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Delayed transfers of care: problems of definition, measurement and governance

Dr Peter Levin

– EXECUTIVE SUMMARY –

- Recent Government Mandates to NHS England have instructed it to reduce 'NHS-related delayed transfers of care' from hospitals. The 2019 NHS Long Term Plan duly set as a goal 'to achieve and maintain an average Delayed Transfer of Care (DTOC) figure of 4,000 or fewer delays'.
- NHS England provides hospital trusts with guidance, updated in 2018, on how to prepare their DTOC figures. This guidance attempts to shoehorn together two completely unrelated approaches, one of which does not even offer a procedure to follow.
- In practice, every trust is free to decide for itself how to measure its DTOC figures, as recent examples from Cornwall and elsewhere show.
- It follows that such figures cannot meaningfully be added together. So they do not provide a sound basis for the NHS Long Term Plan or any other policy proposals.
- This situation has been known about at local level for several years, and concerns have been relayed upwards. So why has nothing been done about it? One reason may be that the process of 'refreshing' the guidance in 2018, entrusted to a multi-agency group, was unmanageable.
- NHS England said the refreshed guidance on definitions, counting and reporting would remove ambiguity, but it did not. It was supposed to emphasize local collaboration, but it removed an injunction to that effect in the previous version. It was claimed that it would offer 'good practice examples' from around the country, but it presented none at all.
- This paper examines the problems around finding a satisfactory definition and way of measuring DTOCs, and makes a number of recommendations for resolving them. These include (1) replacing the blame-implying term 'delayed transfer' with 'transfer interval'; and (2) measuring the transfer interval from the point at which a patient is assessed as medically fit for discharge, to the point of actual discharge. This would provide a standard that could be applied uniformly across the country.
- As for governance, it is also suggested that NHS England's 'comply or explain' regime, which distracts hospital trusts into playing a game of 'satisfy the statisticians', be abandoned in favour of one that supports trusts and local authorities to minimize over-staying in hospital. Empowering patients to push for prompt discharge would also help to achieve this.

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1. The NHS Mandate and the Long Term Plan

The Government's Mandate to NHS England (NHSE) for 2018-19[1] instructed it to reduce NHS-related delayed transfers of care. The NHS Long Term Plan, published in January 2019, duly said:

> The NHS and social care will continue to improve performance at getting people home without unnecessary delay when they are ready to leave hospital ... The goal over the next two years is to achieve and maintain an average Delayed Transfer of Care (DTOC) figure of 4,000 or fewer delays, and over the next five years to reduce them further.[2]

In the past a major objective has been to 'free up' hospital beds, as NHS England still puts it,[3] but nowadays the stated aim is, by reducing patients' length of stay in an acute hospital, to reduce their risk of suffering 'physical and cognitive deconditioning'.[4]

NHS England (NHSE), which governs the National Health Service in England, is an 'arm's length' body responsible to the UK Department of Health & Social Care (DHSC). Recently it has been particularly concerned about the delayed transfer of two categories of patient: those who will need to move from an acute hospital to somewhere with local authority support, and those who will require a non-acute inpatient NHS bed – in a community hospital, for example.[5] In February 2020, a quarter of all recorded delayed days experienced by patients in acute care in England were spent waiting for transfer to NHS non-acute care. So this is a sizeable category.[6]

2. Guidance from the Department of Health & Social Care

The DTOC figures for England are compiled from returns submitted by individual hospital trusts. These bodies are provided with guidance from two sources, DHSC and NHSE.

DHSC publishes *Care and support statutory guidance.*[7] This is based on the Care Act 2014 and Regulations made under that Act. It specifically addresses 'the process for managing transfers of care from hospital for patients with care and support needs'. It focuses primarily on patients who will need local authority support on leaving, but the issues involved in transfers will be very similar for patients moving to a community hospital or other non-acute NHS provider.

Although the DHSC guidance does not identify a procedure as such – with a flow chart, for example – it sets out a series of steps to be taken to identify and quantify a DTOC. The procedure in a straightforward case is as follows.

When the hospital trust considers that a patient who is receiving acute care may need care and support when they are discharged, it must issue an Assessment Notice to the relevant local authority. The Assessment Notice is only the trigger for assessment and care planning, but it must give an indication of the patient's expected discharge date, if that is known.

