

Why not home? Why not today?

Behind every delayed transfer of care from hospital to home, there is a person, in the wrong place at the wrong time

<p>Monthly Delayed Transfers of Care Situation Report</p>

Principles, Definitions and Guidance

November 2018

1. Introduction

Why count delayed transfers of care from hospital to home?

1.1. There will always be a risk that counting delayed transfers of care (DTOCs) becomes an end in itself, rather than a means to an end. We must remember that we do not collect this data just because we can, but because we can use it to improve outcomes for the people who need health and social care services and support, to encourage acute and community hospital trusts to plan for each discharge well before a patient no longer requires acute care and to facilitate system-wide partnership and co-operation in delivering the best possible outcomes for patients. Counting DTOCs helps whole systems to understand unmet need and identify bottlenecks and ensures that pathways through the system are patient-oriented rather than organisation or service-centred. In the interests of consistency and clear communication, this guidance will apply to counting DTOCs for patients in inpatient NHS beds, including those in mental health and community health inpatient settings, but not those in paediatric or maternity settings.

Principles

1.2. The principles underpinning the counting and collecting of data about DTOCs are to:

- Improve services for patients by reducing situations where people are in hospital longer than they need to be, which has a detrimental effect on their recovery, rehabilitation and long-term health and well-being; this may be particularly problematic for people who are frail or have long-term care and support needs
- Encourage system-wide investment in services and support which can reduce and prevent the likelihood of delays occurring in the first place
- Reinforce the importance of integrated and partnership working between acute, mental health and community trusts, intermediate and rehabilitation services, social care, service providers and primary care, to meet the needs of patients and their carers at the right time in the right setting
- Ensure discharge systems are integrated, so that planning is proactive and undertaken in parallel, rather than reactive and undertaken sequentially, which will contribute to improved flow
- Develop a fair and consistent system of notification for alerting community and social services to the likely need for assessment and services post-discharge and to promote forward planning for discharge by communicating clear proposed patient discharge dates

Sharing information every day with patients, about what is happening with them, is essential to them being an equal partner in decision making. This improves flow, as the patient or their family will ask why planned interventions and/or decisions are not happening.

There are several questions to which every patient should know the answer:

1. What is wrong with me?
2. What is going to happen now, later today and tomorrow to get me sorted out?
3. What things do I need to be able to do to get home?
4. How will I contribute to discussions and plans about what needs to happen in order for me to get home?
5. When should I expect to be going home, assuming that my recovery is on track?

Throughout this guidance we describe delays in terms of patients waiting to go home because a discharge to their home should be the default expectation for every patient. Since this is not always possible or practicable, DTOCs also cover situations where a patient is experiencing a delay awaiting a transfer to a non-acute bed for intermediate or interim care.

2. Definition of a Delayed Transfers of Care (DTC)

2.1. A delayed transfer of care (DTC) from NHS-funded acute or non-acute care occurs when an adult (18+ years) patient is ready to go home and is still occupying a bed.

2.2. A patient is ready to go home when all of the following three conditions are met:

- a **clinical decision** has been made that the patient is ready for transfer home
- a **multidisciplinary team (MDT) decision** has been made that the patient is ready for transfer home
- the patient is considered to be **safe to discharge/transfer** home.

Clinical decision

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

2.4. 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.

2.5. A patient being classified as medically optimised does not equate to them becoming a DTC and is not sufficient for any delay to be reportable as a DTC.

Medically optimised means professionals asking themselves the following questions (where relevant):

- 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?
- If I saw the patient today in outpatients, or in the Emergency Department, would I admit them or would I try to get them straight home again with any additional support they needed?

Medically optimised for discharge decision making process:

- Does **not** mean whether all the assessments have been completed and all equipment delivered.
- Is **not** dependent upon whether or not the patient is back to a baseline level of function.
- It **is** date and time specific and as such should be acted upon in a timely manner otherwise the clinical decision may need to be reassessed.

Multidisciplinary team (MDT)

2.6. A multidisciplinary 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, paid carers, unpaid carers or volunteers. Their knowledge will contribute to making the right discharge decision at the right time for the patient.

2.7. The role of the MDT is to balance the acute health care requirements of the patient, the desire of patients to return to their home environment as soon as possible, the potential harms associated

with staying in hospital and the risks of being discharged home too early, which could result in a re-admission.

2.8. Non-participation by parties external to the trust reporting the delay, including family members and patient advocates, in the requirements of the MDT, does not represent a valid reason to prevent a delay being recorded as a DTOC.

Safe

2.9. Safe to discharge means asking the question “if what the patient needs were available now, are they safe to go home?” A delay in an assessment, or the lack of provision to meet a need, does not necessarily mean it is unsafe to discharge someone.

