

Monthly Delayed Transfer of Care Situation Reports

Definitions and Guidance

Monthly Delayed Transfer of Care SitReps Definitions and Guidance

Version	Date issued	Changes made
1.00	18 December 2006	
1.01	31 March 2008	<ul style="list-style-type: none"> • Indicator of response to pressures on system (G1) has been removed from the collection. • The derived fields have been removed from the guidance. • Cat A and B details recorded lines are now voluntary. • New line added - number of category B calls responded to within 19 minutes of call connection to control room.
1.02	18 January 2010	<ul style="list-style-type: none"> • Paediatric Critical Care fields have been updated to Paediatric Intensive Care. • Paediatric Intensive Care definitions have been updated.
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1.07	8 April 2013	<ul style="list-style-type: none"> • Removed references to PCTs and SHAs. • Revised to make the definitions clearer to avoid confusion and misinterpretation.
1.08	8 April 2015	<ul style="list-style-type: none"> • Revised to reflect the amendments made by the Care Act 2014 and its Regulations.
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Delayed transfers of care of acute and non-acute (including community and mental health) patients

1. Background

1.1 Information about delayed transfers of care is collected for acute and non-acute patients, including mental health and community patients, on the Monthly Delayed Transfers Situation Report (SitRep) return. The focus of the return is to identify patients who are in the wrong care setting for their current level of need and it includes patients waiting for external transfer in all NHS settings, irrespective of who is responsible for the delay.

1.2 This guidance applies to **both acute and non-acute** patients, including community and mental health patients. This is irrespective of whether the delay is potentially reimbursable and which organisation is responsible for the delay. The data collected on this form should include all delays that occur.

1.3 It is recommended that there should be more emphasis on local collaborative solutions to address barriers first as part of a wider picture of joint and integrated working which is embedded in the Care Act 2014.

2. Care Act 2014

2.1 This guidance and the Monthly Delayed Transfers SitRep return reflect changes made by the provisions of the Care Act and the Care and Support (Discharge of Hospital Patients) Regulations 2014 in relation to the reimbursement regime for delayed discharge of hospital patients with care and support needs.

This guidance should be read in conjunction with the new Care and Support Statutory Guidance issued under the Care Act. This can be found here:

[Care and Support Statutory Guidance document](#)

2.2 The Act updates and re-enacts the provisions of the Community Care (Delayed Discharges etc.) Act 2003, which set out how the NHS and local authorities should work together to minimise delayed discharges of NHS hospital patients from acute care. The NHS is still required to notify relevant local authorities of a patient's likely need for care and support and (where appropriate) carer's support, where the patient is unlikely to be safely discharged from hospital without arrangements for such support being put in place first (an assessment notice). The NHS also has to give at least 24 hours' notice of when it intends to discharge the patient (a discharge notice). From 1 April 2015, if a local authority has not carried out an assessment or put in place care and support or (where applicable) carer's support, and that is the sole reason for the patient not being safely discharged, the NHS body has

a discretion as to whether to seek **reimbursement from the relevant local authority** for each day an acute patient's discharge is delayed.

2.3 In contrast to the recording of delays, the assessment and discharge notifications required under the Care Act¹ only apply to NHS patients receiving **acute care**.

“Acute care” means intensive medical treatment provided by or under the supervision of a consultant that lasts for a limited period, after which the person receiving the treatment no longer benefits from it. The following are not “acute care”:

- care of an expectant or nursing mother;
- mental health care;
- palliative care;
- a structured programme of care provided for a limited period to help a person maintain or regain the ability to live at home;
- care provided for recuperation or rehabilitation.

2.4 Given the different scope for SitRep reporting and Care Act notifications, relevant NHS bodies will need to monitor the following separately for acute and non-acute (including community and mental health) patients:

- Which local authority is responsible for each patient delayed
- Number of patients whose discharge is delayed – subdivided by responsible local authority
- Number of days delayed (including reimbursable days) – sub-divided by responsible local authority
- Agency responsible for the delay (NHS, Local Authorities, or both)
- DTOC allocation is by residence, irrespective of who is responsible for the delay it is the Local Authority of residence

2.5 Local monitoring will need to take place on a **daily** basis in order to calculate any reimbursement charges payable for any delays in discharges of acute care caused by a local authority not undertaking assessment, or putting in place any arrangements to meet care and support in time.

2.6 SitRep returns for both acute and non-acute patients will continue only to be required on a **monthly** basis. However, daily monitoring should take place in order to record the number of delayed days each month for the SitRep. There may also be times, where this data may need to be reported nationally.

2.7 The Delayed Transfers SitRep and reimbursement definitions of acute care are consistent in that they both refer to patients and not beds. Reimbursement applies to delays affecting those patients admitted for, and who have been receiving, acute care. In the understanding that acute care is not always provided from an acute bed, the focus of reimbursement stresses

¹ See Schedule 3 to the Care Act and the Care and Support (Discharge of Hospital Patients) Regulations 2014 (S.I. 2014/2823)

the type of care the patient has received at the hospital, not the bed he or she has been allocated to. The return covers patients in inpatient NHS beds.

3. Definition of a Delayed Transfer

3.1 A SitRep delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

A patient is ready for transfer when:

- a. A clinical decision has been made that patient is ready for transfer **AND**
- b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
- c. The patient is safe to discharge/transfer.

3.2 A multi-disciplinary team (MTD) in this context should be made up of people from different professions, including social workers where appropriate, with the skills and expertise to address the patient's on-going health and social care needs. If there is any concern that a delay has been caused by the actions or inactions of a Local Authority, they should be represented in the MDT. The way that the team is organised and functions is fundamental to timely discharge and to the patient's wellbeing.