On receiving the Assessment Notice, the local authority must assess the patient's needs and determine whether any of those needs meet certain eligibility criteria. If they do, it has to decide what it will do to meet those needs, and then inform the hospital.

The local authority must have made arrangements for meeting the patient's needs before the proposed day of discharge, which will be not less than two days after the Assessment Notice has been received. (A Notice received after 2pm is treated as received on the following day.)

The patient should be told the discharge date at the same time as or before the local authority.

Where the hospital has issued an Assessment Notice to the local authority, it must also issue to it, either then or later, a Discharge Notice stating the proposed date of the patient's discharge, even if that only confirms the date already given in the Assessment Notice.

If the local authority has failed to arrange to receive the patient by the day after the date specified in the Discharge Notice, then a delayed transfer exists. The days of delay will mount up until the patient is finally discharged.

In law the hospital trust can seek reimbursement from the local authority in respect of a patient's delayed transfer of care, if it has issued both an Assessment Notice and a Discharge Notice, but the statutory guidance says that while this power is available for use by NHS bodies, they and local authorities are encouraged to focus on working effectively together.

The consequence of this guidance is that the hospital trust and the local authority have some discretion in how far ahead to set the discharge date. The further into the future it is, the smaller will be any delay in transfer.

We can now construct a step-by-step chart for the discharge process, as shown in Box 1.

Box 1. The process of discharging a patient from an acute hospital into local authority-supported accommodation.

1. The hospital considers whether a hospital patient who is receiving acute care may need social care provision after discharge. It consults with the patient, then takes a decision.
2. The hospital decides a proposed discharge date, which can be provisional at this stage.
3. The hospital informs the patient of the proposed discharge date.
4. The hospital issues an Assessment Notice to the local authority, stating the proposed discharge date, if known.
5. The hospital issues a Discharge Notice to the local authority (but this may be delayed until after step 7 or 8), either confirming the discharge date contained in the Assessment Notice or setting a new one.
6. The local authority carries out a needs assessment of the patient and decides, if certain eligibility criteria are met, what arrangements it proposes to make to meet those needs.
7. The local authority informs the hospital of the outcome of its assessment and decisions.
8. The hospital and the local authority reach agreement as to the social care provision to be made after discharge.
9. The local authority makes the appropriate arrangements.
10. The patient is discharged and transferred.
11. If the actual discharge takes place after the date specified in the Discharge Notice, the number of days elapsed is the Delay in Transfer of Care, the DTOC, for that patient.

Where discharge is to a place of further NHS care, such as a community hospital, the process will be similar but will relate to the new NHS provider instead of the receiving local authority.

3. Guidance from NHS England

In November 2018 NHS England published guidance on reporting DTOCs, in the form of an 18-page document entitled *Monthly Delayed Transfers of Care Situation Report – Principles, Definitions and Guidance',* referred to here as 'the NHSE guidance'.[8]

The NHSE guidance is very different from that of DHSC. An extract is shown in Box 2.

Box 2. From NHSE's guidance

Definition of a Delayed Transfers of Care (DTOC) *(sic)*

A delayed transfer of care from NHS-funded acute or non-acute care occurs when [an adult] patient is ready to go home and is still occupying a bed. A patient is ready to go home when all of the following three conditions are met:

(1) A clinical decision has been made that the patient is ready for transfer home;
(2) A multidisciplinary team (MDT) decision has been made that the patient is ready for transfer home; and
(3) The patient is considered to be safe to discharge/transfer home.

A clinical decision in an acute setting, means a consultant-led medical decision. (In a non-acute setting, it means a decision taken by a clinical member of the MDT, eg a doctor, nurse or therapist.)

The clinical decision, that a patient is medically optimised, is the point at which care and assessment could be continued at home or in a non-acute setting or the patient is ready to go home. …

'Medically optimised' means professionals asking themselves the following questions [including]:

- Does the patient's care need to be continued in the current clinical setting?
- Are the needs of the patient better met in a different care setting?
- If the support and services required to meet the assessed need at home were available at this moment, would the MDT in the hospital confirm that the patient could now go?