2.10. Concerns about safety on discharge should be identified and addressed through early discharge planning, so they do not contribute unnecessarily to delays.

2.11. Where there are general concerns about safety on discharge, the views of the patient or their advocate/representative must be sought about these concerns. This should also include what, if anything, they wish to happen in relation to these concerns. The views of any carers in their own right should also be sought.

2.12. If there are concerns that a patient will be at risk of abuse or neglect on discharge, their views must be sought about that risk and to where they will be discharged. A decision should be made about whether to raise a safeguarding concern with the Local Authority, in line with the policies and procedures of the local Safeguarding Adults Board.

2.13. A person must be assumed to have the mental capacity to make their own discharge decision unless it is proven otherwise. Professionals should be able to demonstrate that they have made every effort to encourage and support a patient to make a discharge decision themselves. A decision that some may consider unwise does not in itself indicate a lack of mental capacity to make the discharge decision.

2.14. If it is proven that a patient lacks the mental capacity to make the discharge decision, then a decision should be taken in their best interests under the Mental Capacity Act (2005), to enable discharge to take place safely and promptly. For these decisions to be lawful, professionals must take account of the Mental Capacity Act Code of Practice (2007), and ensure the Section 4 Checklist is addressed. If it is believed that the person will need to be deprived of their liberty after discharge, professionals must also take account of the Deprivation of Liberty Safeguards - Code of Practice (2008).

2.15. The Deprivation of Liberty Safeguards are not available in an ordinary housing setting but it is important to note that it is unlawful to deprive a person of liberty in **any** setting, without authorisation. This means that where there are concerns about whether a person has the mental capacity to make their own decision about their discharge it will be important to work out whether the arrangements at home will amount to a Deprivation of Liberty. This means asking whether the person will be subject to "Complete or continuous supervision and control and not free to leave." If this is the case, an application will need to be made to the Court of Protection for a Deprivation of Liberty Order, in order for the person to go home. If the use of an interim placement is being considered, to enable the person to be discharged in the meantime, a decision will be required in their best interests about whether this would be preferable to remaining in hospital.

2.16. Where further activity is required, for example by a Local Authority making safeguarding enquiries, or by an external body, such as the Court of Protection considering an application for a Deprivation of Liberty Order, it is important to make a strong argument for it to be expedited to facilitate safe, prompt, and timely discharge.

2.17. Until such activity is complete, if the patient is not deemed safe to discharge, then they are not counted as a DTOC, unless an interim placement can be agreed. A decision about a patient being safe to discharge should be reached as soon as possible however, so they are not delayed unnecessarily in hospital.

2.18. Some patients are temporarily discharged as a leave of absence from hospital under Section 17 of the Mental Health Act (1983). Where a leave of absence relates to a trial period to confirm that a patient is either medically optimised or safe for permanent discharge then any delay relating to this discharge is not a DTOC and hence is not reportable. However, where a patient has been deemed suitable for discharge and has to return to hospital care because there is a lack of post-discharge support then this would count as a reportable DTOC, with each delayed day following the patient being ready for discharge being countable, including the period covered by the leave of absence.

3. Monthly SitRep (MSitDT) return reporting

3.1. Information about delayed transfers of care (DTOCs) at midnight is collected for NHS-funded **acute** and **non-acute** inpatients who are **adult** (18+ years of age), including those in mental health and community health inpatient settings, as well as in acute trust settings. A patient is classed as a DTOC, if they are still in a bed at midnight at the end of the day being reported (see Figure 1), whereas, if they went home during the day that is being reported, they are not classed as a DTOC on that day.

3.2. The monthly SitRep (MSitDT) return includes:

- Setting: acute or non-acute
- Mental health: separate out delays in mental health inpatient beds
- Counting: number of delayed days in total during the calendar month
- Attribution: owner of the delay, namely NHS, Social Care or Joint
- Reason code: category for the cause of the delay

3.3. The aim of counting and attributing delays is not to apportion blame, or to punish or fine systems, but to understand where are the pinch-points, to recognise the importance of people's rights and to enable partners to work together to take action to address problem areas, so as to deliver positive outcomes for patients and their carers. The accurate and consistent reporting of delays by reason code will enable a detailed understanding of the factors contributing to unnecessary delays.

All delayed days within the calendar month should be counted and they should not be generated from weekly figures that have been apportioned between months. For each patient, the delayed days figure should reflect the number of midnights for which they are ready to go home yet remain in hospital from the day after their proposed date of discharge and each day thereafter.