3.3 Where delays occur for people of no fixed abode, the crucial issue is to identify the local authority responsible for providing them with care and support services. If they are admitted to hospital from a public place then the postcode of that place should be used to identify the responsible local authority.

3.4 For asylum seekers or other patients from overseas, they should be listed under the local authority in which they currently reside. It is the responsibility of the local authority to decide whether they are eligible for social services. The basic principle is that, where local authorities are responsible for providing care and support services for an individual, the NHS body may seek reimbursement for any delays attributable to social care should they wish to do so.

4. Medically Optimised

4.1 To help them manage patient flow more effectively, some NHS organisations collect data on the number of patients for whom a clinical decision has been made that they are ready to transfer. A number of terms are used, including 'medically fit for discharge' 'clinically optimised' or 'medically optimised'. It is important to remember, however, that 'medically optimised' is **not** the same as a delayed transfer of care.

4.2 The determination that a patient is medically optimised is from a medical perspective only, and is a decision made usually by the consultant or team who are responsible for the patient. The patient has not had a MDT decision at this point and, indeed, may need further therapy or social care in-pat prior to a MDT decision being made, so is not a reportable delay.

4.3 'Medical optimisation' is the 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 to this reality.

4.4 All staff must understand that there is recognition that patients may still have on-going care and assessment needs (e.g. therapy or social care assessment), but that these needs can and should be met in the community.

5. Assessment Notices

5.1 The Care and Support Statutory Guidance explains that, in general, the NHS should seek to give the local authority as much notice as possible of a patient's impending discharge. This is so the local authority has as much notice as possible of its duty to undertake a needs and (where applicable) carer's assessment.

5.2 However, an assessment notice must not be issued more than 7 days before the patient is expected to be admitted into hospital. This is so the notice is not provided too far in advance of admission to avoid the risk of wasting preliminary planning in the event that the patient's condition changes. A balance should be struck between giving the local authority early notice of the need to undertake an assessment of the patient and the risk that the patient's condition may change significantly such that any early planning needs to be reviewed.

5.3 Accordingly, if the NHS is able either to issue an assessment notice up to seven days before the date of the patient's admission into hospital and/or have a good indication of the likely proposed discharge date that is unlikely to change, then the NHS should issue the assessment notice as soon as possible.

5.4 The information contained in an assessment notification is intended to be minimal, both to reflect patient confidentiality and to minimise bureaucracy; it is only the trigger for assessment and care planning. Details of what the assessment notice must include are set out at Annex A.

5.5 On receiving an assessment notice, the local authority must carry out a 'needs assessment' of the patient and (where applicable) a carer's assessment so as to determine, in the first place, whether it considers that the patient and where applicable, carer has needs. The local authority must then determine whether any of these identified needs meet the eligibility criteria and if so, then how it proposes to meet any (if at all) of those needs. The local authority must inform the NHS of the outcome of its assessment and decisions.

5.6 To avoid any risk of reimbursement liability, the local authority must carry out a needs assessment and put in place any arrangements for meeting such needs that it proposes to meet in relation to a patient and, where applicable, carer, before “the relevant day”. The relevant day is either the date upon which the NHS proposes to discharge the patient (as contained in the discharge notice) or the minimum period, whichever is the later.

5.7 The minimum period is 2 days after the local authority has received an assessment notice or is treated as having received an assessment notice. Any assessment notice which is given after 2pm on any day is treated as being given on the following day. Examples of how these timescales work are given at Annex B.

6. Discharge Notices

6.1 Patients and carers should be informed of the discharge date at the same time as, or before, the local authority. In addition, hospital staff may give the local authority an early indication of when discharge is likely as part of helping their planning.

6.2 Where the NHS has issued an assessment notice to a local authority, requiring the local authority to assess a patient’s care and support needs, it must also give written notice to the local authority of the proposed date of the patient’s discharge notwithstanding that it included the proposed discharge date in the assessment notice. This is known as a discharge notice and its purpose is to confirm the discharge date as it either may not have been previously known at the time of the issue of the assessment notice, or, may have subsequently changed since the assessment notice was issued.

6.3 Hospital Discharge Coordinators should develop positive and constructive working relationships with their local authority adult social care team in order to assist the NHS to quickly identify which local authority the assessment notice should be sent to. This will ensure a timely, person centred assessment and discharge, and to reduce the possibility of inter-authority disputes regarding Ordinary Residence.

6.4 To ensure that a local authority receives fair advance warning of the discharge, the NHS body must issue a discharge notice indicating the date of the patient’s proposed discharge. The minimum discharge notification allowed is at least one day before the proposed discharge date. Again, where the discharge notice is issued after 2pm, it will not be treated as having been served until the next day. Again, examples of how these timescales work are at Annex B.

6.5 The NHS cannot seek to recover any reimbursement from the local authority in respect of a patient’s delayed transfer of care unless it has first issued both an assessment notice and a discharge notice. Details of the information that a discharge notice should contain are outlined in Annex C.

7. Timing of Delayed Transfers SitRep

Monthly snapshot

7.1 Some items reported in the monthly SitRep are snapshots at a particular point in time (rather than a cumulative total during the period). The snapshot counts should report the position at midnight on the last Thursday of the calendar month. In other words, the snapshot should be taken at the end of Thursday / start of Friday.

Snapshots at midnight on the last Thursday of the month are reported for the following items:

- **(a)** Number of patients whose transfer is delayed at midnight on the last Thursday of the month

Monthly total of all delayed days

7.2 **For the purposes of recording monthly overall levels of DTOC**, there is a separate definition set out in the NHS SitRep guidance and repeated in the Care Act Statutory Guidance. Through this process, a picture of all delays – attributable to both the NHS and Local Authority– is captured.