There are numerous indications of confusion, to put it politely, in all this.

Decisions. We have at least three decisions here, not two. Condition (3), exactly like conditions (1) and (2), must involve a decision – in the sense of a judgment – as to whether or not the patient is safe to discharge. However, we are not told who should take this third decision, who should do the considering. Nor are we told whether the three decisions are to be taken in any particular order.

Terminology. 'Ready for transfer home' versus 'safe to transfer home'. The NHSE guidance uses both these terms without explaining the distinction between readiness and safety. It may be that 'ready for transfer' is intended to mean 'ready to depart', while 'safe to transfer' is intended to mean 'can safely be accommodated at the destination': if so, this is not made clear.

A clinician will have no first-hand knowledge of the circumstances of a patient's home or other potential destination. This could be 'home' in the sense of single-household accommodation; a community hospital, when the patient is in need of further NHS care; a nursing or residential

care home, as might be needed by a frail elderly person; or intermediate care of some kind. A patient could be 'safe' to be discharged to one of these destinations but not to another.

The multi-disciplinary team. The guidance document says: 'A multi-disciplinary team (MDT) in this context should involve people from all the relevant professional groups who have knowledge of the patient and the support they will need in their home setting. Where consent has been given by a patient, then consideration should always be given to involving family members, carers, etc.' We are not told whose responsibility it would be to convene this team, how it would be decided who should be invited to join it, or how it would work.

'Medically optimised'. On a number of counts, the guidance is unclear:

- Whether a patient is 'medically optimised' cannot logically be ascertained by merely 'asking questions': it will depend on what the answers are and on who is giving them.
- Saying that the clinical decision is the point at which 'the patient is ready to go home' is not consistent with the clinical decision being only one of the three conditions that have to be met for a patient to be ready to go home.
- Whoever is taking the decision as to whether a patient is 'medically optimised' is being required to second-guess what the MDT would decide. And as for 'the MDT in the hospital', the guidance says explicitly that the MDT should 'involve people from all the relevant professional groups', which will include social workers and others who may not be employed by the hospital.

  (Incidentally, while 'optimisation' may be a term in common use by the medical profession, the dictionary definition of 'optimizing' is 'making the best of', whereas it is being used here to mean 'meeting a threshold', manifestly not the same thing.)

Although the NHSE guidance elaborates on the three conditions that need to be met for a patient to be ready to go home, and says a DTOC begins when all three have been met, it goes on to provide the same instruction as the DHSC guidance about Assessment and Discharge Notices. That is, a DTOC begins when the day of discharge specified in the Discharge Notice has elapsed, not on a day when some or all of the three conditions have been met. So the NHSE guidance contains instructions that are mutually inconsistent. They are literally incoherent and impractical.

4. DHSC and NHSE guidance compared

The DHSC guidance is written to guide NHS and local authority staff through the discharge process. Although it does not present a step-by-step chart, it is straightforward – as shown in Box 1 – for a reader to create one. The NHSE guidance, on the other hand, leaves the reader mystified as to the steps to be followed. Stipulating three conditions does not help.

The DHSC guidance is clearly written, with the reader, a person with responsibility for the discharge process, in mind. It is logically set out and the language and what it means are clear. It

is illustrated with case studies of the treatment of individual patients. None of these is true of the NHSE guidance.

The NHSE guidance bears the marks of insertions evidently made to reflect the concerns of clinicians: a 'clinical decision', 'a consultant-led medical decision' and 'medically optimised'. These decisions/conditions are not set in the context of any procedure. Consequently they serve only to confuse the situation.

5. Local autonomy: what happens in the hospitals?

Both sources of guidance allow hospitals freedom to choose how to calculate days of delay. The discretion that exists at local level is illustrated by the answer given at a meeting of the Board of the Royal Cornwall Hospitals Trust (RCHT) in February 2020 to a question from myself: 'How is it decided, and by whom, and at what point, that an inpatient should be categorized as Delayed Transfer of Care?'

