of ‘Medically fit for discharge’ or ‘medically optimised’ that has been agreed NHS England, Monitor, the TDA and the Department of Health. We suggest that this is used to judge whether someone is medically ready for discharge and, if they are not a reportable DTOC understand, what specifically they are waiting for in terms of safety or MDT decision and challenge whether an acute trust is the best place for outstanding decisions to be made.

It is the legal responsibility of the acute trust to send the notifications and social care cannot refuse to accept them before the person is medically fit. In return the acute trust has to ensure that it is not sending large numbers of notifications inappropriately, causing large amounts of wasted work for social care whose reaction has in some cases been to wait to undertake assessment until the person is medically fit. This misses the point of the Act.

This is a process that managers can review and provide feedback and training on. There is potential to use existing tools to highlight people likely to need an assessment. This can link to the current development of acute frailty pathways in many hospitals. However, the Care Act is clear that wards should flag a ‘likely need for social care services implying a small margin of error is to be expected’
‘Choose to Admit’ and ‘Discharge to Assess (at home)’

There is increasing evidence that if a good functional assessment and collection of information on what a person is normally like is taken on admission, ideally at the point of handover from the ambulance service, a plan for discharge can be set at this point. Ensure that this information follows the patient if admission is required, with daily senior consultant review and structured board rounds it is possible to plan in advance and source the necessary care and equipment while the person is in the final stages of treatment. If further assessment of need is required the person should go home with short term support (intermediate care/reablement) and have further assessment as they recover in their normal environment.

If the care or equipment is not available they will count as a delayed transfer of care taking account of the above timescales. Implementing the Emergency Care Intensive Support Team (ECIST), SAFER flow bundle will support proactive planning?

There is increasing good practice information from sites working to ensure only those patients who require acute care are admitted ‘choose to admit’ and support discharge home with a ‘discharge to assess’ model.

Timescales for Health Delays

We suggest good practice is to use the same timescales for health delays as are set in the Care Act for social care. In the best systems the same notification paperwork is used whether the person is going to be supported by social care, health or joint services on discharge. The notifications go to a single integrated hub that can decide the most appropriate service available to support the person.

Decisions on Long-Term Care

Decisions on long-term care should not be made in an acute setting. With this in mind, acute trust staff need to be able to describe functional needs rather than stating what service or placement a person requires. It is not acceptable for acute staff to commit social care resources by independently stating what the specific service need may be.

The Care Act is clear that these decisions should be made in a way that a person’s preference is central and needs to be undertaken in way that empowers and involves the person at every stage. Therefore doing this once the person is home with short term support is more likely to allow the person and their family (if appropriate) to make an informed, timely decision about how and where they would like to live. This also applies to decision about Continuing Health Care, where the framework is clear that decisions should not be made while the person is acutely unwell or where there is potential for further improvement.

Decisions about long-term care either to a placement or at home should not be made in an acute setting. The majority of people should be supported to go home with a short term package that supports recovery, reablement and rehabilitation. Assessment of the person and their carer should happen in this intermediate period. Although there may be
occasions where it is necessary to do this in a bed based setting, home should always be considered as the first option.

**Internal Delays**

It is good practice to collect information on internal delays that are in the direct control of the Trust from the moment a person is admitted to hospital with the aim that every day in hospital adds value from a patient perspective. Typically these include delays in diagnostics and in assessments, including consultant reviews by another specialty.

There can be as many, if not more days lost during a person’s time in hospital as there are at the point of transfer/discharge from the acute setting. Systems that are routinely collecting the internal as well as external delays they are finding that where patients are stated as being ready for discharge, they are not reportable DTOCs because there are internal process issues.

Some trusts have developed a system of counting green and red time in hospital to monitor, manage and escalate issues that are leading to internal delays.

**Informed Patients, Relatives and Carers (with the consent of the patient)**

Sharing information everyday with patients about what is happening with them is essential if they are going to be an equal partner in decision making. We know that this improves flow as the patient or their family will ask why planned interventions and/or decisions are not happening.

All patients should be able to answer the following questions every day.

- What is wrong with me?
- What is being done to fix it, what am I waiting for next?
- What do I need to be able to do to go home, and has anyone asked me?
- When am I going home?

**Planned Admissions**

For elective patients where pathways and length of stay are predetermined, both parts of the notification process can be sent up to 7 days before admission although it can be earlier if there is local agreement. This has been achieved in many systems with notifications sent direct from OP Clinic or pre-op clinics. This ensures that the person has thought about what help they made need on discharge before coming to hospital. Care can then be in place on the day they are fit for discharge. It has significant benefit for the patient and their family who are clear what is going to happen pre admission and are therefore better able to plan.

6. **CONCLUSION**

In a system that is working well, there will be less difference between the numbers of medically ready for discharge and the reportable DTOCs. Acute trusts should:
• Focus on standardising and reducing variation in their internal processes,
• Ensure timely and appropriate notifications,

External partner organisations should:
• Develop the ability to provide for the assessed need on the day the person no longer needs acute care,
• Focus on proactive planning to a single expected date of discharge,
• Ensure a range of short term services is available to allow assessment in a person’s home wherever possible.

Implementing the Care Act well will improve communication with patients and between professionals. The counting of DTOCs will aid the system to understand unmet need and bottlenecks and ensure that pathways through the system become patient rather than organization- or service-centered.
The sub-categories have been developed to provide an accurate reflection of system delays and they can be added up to match the sit rep reporting requirements which asks for health, social or joint delays to be recorded.

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<td>Housing issues – homeless (discharge to local Council Offices)</td>
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**APPENDIX 2**

**DAY 1**

Assessment Notice sent by 2pm

An assessment notice can be sent up to seven days prior to admission, but must be sent at least 2 days prior to proposed discharge date. Any notification sent after 2pm counts as having been sent on the following day.

**DAY 2**

Discharge Notice sent by 2pm with proposed date of discharge

A discharge notice must give at least one day's notice of the proposed discharge date. Weekends, Bank Holidays etc. are not exempted and are counted the same as any other day.

**DAY 3**

PROPOSED DISCHARGE DATE

This is the discharge date proposed on the discharge notice. Note that this diagram illustrates the minimum timescales for notification. Where possible, the NHS should give greater notice than the minimum.

**DAY 4**

Delay becomes potentially reimbursable if services are not in place by 11am on the following day

The NHS has the discretion to ask for reimbursement from the Local Authority for each day an acute patient's discharge is delayed. The Local Authority is not held liable for reimbursable delays on a given day if it has, by 11am that day, put arrangements in place such that it is then safe for the patient to be discharged.