This should include the delayed days for all patients delayed in the month, including patients not present at the time of the monthly snapshot. The monthly SitRep reporting period is a calendar month. The reporting period covers from 00.00 on the 1st calendar day of the month to 23:59 on the last calendar day of the month.

A total count between these times should be reported for the following items:

- **(b)** Number of days delayed within the month for **all** patients delayed throughout the month

8. Number of Patients whose Transfer of Care is Delayed

8.1 The Monthly SitRep Delayed Transfers (MSitDT) return is split into two sections; one for non-acute patients and one for acute patients. The first question in both sections is on the number of patients whose transfer of care is delayed. This should be a snapshot count of the number of patients delayed at midnight on the last Thursday of the reporting period (a calendar month). Being a snapshot, it will only include patients that are currently delayed at that point in time (midnight on Thursday). The columns for this question are labelled (a).

Data in columns **(a)** - a snapshot at midnight on the last Thursday in the reporting month, of the number of patients currently delayed at that point in time. Therefore, this would not include any other patients that have been delayed in that month.

8.2 The number of patients whose transfer of care is delayed is also split by whom the delay is attributable to (attributable to NHS; attributable to Care and Support provided by Local Authorities; and attributable to both) and the reasons for the delay (see Section 7).

8.3 All data must also be subdivided by the local authority responsible for the patient's care and support needs. This is the local authority where the patient is ordinarily resident or, if it appears that the patient is of no settled residence, the local authority in whose area the hospital is situated.

9. Number of Days Delayed within the Month

9.1 The MSitDT return is split into two sections; one for non-acute patients and one for acute patients. The second question in both sections is on the number of days delayed within the month. This should be the total number of 'delayed days' during the reporting period (a calendar month). This will include the days accrued by patients identified in the return as being delayed transfers at the time of the snapshot (a), plus any days accrued during the month for patients delayed at other points in the month. Please note that this includes weekends and public holidays. These rules apply for when a notice is deemed to have been received regardless of whether it is a week day, weekend or public holiday. This is to reflect the policy expectations that both the NHS and local authorities should have arrangements in place for providing services 7 days a week. The columns for this question are labelled (b).

Data in columns **(b)** - the total number of delayed days for **all** patients that have been delayed in the reporting month.

9.2 The number of delayed days in the month is also split by who the delay is attributable to (attributable to NHS; attributable to Local Authority; and attributable to both) and the reasons for the delay (see Section 7). Only the number of delayed days attributable to care and support delays in respect of hospital patients receiving acute care will qualify for reimbursement charges. All delays must be recorded however non-acute Social Care delays will not be reimbursable.

9.3 For a delay to qualify as reimbursable, an 'Assessment Notice' under paragraph 1(1) of Schedule 3 and "Discharge notice' under paragraph 2(1) of Schedule 3 must be issued. Delays do not have to be reimbursed, or qualify for reimbursement, to count as Social Care delays.

9.4 All data must also be subdivided by the local authority that has care and support responsibility for the patient, which is the local authority where the patient ordinarily resides.

10. General Information

10.1 There is an expectation that delays to transfers of care will be minimised through the following steps:

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- Discharge planning begins on admission to hospital or in the early stages of recovery
- There are no built-in delays in the process of deciding that a person will no longer benefit from acute care and is safe to be transferred to a non-acute (including community and mental health) setting
- That the NHS and Local Authority will jointly review policies and protocols around discharge, including handling of choice of accommodation; and have systems and processes for assessment, safe transfer and placement, as part of their capacity planning
- These steps should be guided by good professional practice and safe, person-centred transfers. Although an acute ward is not appropriate once an acute episode is over, joint planning is needed to ensure that appropriate care is available in other settings.

10.2 These figures are being collected for all adults (over 18s) in the Monthly Delayed Transfer of Care SitReps (MSitDT).

11. Reasons for Delayed Transfer of Care

11.1 Both the number of patients whose transfer of care is delayed (a) and the number of days delayed within the month (b) are subdivided by the reasons for delay:

	Attributable to NHS	Attributable to Local Authority (Care)	Attributable to both
A. Awaiting completion of assessment	✓	✓	✓
B. Awaiting public funding	✓	✓	✓
C. Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	✓	✗	✗
D i). Awaiting residential home placement or availability	✓	✓	✗
D ii). Awaiting nursing home placement or availability	✓	✓	✓
E. Awaiting care package in own home	✓	✓	✓
F. Awaiting community equipment and adaptations	✓	✓	✓
G. Patient or Family choice	✓	✓	✗
H. Disputes	✓	✓	✗
I. Housing – patients not covered by Care Act	✓	✗	✗

11.2 A patient should only be counted in ONE category of delay each day, this category should be the one most appropriately describing their reason for delay and total numbers allocated to reasons for delay should equal the number of patients delayed. The table also shows which reasons can be attributed to NHS, Local Authority and both.

11.3 The delayed days for a given patient can be split across the reasons for the delay. For example, if the total length of delay is 10 days, the first two days were due to waiting for the assessment to be completed and the following eight days were due to waiting for a nursing home placement, then the delayed days will be split across reason A and D ii.

11.4 Data for the indicators covering reasons for delay should include ALL adults who have been receiving treatment and are awaiting discharge, not just those aged 75 and over.