Shortly after the meeting, I received this written (and partial) response from the RCHT Deputy Director of Operations, by email:

> The NHS Data Dictionary rules are that the clock counts from the point of the receiving service accepting the referral for the assessment and a patient is classified as a DTOC after 3 days. Operationally, we are working across the Cornwall system to consider any patient waiting longer than 48 hours for another service to be a delay, but not a formal DTOC. The Embrace [project] diagnostic has shown this is an important milestone and the Embrace work is aiming to deliver a reduction to 48 hours from referral to another service to the patient being transferred.

Interestingly, the published minute of the meeting recording the answer to my question omits the references to the NHS Data Dictionary, 'the clock' and 'the referral for the assessment'.[9] It begins:

> A patient is classified as a Delayed Transfer for Care after 3 days. Operationally, we work across the Cornwall system ...

But neither the DHSC guidance nor the NHSE guidance makes any mention of '3 days', 'the receiving service' or 'referral'. And the RCHT description makes no mention of any of the three conditions laid down in the NHSE guidance.

What are we to make of this?

In a nutshell, it appears that the Trust is free to make up its own rules for deciding when a delay to a transfer commences.

From which it further follows that hospital trusts in general are free to make their own rules.

This is not a new finding. Newton Europe, in a study carried out in Northern England and published in 2017, found 'major variation' in how the expected date of discharge was set among systems and individuals within them, with some setting it as the expected 'medically optimised

date', while others were putting back the date to allow for administrative delays, e.g. making an allowance because 'they know home care takes a week to put in place'.[10]

In another study of 14 hospitals spread over nine geographical areas, Newton Europe again found wide variations, including in the proportion of patients judged medically fit for discharge. This appears to be a further indication of the discretion afforded to staff as to whether a case should be recorded as DTOC or not. They concluded that the approach to decision-making across the sector was one of 'fixing' the nationally reported statistics, rather than optimizing the outcomes for individuals, and was entrenched within some systems' behaviours and culture.[11]

(Newton Europe also found that the longer a patient waited to be discharged after being judged medically fit for discharge, the more likely it was that after eventually being discharged they would find themselves placed in a setting with services that were not best matched to their individual needs.)

Newton Europe decided to adopt their own definition of a delayed discharge. They measure delay from the day when a patient is declared medically fit for discharge, despite the fact that in the NHSE guidance this seems to be only one of the three conditions ('the clinical decision') for a transfer of care to be counted as delayed. The difficulty with this is that, as noted above, discharge is a transfer from an origin to a destination. By definition, 'medically fit for discharge' applies only to the origin of a transfer. A delay may be caused by conditions at a proposed destination. And there is, as Newton Europe observe, a 'disconnect' between services at origin and destination.

6. Why did the latest NHSE guidance ignore what was already known?

Although, as noted above, in 2017 Newton Europe had already identified 'major variation' in how the expected date of discharge was set among systems and individuals within them, the newly-revised guidance published by NHSE in November 2018 took no account of this: it did no more than reiterate the instructions on using Assessment and Discharge Notices and the 'three conditions' of the previous version (published in October 2015).[12] So it failed to rectify the major problem in defining and counting DTOCs that Newton Europe had identified.

On NHS England's website, there is some relevant information (undated) about how the NHSE guidance came to be written:

> NHS England and NHS Improvement, Department of Health and Social Care, Association of Directors of Adult Social Services, Local Government Association and Emergency Care Intensive Support Team colleagues have been working collaboratively to refresh the Monthly Delayed Transfer of Care Situation Report … . The work on refreshing the DTOC guidance was identified and commissioned in response to a number of ongoing operational issues and concerns from local health and social care systems.

> The refreshed guidance on definitions, counting and reporting is seeking to remove ambiguity and improve operational clarity, with the aim of improving partnership working and reducing disputes. The guidance now places more emphasis on local collaborative solutions to any barriers first as part of a wider picture of joint and integrated working (which is embedded in the Care Act). The multi-agency group that refreshed the guidance has also pulled together a series of good practice examples from systems from around the country. All of the products were consulted and tested with a sample of local systems. [13]

With such a plethora of high-powered talent bringing its brains to bear, what could possibly go wrong?

Something plainly did. Although there is no published information on precisely how the new version was drafted, we can see that the 'refreshed guidance'

- did not remove ambiguity.
- did not place emphasis on local collaborative solutions to any barriers. Indeed, it removed an injunction in the previous version that 'this guidance should be read in conjunction with the Care and Support Statutory Guidance issued under the Care Act'.
- did not present even one 'good practice example' from 'around the country'.