Definitions

A) Awaiting completion of assessment

11.5 All patients whose transfer is delayed due to them awaiting completion of an assessment of their future care needs and an identification of an appropriate care setting. This can include any assessment by health and/or social care professionals of a patient's future care needs. Therefore, delays can be due to either: NHS, Local Authority or a combination of both. NHS bodies will want to identify with their Local Authority partners where in the process, and why, delays are occurring.

11.6 NHS bodies need to monitor locally the amount of time taken to arrange assessment. Good practice would suggest this process should be in place prior to the decision to discharge being made.

B) Delay awaiting public funding

11.7 All patients whose assessment is complete but transfer has been delayed due to awaiting Local Authority funding (e.g. for residential or home care), or NHS funding (e.g. for NHS-funded Nursing Care or NHS Continuing Healthcare). This should also include cases where the Local Authority and NHS have failed to agree funding for a joint package or an individual is disputing a decision over fully funded NHS Continuing Healthcare in the independent sector. It does not include delays due to arranging other NHS services (residential or community) – see below.

C) Delay awaiting further NHS care, including intermediate care

11.8 All patients whose assessment is complete but transfer is delayed due to awaiting further NHS care, i.e. any non-acute (including community and mental health) care, including intermediate care. It also includes where a decision has been made to defer a decision on NHS Continuing Healthcare eligibility, and to provide NHS-funded care (in a care home, the patient's own home or other settings) until an eligibility decision is made but the transfer into this care is delayed.

Acute delayed transfers of care:

Include all delays of patients leaving acute care. This includes patients waiting to move to non-acute care within the same NHS body. Do **not** include delays of patients continuing to receive acute care moving from one bed to another, even if these beds are in different NHS bodies.

Non-acute (including community and mental health) delayed transfers of care:

Include all delays of patients leaving non-acute (including community and mental health) care. This includes patients waiting to move to other types of non-acute (including community and mental health) care within the same NHS body. Do **not** include delays of patients continuing to receive the same type of non-acute (including community or mental health) care moving from one bed to another, even if these beds are in different NHS bodies.

11.9 These should not include delays in providing NHS-funded care provided in the patient's own home, such as that provided by a District Nurse (rather than a conscious decision to defer consideration of eligibility for NHS Continuing Healthcare). These delays should be recorded under 'E' – delay due to awaiting care package in own home. See below for details.

D) Delay awaiting Residential/Nursing Home Placement/Availability

11.10 All patients whose assessment is complete but transfer is delayed due to awaiting Nursing/Residential home placement, because of lack of availability of a suitable place to meet their assessed care needs.

11.11 This does not include patients where Local Authority funding has been agreed, but they or their family are exercising their right to choose a home under the Choice of Accommodation Regulations and Guidance. These patients should be counted under category G.

E) Delay due to awaiting care package in own home

11.12 All patients whose assessment is complete but transfer is delayed due to awaiting a package of care in their own home.

11.13 The delay should be logged as the responsibility of the agency responsible for providing the service that is delayed. This should be possible to ascertain even where agencies operate in partnership, as statutory responsibilities for care do not change under partnership arrangements. NHS input to a home care package might include the services of a district nurse or CPN, an occupational therapist or physiotherapist.

11.14 The 'further non-acute (including community and mental health) NHS care' box should be used to record NHS services where these are not provided in the patient's home, examples of which might include intermediate care, rehabilitative care, care provided in a community hospital, or fully-funded NHS Continuing Healthcare.

11.15 The delay should *only* be logged as the responsibility of *both* agencies where both NHS and local authority services are delayed.

NHS Continuing Healthcare

11.16 The National Framework for NHS Continuing Healthcare (NHS CHC) and NHS-funded Nursing Care November 2012 (Revised)¹ sets out the principles and processes for determining eligibility for NHS CHC and also an approach to hospital discharge which should not lead to delayed transfers of care. It should not be necessary, in many cases, to wait for an NHS CHC assessment before discharging someone from hospital. Such discharges will be agreed locally between the relevant health bodies until a decision on NHS CHC eligibility has

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf (see paragraphs 62 to 74 and PG 13)

been made. In a hospital setting, before an NHS trust, NHS foundation trust or other provider organisation gives notice of an individual's case to a Local Authority, in accordance with section 2(2) of the Community Care (Delayed Discharges etc.) Act 2003, it must take reasonable steps to ensure that an assessment for NHS continuing healthcare is carried out in all cases where it appears to the body that the patient may have a need for such care. This should be in consultation, as appropriate, with the relevant LA.

11.17 In order to ensure that unnecessary stays in acute care are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. The interim services should continue in place until a decision on eligibility for NHS Continuing Healthcare is made. Unless there is an alternative agreement in place locally about who should fund in these circumstances, the NHS should fund. There must be no gap in the provision of appropriate support to meet the individual's needs.

11.18 To qualify for NHS CHC, an individual must have a 'primary health need' which is assessed using the National Framework. The first step for most individuals is the Checklist Tool². This is a screening tool to help health and social care staff identify whether it is appropriate to undertake a full assessment for NHS CHC. The Checklist does not indicate whether the individual is eligible for NHS CHC, only whether they require full assessment of eligibility for NHS CHC.

11.19 On receipt of a checklist indicating the need for a full assessment, the relevant Clinical Commissioning Group (CCG) will arrange for a multidisciplinary team to carry out a comprehensive assessment of needs, and use this information to complete a 'Decision Support Tool' (DST)³. The MDT will then make a recommendation to the CCG as to whether the individual is eligible for NHS CHC. The CCG should usually accept this recommendation except in exceptional circumstances.

11.20 In the context of the transfer of individuals from an acute setting to an appropriate care setting following an episode of acute care, it may be appropriate to discharge the individual to an appropriate environment (e.g. a residential home, nursing home or individual's own home) with reablement/rehabilitation input as required, and within 4 to 6 weeks either:

- repeat the checklist or
- complete the DST so that the correct decision-making process is undertaken.

11.21 This period of time is intended to allow the individual to stabilise and their longer-term needs to become clearer. During this period, health and social care services would be funded by the NHS (although perhaps procured by the LA, where such arrangements are in place), until a decision on eligibility for NHS CHC can be made.

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213138/NHS-CHC-Checklist-FINAL.pdf

³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213139/Decision-Support-Tool-for-NHS-Continuing-Healthcare.pdf

F) Delays due to awaiting community equipment and adaptations

11.22 All patients whose assessment is complete but transfer is delayed due to awaiting the supply of items of community equipment. (Note that from 1 April 2015, the Care and Support (Charging and Assessment of resources) Regulations 2014 stipulate that all items of community equipment and minor adaptations must be provided free of charge.)

11.23 Where equipment is provided via a service delivered in partnership between the NHS and the local authority, it should nonetheless be possible to identify the cause of any delay, and the parties responsible. Where delays are solely the responsibility of the local authority, such delays should be included in the attributable to social care columns.

G) Delay due to patient or family exercising choice

11.24 All patients whose assessment is complete and who have been made a reasonable offer of services, but who have refused that offer. It would also include delays incurred by patients who will be funding their own care e.g. through insisting on placement in a home with no foreseeable vacancies.

11.25 Note that the Choice of Accommodation Regulations and Guidance should not be used as a reason to delay a patient's discharge. The provisions of the Direction on Choice continue to apply to patients leaving hospital for a place in a care home. Health and care and support systems should put in place locally agreed protocols on patient information incorporating how the issue of patient choice will be dealt with. These should make it clear that an acute setting is not an appropriate place to wait and alternatives will be offered.

11.26 Where social services are responsible for providing services and a person's preferred home of choice is not immediately available, they should offer an interim package of care. All interim arrangements should be based solely on the patients assessed needs and sustain or improve their level of independence. If no alternative is provided which can meet the patient's needs, social services are liable for reimbursement charges.

11.27 Where patients have been offered appropriate services, either on an interim or permanent basis, by the local authority but are creating an unreasonable delay as above, such delays are not held to be the responsibility of the local authority and thus do not incur reimbursement charges. The responsibility for discharging the patient reverts to the NHS body. Such delays should be recorded in the column 'Attributable to the NHS'.

H) Disputes

11.28 This should be used only to record disputes between statutory agencies, either concerning responsibility for the patient's onward care, or concerning an

aspect of the discharge decision, e.g. readiness for discharge or appropriateness of the care package.

11.29 Disputes may **not** be recorded as the responsibility of both agencies. NHS bodies and local authorities are expected to operate within a culture of problem solving and partnership, where formal dispute is a last resort. The patient should not be involved in the dispute, and should always be cared for in an appropriate environment throughout the process.

11.30 Accordingly, frontline staff should allocate responsibility for the patient's care to one organisation, who may then take the dispute to formal resolution without involving the patient or affecting his/her care pathway. The delay should be recorded as the responsibility of the agency that is taking interim responsibility for the patient's care.

11.31 Where a delay is caused because of a patient's disagreement with an aspect of the care package or decision to discharge, this should **not** be listed under disputes but recorded under patient choice.

11.32 For example, a disagreement with the decision to discharge would be listed as NHS responsibility, assessment. If a patient had been offered a care package in their own home and they felt they should be offered a residential care placement, it would be listed under social services responsibility, residential care.

I) Housing – patients not covered by the Care Act

11.33 The Care Act emphasises the importance of local authorities and housing providers working together to provide suitable accommodation in order to meet people's needs for care and support. If there are delays in arranging the interim placement, the reason for delay should be recorded under that of the delayed interim package (e.g. residential care, care package in own home).

11.34 However, some patients delayed for housing reasons may not be eligible for care and support services and therefore are not the responsibility of social services but may be in some cases be of a Local Authority housing service. Examples could be asylum seekers or single homeless people.

11.35 Accordingly, a box covers housing delays **where these relate to people who are not eligible for care and support**. All other patients with long-term housing delays should be found an interim placement, and any delays in arranging this logged under the care package they are waiting for as discussed above.

11.36 The focus of the form is on delays to patients leaving the medical environment. Where patients are eligible for community care services, and major home adaptations or alternative housing arrangements are needed for safe discharge, social services staff should inform and work with housing counterparts to arrange the necessary services. Remaining in a medical setting whilst long-

term adaptations are made, however, is not an appropriate care option. In these circumstances, social services will need to make appropriate interim provisions to enable the patient to move on from the medical environment. Social Services are deemed liable for reimbursement for delays in the arrangements of interim care and support provision in these circumstances.

11.37 The revised form reflects these arrangements. If there is likely to be a housing-related delay, social services should focus on finding an interim placement. Any delays in providing interim care should be recorded under the appropriate box on the new form, for instance, under domiciliary care or residential care, as appropriate.

11.38 Interim arrangements are of course intended to be provided on a temporary basis. If long-term arrangements of housing support are a significant problem in making discharge arrangements for patients, local authorities should ensure they have their own monitoring arrangements to inform progress.

11.39 Some patients delayed waiting for housing support are **not** eligible for community care services. This means their discharge is not the responsibility of social services and such delays are not eligible for reimbursement. In response to feedback from local authorities, we have introduced a new category 'I' on the form to cover this group of patients, who might include asylum seekers or single homeless people. Please see the section I in this guidance document for further detail.