Moreover, the new version's references to legislation are in a non-standard format and it is idiosyncratic in its layout, with boxes containing disconnected blocks of text inserted at various points. It seems a reasonable inference from this that a leading role in drafting was played by people of limited relevant experience, and in particular that the involvement of some individuals (clinicians?) was limited to suggesting 'we need to say something about X'.

I conclude that Newton Europe's work was ignored because those in charge of putting together the inputs from the various contributing bodies found the task beyond them. Possibly they took it as merely a redrafting exercise. The fact is that they did not address the need to put the three conditions for discharge in the context of a procedure, nor did they address the fact that the system of Assessment and Discharge Notices, which they allowed to stand, allowed local discretion in setting expected dates of discharge.

7. NHSE's approach to reaching its goal

Having committed itself in the NHS Long Term Plan to the goal of reducing the quantity of delayed transfers of care, and having published incoherent guidance to the providers of health and social care, what means does NHSE have for reaching this goal?

Since 1 April 2019, NHS England has been working with NHS Improvement as a new single organisation. In their joint 'manifesto', *What we do*, NHSE and NHS Improvement (NHSEI) say their operating model has been designed to support delivery of the NHS Long Term Plan.'[14]

> Local health systems are supported by our seven integrated regional teams who play a major leadership role … They make decisions about how best to support and assure performance in their region …
>
> Our revitalised culture of support and collaboration will be underpinned by a new approach, including:
>
> - a move away from relying solely on arm's-length regulation and performance management to supporting service improvement and transformation …
> - strong governance and accountability mechanisms …
> - a reinforcement of accountability at board, governing body and local system integrated care system level for … making their contribution to critical national improvement programmes, *on a comply or explain basis*. (my italics)
>
> Our approach to delivering the NHS Long Term Plan will balance national direction with local autonomy … Local implementation will be led by the clinicians and leaders who are directly accountable for patient care and making efficient use of public money. …

8. On a 'comply or explain' basis

So. 'Our revitalised culture of support and collaboration will be underpinned by a new approach.' The word 'support' is a favourite one of NHS England. It occurs more than 400 times in the NHS Long Term Plan's 120 pages. It gives the impression of 'working together' in partnership with local NHS trusts. But the regional teams whose job it is to play a 'major leadership role' are clearly in a position to give orders to 'accountable' NHS trusts and demand information from them, under the threat of sanctions if they do not 'comply or explain'.

If the regional bodies had been doing their job they would have noted the problems with measuring DTOCs and would have reported these up the line. The fact that there is no evidence of them doing this again suggests that they see their role as enforcing rather than supporting. So much for 'local autonomy'.

9. The role of NHS Digital

A significant part in enforcing accountability is played by the requirement that NHS trusts submit monthly figures on the use made of their services. We have an example of this mechanism on the slides presented in October 2019 by staff of NHS Digital (another of DHSC's arms-length executive agencies) to a 'webinar' entitled *Delayed Transfers of Care (DToC): Understanding how to make a successful DToC submission to the Mental Health Services Data Set (MHSDS).* **[15]**

Although the presentation repeats the 'definition' of a delayed transfer of care from NHS-funded acute or non-acute care as occurring when a patient is ready for transfer and is still occupying a bed (as per NHSE guidance), when it comes to counting delayed days it is again forced to rely on the arithmetic of Assessment Notices and Discharge Notices.

The reference in the title to making a 'successful' submission is also interesting. Success is gauged not by the usefulness of the information but by whether the rules have been followed:

> For MHSDS to function four tables must be populated. These are mandatory. Without these your submission will not be accepted and will fail. [But] Submitting only the mandatory tables would not usually be a full submission, as it is often required tables and fields that contribute to measures. (Slide 14)

'Must', 'submit' and 'fail' are words from the vocabulary of enforcement.

Webinar slide 24 provides a further demonstration of the subservient position of trusts. They are told '44% of DTOC submissions are OK, 56% need improvement'. Hospital trusts seem to be finding themselves in a game of trial-and-error, in which they have to work out how to give the statisticians of NHS Digital what they want. Trusts are clearly not participants in a mutually supportive relationship with the shared aim of assisting hospitals to get patients home sooner.