NB. Figures on delayed transfers of care must be agreed with the Directors of Social Services, in particular those whose residents are regular users of hospital services. NHS bodies will need to have a secure and responsive system with local care and support partners, which will enable these figures to be agreed by an appropriate person acting in the authority of the Director of Social Services within the necessary timescale for returning data.

12. Example DTOC cases

12.1 In order to calculate the total the amount of delayed days, there is a need to count 'midnights' and count the 'day' against the start of that day's delay. For example, take a patient who is ready for discharge on Thursday 26th March and discharged on Thursday 2nd April. Come midnight on the 27th the patient has become a delayed transfer and the first "day" delayed is counted against the 26th in March. So in total this patient experienced 7 delayed days with 6 delayed days in March and 1 day in April.

12.2 Here are some examples of patients who have experienced a delayed transfer during the month and how you would fill in the Monthly Delayed Transfers SitRep report for them. The March 2015 return has been used as the calendar month for these examples. As a reminder, there are two data items collected in the return:

Columns labelled A = A snapshot count of the number of patients whose transfer is delayed, taken at midnight on the last Thursday of the month.

Columns labelled B = Total number of days ALL patients have been delayed during the month.

- **Patient 1** - They were ready for discharge (or transfer) on Monday 23rd Mar and were discharged on Saturday 28th Mar. This patient was present in the snapshot count taken at midnight on Thursday 26th Mar. Against the applicable reason and accountability you would add "1" to column A and "5" to column B.
- **Patient 2** - They were ready for discharge on Thursday 26th Mar and were discharged on Thursday 2nd Apr. This patient was present in the snapshot count taken at midnight on Thursday 26th Mar. Against the applicable reason and accountability you would add "1" to column A and "6" to column B. (Note: they were delayed for 7 days in total – 6 of those days in Mar and 1 day in Apr)
- **Patient 3** - They were ready for discharge on Wednesday 4th Mar and were discharged on Friday 20th Mar. This patient was not in the snapshot count taken at midnight on Thursday 26th Mar, but were delayed during March. Against the applicable reason and accountability you would add "0" to column A and "16" to column B.
- **Patient 4** - They were ready for discharge on Sunday 22nd Feb and were discharged on Friday 20th Mar. This patient was not in the snapshot count taken at midnight on Thursday 26th Mar, but was delayed during March. Against the applicable reason and accountability you would add "0" to column A and "19" to column B. (Note: this patient would have been present in the February snapshot taken on 26th Feb and had 7 delayed days during February as well.)
- **Patient 5** - They were ready for discharge on Sunday 22nd Feb and were discharged on Thursday 2nd Apr. This patient was present in the snapshot count taken at midnight on Thursday 26th Mar. Against the applicable reason and accountability you would add "1" to column A and "31" to column B. In other words, they were delayed for all 31 days of March. (Note: this patient also had 7 delayed days during February and 1 delayed day during April)
- **Patient 6** - They were ready for discharge on Sunday 29th March and have not yet been discharged (at the time you are producing the reports). This patient was not in the snapshot count taken at midnight on Thursday 26th Mar, but was delayed during March. Against the applicable reason and accountability you would add "0" to column A and "3" to column B.
- **Patient 7** - They were ready for discharge on Tuesday 31st Mar and were discharged on Wednesday 1st Apr. This patient was not in the snapshot count taken at midnight on Thursday 26th Mar, but was delayed during March. Against the applicable reason and accountability you would add "0"

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to column A and "1" to column B. The 1 delayed day that the patient experienced would be reported on in the March SitRep return. The patient was discharged on the 1st day of April so they did not experience any delayed days during April.

Annex A: Content of an assessment notice

An assessment notice must include the following:

- The name of the patient
- The patient's NHS number
- If given before the patient's admission, the expected date of admission and the name of the hospital in which the patient is being accommodated
- An indication of the patient's discharge date, if known
- The following statements:
 - a) That the NHS body by whom the assessment notice has been given ("the NHS body") has complied with the requirement to consult the patient and, where feasible, any carer the patient has.
 - b) That the NHS body has considered whether or not to provide the patient with NHS continuing health care and the result of that consideration.
 - c) As to whether the patient or carer has objected to the giving of the notice.
 - d) The name and contact details of the person at the hospital who will be responsible for liaising with the local authority in relation to the patient's discharge from that hospital. This must be one or a combination of the person's telephone number and/or their work-based e-mail address.

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The following template may be useful. Those fields marked with an asterisk are not legal requirements but should be included where known as a matter of good practice.

NOTICE OF REQUEST FOR Assessment under the Care and Support (Discharge of Hospital Patients) Regulations 2014	
Name	
Date of birth	
Address*	
NHS Number	
Expected date of admission (where known)	
Name and contact details of the carer (where applicable)*	
Name and contact details of the person at the hospital liaising with the local authority	
Patient's lead clinician at the hospital*	
PLEASE CONFIRM THE FOLLOWING	
The patient has been consulted about the assessment	
Where applicable and feasible, the carer has been consulted about the assessment	
An assessment of the patient's continuing health care needs has been completed and a decision made	
The patient has not objected to the giving of an assessment notice	
The carer has not objected to the giving of a notice	

Annex B: Minimum periods for needs/carer's assessment or arranging care and support [in relation to the discharge of NHS acute care hospital patients with care and support needs] ⁴