The consequence is that while hospital trusts can satisfy NHS England by improving their DTOC figures, they can achieve this by simply allowing a day or two longer for home care to be put in place. Such an 'improvement' will plainly not denote success in getting patients home sooner.

10. Why NHSE's guidance system has failed

This case study reveals that the DTOC notification system has a major failing: it allows each hospital trust to decide for itself how to count days of delay. As we can see, this situation has come about and persisted through a concatenation of factors:

- Trusts were effectively given discretion to set their own expected date of discharge.
- Despite the resources put into writing and revising NHSE England's guidance, this feature of the system was not identified.
- Because – it would appear – of clinicians' involvement, the attempt to structure the method of calculating DTOC figures around meeting 'three conditions' without specifying what procedure should be used for arriving at the figures to be submitted, was doomed to failure.
- The regional authorities, although nominally given the role of supporting the hospital trusts, failed to perform that role.
- NHS Digital found itself playing the part of 'enforcer', with the result that trusts found themselves playing a game of 'satisfy the statisticians' rather than receiving support.
- NHS England seems to have been unaware of what was going on: its communication system did not tell it what was happening on the ground. The regional bodies were evidently blocking rather than facilitating communication between hospital trusts and the centre.

11. The need to take a 'systems view'

The findings of this study have underlined the importance of taking a 'systems view' of structures and processes within the establishment that provides health and social care. Doing this would enable a recasting of the relationships between NHS England and Improvement and the localities in a way that makes mutual support a reality.

Taking a systems view is what we are doing when we ask how a system works. It was asking this question that revealed the exercise of discretion at local level that resulted in wide variations in how DTOC figures were generated.

A systems view also implies viewing as a whole a patient's 'trajectory' from suffering an illness or injury to eventually being settled in permanent accommodation. Newton Europe have performed a valuable service in pointing to the difficulty of establishing a common date from which to calculate a delay, and they recommend that the date of deciding that a patient is medically fit for discharge should be that date.

However, if we take a systems view of a patient's trajectory we can see that that decision can mark a major break in it. It is the point at which clinicians can say, as they do daily at handovers in hospitals: 'Our job is done. This patient is no longer our responsibility. We are handing responsibility for them over to other people.'

The 'other people' in this context will often be ward-based staff. A study published by the Local Government Association (LGA) found that ward-based staff such as nurses were predisposed to argue that patients should move on to a short or long-term residential placement rather than return home. This despite lacking knowledge of the full range of alternatives that were available to support patients at home.[16]

12. What changes need to be made?

Taking a systems view, of a patient's trajectory as a whole, it is clear that there needs to be an awareness all through a patient's progress of the options available for them to move on. Someone with this awareness should be present at the 'front door', so unnecessary admissions can be avoided, and at the point when the patient is considered medically fit for discharge. They should be aware of all the treatments and care available within the community, and ideally in a position to set up a service for patients that might have obviated the necessity for them to present themselves at the Emergency Department in the first place.

This role is already played at the discharge end of a patient's trajectory by discharge coordinators. Interestingly, the LGA study found that where the discharge coordinator had clear accountability for the discharge process, 'ward staff tended not to get involved in discussions with the patients about their longer-term options'. So another way of gaining an overview of a patient's entire trajectory through the hospital system would be for the discharge coordinator to be involved from the point of the patient's admission.

13. From three conditions to a procedure

I come back to the question of how to formulate NHSE's guidance in terms of a procedure that practitioners can follow. We know that according to NHSE's guidance a DTOC begins when three conditions have been met. How can this requirement be made into a procedure?

Newton Europe's approach is to count delay from the point when a patient is judged medically fit for discharge. This presents two difficulties.

First, it ignores two of NHSE's three conditions: that a multidisciplinary team decision has been made that the patient is ready for transfer home; and that the patient is considered to be safe to discharge/transfer home.