From 1 April 2015, changes introduced by the Care Act 2014 mean that reimbursement liability for delayed transfers of care in relation to NHS hospital patients receiving acute care is no longer mandatory. However, the NHS must still issue assessment notices and discharge notices (previously known as section 2s and 5s⁵), regardless of whether or not the NHS body intends to claim any such reimbursement. The issue of both an assessment notice and a discharge notice triggers the potential for an NHS body to seek reimbursement from the responsible local authority if that local authority has either not carried out any necessary assessment (i.e. a needs or, where applicable, a carer's assessment), or not put in place arrangements for the care and support (***such that it is then safe for the patient to be discharged***) that it proposes to meet by the end of the relevant day.⁶ The relevant day is the later of either the proposed discharge date specified by the NHS in the discharge notice or the last day of the minimum period.⁷ The minimum period after which reimbursement could be sought is the end of 2 days after the day on which the local authority has either received, or is treated as having received, an assessment notice.⁸ (Notices issued after 2pm are treated as being given on the following day.)⁹ That said, a local authority will not be liable for any reimbursement if it has by 11am on the relevant day put in place arrangements for meeting some or all of the needs.¹⁰

The table below gives the ***earliest possible*** day from which the NHS may seek reimbursement from a local authority in the circumstances set out in the Care Act and its regulations. ***This assumes that the NHS has issued the discharge notice with the minimum period of notice allowed (i.e. at least one day in advance of the proposed discharge date¹¹) and that the proposed discharge date falls at the end of the minimum period allowed (see above).*** However, in the majority of cases, the NHS should give

⁴ See Schedule 3 to the Care Act 2014, the Care and Support (Discharge of Hospital Patients) Regulations 2014 (S.I. 2014/2823) ("Discharge of Hospital Patient Regulations") and the Care and Support Statutory Guidance, paragraphs 15.37 to 15.47 and Annex G.

⁵ Requirements for such notices were contained in the Community Care (Delayed Discharges etc) Act 2003 which, as of 1st April 2015, has been disapplied in England.

⁶ See paragraph 4(1) and (2) of Schedule 3 to the Care Act 2014.

⁷ See paragraph 2(5) of Schedule 3 to the Care Act 2014.

⁸ See paragraph 2(6) of Schedule 3 to the Care Act 2014 and regulation 8 of Discharge of Hospital Patient Regulations.

⁹ See regulation 11 of the Discharge of Hospital Patient Regulations.

¹⁰ See regulation 9(4)(a) of the Discharge of Hospital Patient Regulations.

¹¹ See regulation 5 of the Discharge of Hospital Patient Regulations.

local authorities greater notice than the minimum allowed, so local authorities should have longer time periods than those given in the examples below to undertake an assessment and put in place any arrangements to meet care and support needs.

Exemptions for the delayed discharge period that previously existed for weekends and bank holidays no longer apply, and as such all days could become potentially reimbursable.

Assessment Notice issued¹²:	The latest at which a Discharge Notice could be issued (assuming minimum period of service is used)	Minimum Period	To avoid the risk of any reimbursement liability, any services to be in place by	Comments
Monday on or before 2pm	Tuesday on or before 2pm	Tuesday Wednesday	11am on Thursday	<p>A discharge notice must give at least one day's notice of the proposed discharge date. It will be treated as having been given on the following day if issued after 2pm.</p> <p>The minimum period before which any reimbursement may be sought must last for at least 2 days, beginning with the day after the assessment notice is given (or treated as given).</p> <p>A day is not to be treated as a day for which a local authority could be liable for reimbursement if it has by 11am on that day put in place arrangements for meeting some or all of the needs such that it is then safe for the patient to be discharged.</p>

¹² To note, the NHS cannot issue an assessment notice until it has first consulted with the patient and, where feasible, any carer and has considered whether or not to provide the patient with NHS continuing health care: see paragraph 1(4) of Schedule 3 and regulation 3(f) (i) and (ii).

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Monday after 2pm Tuesday on or before 2pm	Wednesday on or before 2pm	Wednesday, Thursday	11am Friday	Notices issued after 2pm are treated as if issued on the following day, so the assessment notice is treated as being issued on Tuesday.
Tuesday after 2pm Wednesday on or before 2pm	Thursday on or before 2pm	Thursday, Friday	11am Saturday	Weekends are not exempted so Saturday becomes the earliest possible date on which any arrangements to meet care and support needs are put in place in order to avoid the risk of any reimbursement liability being sought.
Wednesday after 2pm Thursday on or before 2pm	Friday on or before 2pm	Friday, Saturday	11am Sunday	As above. Weekends are not exempted so Sunday becomes the earliest possible date on which any arrangements to meet care and support needs are put in place in order to avoid the risk of any reimbursement liability being sought.
Thursday after 2pm Friday on or before 2pm	Saturday on or before 2pm	Saturday, Sunday	11am Monday	As above. Weekends are counted and not disregarded so Saturday becomes the first and Sunday the 2nd day of the minimum period before which reimbursement could be sought.
Friday after 2pm Saturday on or before 2pm	Sunday on or before 2pm	Sunday, Monday	11am Tuesday	As above. Weekends are not disregarded so Sunday becomes the first day of the minimum period before which reimbursement could be sought.
Saturday after 2pm Sunday on or before 2pm	Monday on or before 2pm	Monday, Tuesday	11am Wednesday	As above.
Bank Holiday weekend: Saturday after 2pm Sunday on or before 2pm	Bank Holiday Monday on or before 2pm	Monday, Tuesday	11am Wednesday	Bank holidays and weekends are counted and no longer disregarded. Assessment notice treated as being issued on a Sunday, making the second day of minimum interval a Tuesday.
Sunday after 2pm	Tuesday on or	Tuesday,	11am Thursday	Bank holidays are no longer disregarded, so

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Bank Holiday Monday on or before 2pm	before 2pm	Wednesday		assessment notice treated as being issued on Monday if the notice was issued on or before 2pm.
Or: Bank Holiday Monday after 2pm Tuesday on or before 2pm	Wednesday on or before 2pm	Wednesday, Thursday	11am Friday	If the notice was issued after 2pm on the Bank Holiday Monday but before 2pm on Tuesday then the notice counts as being issued on Tuesday.
Maundy Thursday on or before 2pm	Good Friday on or before 2pm	Good Friday Easter Saturday	11am Easter Sunday	Saturday is the second day of minimum interval because Good Friday is no longer disregarded. As weekends and holidays are no longer disregarded, services need to be in place by 11am on Easter Sunday to avoid the risk of any reimbursement being sought.
Maundy Thursday after 2pm	Easter Saturday on or before 2pm	Easter Saturday, Easter Sunday	11am Easter Monday	The notice was issued after 2pm on Maundy Thursday, which makes Good Friday (no longer disregarded and therefore counted) the day when the notice is treated as having been issued. This makes Easter Sunday (also no longer disregarded so counted) the second day of the minimum period before which reimbursement could be sought. Easter Monday (again no longer disregarded) by 11am becomes the day in which the local authority needs to ensure that services are in place to avoid the risk of any reimbursement being sought.

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The following table shows the minimum interval from the issue of discharge notice to start of reimbursement charging, *assuming that the proposed discharge date does not fall within the minimum interval since the issuing of the assessment notice*. To ensure that a local authority receives fair advance warning of the discharge, the NHS body must issue a discharge notice indicating the date of the patient's proposed discharge. The minimum interval allowed for discharge notice is at least one day before the proposed discharge date. Again, where the discharge notice is issued after 2pm, it will not be treated as having been served until the next day. **Exemptions that previously existed for weekends and bank holidays no longer apply.** The NHS should give local authorities greater notice than the minimum allowed, so local authorities should have longer than the minimum time periods listed below to undertake any assessments and put in place arrangements to meet care and support (*such that it is then safe for the patient to be discharged*). Reimbursement can only be triggered if services are not in place by 11am on the day after the proposed discharge, subject to the issuing/timescales of the assessment notice.

Discharge notice issued (assuming minimum notice period of one day)	To avoid reimbursement, services need to be in place:
Monday before 2pm	Wednesday before 11am
Tuesday before 2pm	Thursday before 11am
Wednesday before 2pm	Friday before 11am
Thursday before 2pm	Saturday before 11am
Friday before 2pm	Sunday before 11am
Friday after 2pm, Saturday before 2pm	Monday before 11am
Saturday after 2pm, Sunday before 2pm	Tuesday before 11am
Bank holiday Monday before 2pm	Wednesday before 11am
Bank holiday Monday after 2pm, Tuesday before 2pm	Thursday before 11am
Thursday before 2pm	Saturday before 11am
Maundy Thursday after 2pm, Good Friday before 2pm	Sunday before 11am
Easter Saturday after 2pm, Easter Sunday before 2pm	Tuesday before 11am
Easter Sunday after 2pm, Easter Monday before 2pm	Wednesday before 11am
Easter Monday after 2pm, Tuesday before 2pm	Thursday before 11am

Annex C: Content of a discharge notice

A discharge notice must contain the following.

- The name of the patient.
- The patient's NHS number.
- The name of the hospital in which the patient is being accommodated.
- The names and contact details (telephone and/or email) of the person at the hospital who is responsible for liaising with the relevant authority in relation to the patient's discharge from hospital.
- The date on which it is proposed to discharge the patient.
- A statement confirming that the patient and, where appropriate, the carer has been informed of the date on which it is proposed that the patient be discharged.

A statement that the discharge notice is given under paragraph 2(1)(b) of Schedule 3 to the Act. This is to make it clear that the notice is a formal "discharge notice" for the purposes of the Discharge of Hospital Patient provisions.

Annex D – Data items mapped to template

Acute Delayed Transfers of Care	Attributable to NHS (i.e. includes patients making their own arrangements)		Attributable to Local Authority (Care)		Attributable to Both	
	Key to columns		a) Number of patients whose transfer is delayed at midnight on the last Thursday of the month			
			b) Number of days delayed within the month for ALL patients delayed throughout the month			
Reasons for delay - awaiting:	a)	b)	a)	b)	a)	b)
A) Completion of assessment						
B) Public Funding						
C) Further non acute NHS care (including intermediate care, rehabilitation etc)						
D) Care Home placement						
i) Residential Home						
ii) Nursing Home						
E) Care package in own home						
F) Community Equipment/adaptions						
G) Patient or family choice						
H) Disputes						
I) Housing - patients not covered by Care Act						
TOTAL	AT1	AT2	AT3	AT4	AT5	AT6

The table above shows the totals for acute delayed transfers of care. The table for non-acute delayed transfers of care has the totals: NT1, NT2, NT3, NT4, NT5 and NT6.

Data item	Data item description	From template:
D1	Number of acute patients whose transfer of care is delayed	AT1 + AT3 + AT5
D2	Number of days delayed within reporting period - acute patients	AT2 + AT4 + AT6
D3	Number of reimbursable days within reporting period - acute patients	AT4
D4	Number of non-acute (including community and mental health) patients whose transfer of care is delayed	NT1 + NT3 + NT5
D5	Number of days delayed within reporting period - non-acute (including community and mental health) patients	NT2 + NT4 + NT6
D6	Number of reimbursable days within reporting period - non-acute (including community and mental health) patients	NT4