I have found no documented evidence of how these conditions are met in practice. Further study of actual decision-making would be required to discover (a) whether it is usual for the 'medically fit for discharge' decision to precede the other two; and (b) whether it is usual for the multidisciplinary team to take a simultaneous decision as to safety as well as readiness for transfer. But if both of these were found to be the case, we might have a procedure for the NHSE guidance which incorporates that of the DHSC and looks like this:

Box 3: A revised procedure for transferring a patient to local authority-supported accommodation

1. Decision taken by clinicians that a patient is medically fit for discharge.
2. The hospital issues an Assessment Notice to the local authority, stating the proposed discharge date, if known.
3. Simultaneous multidisciplinary decisions are taken that a patient is both ready to discharge and safe to transfer to a known destination.
4. The hospital issues a Discharge Notice to the local authority, either confirming the discharge date contained in the Assessment Notice or setting a new one.
5. The patient is discharged and transferred.
6. If the discharge does not take place on the stipulated discharge date, a delayed transfer of care begins on the day following.

The second difficulty with Newton Europe's approach is that it ignores the evident propensity of some hospital staff to make an allowance of a few days for arranging the patient's new accommodation and support, and the actual transfer. This propensity may conceivably derive from the fact that delay is a pejorative term, something that one is liable to be blamed for, and that if hospital discharge coordinators form a close collaborative relationship with local

authority staff who support patients after they have left hospital, as they are encouraged to do, they may well be reluctant to become involved in a 'blame game'.

This is a difficulty that could probably be resolved by a change in what is measured and in nomenclature. If the starting point were the 'medically fit for discharge' decision and the end point were the date of the patient's actual transfer, and the time between them were known as the 'transfer interval' or something similar, this would both provide a standard that could be applied uniformly across the country, affording a sound basis for comparison as between localities, and avoid the pejorative connotation of 'delayed'.

Box 4. The 'transfer interval'

1. Decision taken by clinicians that a patient is medically fit for discharge. The transfer interval begins at 00.01 hours on the following day.
2. The hospital issues an Assessment Notice to the local authority, stating the proposed discharge date, if known.
3. Simultaneous multidisciplinary decisions are taken, as soon as possible after the 'medically fit for discharge' decision, that a patient is both ready to discharge and safe to transfer to a known destination.
4. The hospital issues a Discharge Notice to the local authority, either confirming the discharge date contained in the Assessment Notice or setting a new one.
5. The patient is discharged and transferred. The transfer interval ends at 00.01 hours on the morning of that day.

Under such a scheme, statistics could be gathered for completed transfers on a month-by-month basis and for transfers yet to be completed on a 'snapshot' basis. Localities with the longest transfer intervals could be supported to learn from those with the shortest, as could those with outstandingly high numbers of yet-to-be-completed transfers.

14. Where is the voice of the patient?

Finally, in all the discussions of DTOCs, nothing has been heard of the voice of the patient, save for pleadings to be allowed to go home. Older people living with frailty who find themselves in hospital can expect to be 'processed' in ways they cannot control. They have little or no say in what happens to them. Other people decide what their diagnosis is, how they should be treated, what tests they should undergo, whether they are fit to return home. And while they are kept waiting for assessments and decisions, their mental and physical condition deteriorates.

An effort needs to be made to give older patients some control over what happens to them. I hope my consumer guide *How to escape from hospital: a guide for older patients (and family and friends)*[17] will gain wider circulation and assist in achieving this aim. Help with this enterprise would be welcome.

Notes and references (Websites last visited on 15 July 2020)

NOTE: To view sites whose URL extends over more than a single line, the URL may need to be pasted into a browser.

[1] Department of Health & Social Care, *The Government's revised mandate to NHS England for 2018-19*, May 2019
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803111/revised-mandate-to-nhs-england-2018-to-2019.pdf

[2] NHS England, *The NHS Long Term Plan*, January 2019, para 1.34
https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[3] NHS England, *Next steps on the NHS Five Year Forward View: Urgent and emergency care*
https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/urgent-and-emergency-care/

[4] As Note 2, p.7 and para 1.34

[5] NHS England, *Monthly Delayed Transfers of Care Situation Report, Principles, Definitions and Guidance*, November 2018, p.2
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/11/Monthly-Delayed-Transfers-of-Care-Situation-Report-Principles-Definitions-and-Guidance.pdf

[6] NHS England, *Delayed Transfers of Care Data 2019-20*
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