4. Setting for delays

4.1. Delayed transfers of care (DTOCs) are recorded for both NHS-funded acute and non-acute settings.

4.2. Acute care means intensive, time-limited medical treatment provided by or under the supervision of an acute consultant that lasts for a time-limited period, until the point the treatment is no longer required or beneficial.

4.3. Non-acute care can be consultant or non-consultant-led and can take place in a variety of settings.

Non-acute care includes:

- 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.

5. Delays in a Mental Health setting

5.1. All delayed transfers of care (DTOCs) in mental health inpatient settings must be reported at a patient-level in the Mental Health Services Data Set (MHSDS). They must also be reported in the monthly SitRep (MSitDT) return, whilst the data quality of the MHSDS is being improved.

5.2. The MHSDS uses a richer set of attribution and reason codes, when compared to those used within the monthly SitRep (MSitDT) return, which have been specifically developed to provide a better understanding of the causes of delays in mental health settings. These mental health related codes have been mapped onto those used in the monthly SitRep (MSitDT) return. This will reduce the burden associated with having to submit information to two different datasets and encourages a focus on the use of the MHSDS reason codes, which are more appropriate for DTOCs from mental health settings. This should support improvements in the quality, completeness and coverage of the data in both collections.

5.3. DTOCs in mental health designated beds must be flagged as such in the monthly SitRep (MSitDT) return, to ensure consistency with the MHSDS.

6. Counting delays

6.1. The monthly SitRep (MSitDT) return captures delays for patients awaiting lower levels of care, either a discharge home or a transfer to a non-acute bed for intermediate or interim care, irrespective of whether these beds are within the same or a different care provider. Patients may spend longer in NHS-funded care than is necessary because of delays caused by internal systems within the reporting trust. Although good practice means these delays should be addressed as part of normal internal business improvement practices, internal delays do NOT equate to a delayed transfer of care (DTOC) and must NOT be reported in the monthly SitRep (MSitDT) return. Delays caused by external systems, which are outside of the control of the care provider, DO equate to a DTOC and must be reported in the monthly SitRep (MSitDT) return.

6.2. If the acute trust owns and operates their own mental health and/or community services, then this would still count as a DTOC if a patient is awaiting transfer out to one of these services.

Internal delays include:

- Late issuing of Assessment and Discharge notifications.
- Lack of MDT engagement by members internal to the reporting trust.
- Lack of Patient Transport Service (PTS) availability.
- Unavailability of To Take Out (TTO) medication.
- Unavailability of Assessments to be undertaken by a member of staff funded by the reporting trust.
- Unavailability of Tests or Procedures.

The following must **be reported**:

- Patients leaving acute or non-acute care, for example patients awaiting a home-based short-term or long-term package of care, or awaiting physiotherapy or occupational therapy rehabilitation at home, where this is not due to an internal reason.
- Patients waiting to move from an acute care setting to a non-acute care setting **within the same care provider**, for example in trusts providing acute and community services you count a delay where the person is awaiting admission to a community hospital bed for ongoing care or rehabilitation.
- Patients waiting to move from one non-acute care setting to another type of non-acute care setting **within the same care provider**

The following must **NOT be reported**:

- Patients continuing to receive any type of **acute care**, moving from one bed to another, even if these beds are in different care providers, including transfers to hospitals nearer where patients live (repatriation), transfers for tertiary treatment and transfers for ongoing care after tertiary treatment.
- Patients continuing to receive the same type of **non-acute** inpatient care, including in mental health or community health inpatient settings, moving from one bed to another, even if these beds are in different care providers, for example patients continuing to receive acute physiotherapy and occupational therapy assessment.

7. Attribution of delays

7.1. One of the functions of the MDT is to agree the attribution of each delayed transfer of care (DTC) to the NHS, to Social Care or as Jointly owned.

7.2. It is important to ensure that information on delays, and the reasons for them, is timely and accurate. For the data to be credible, it must be agreed by all relevant local parties. Systems should check that they have robust arrangements in place to ensure agreement on DTC data. It is good practice for named leads to be in place for both NHS providers and Local Authorities to agree DTC data. NHS providers must ensure, before DTC data is returned, that for Social Care and Joint delays, the level, reason and attribution of delays has been verified with the relevant Local Authorities. The system by which these data are agreed and signed off is for local determination, although it is expected that it would be through the relevant **Directors of Adult Social Services** or their nominated representatives.

7.3. Sign-off should be undertaken on a timely basis and a lack of engagement does not represent a valid reason to prevent a delay being recorded as a DTC. Where there is a disagreement the DTC should be reported as best as possible, defaulting where necessary to being attributable to the NHS, accepting that the details might subsequently be revised. The monthly SitRep (MSitDT) collection system includes a sign-off window to help with the timeliness of this aspect of the return.

Principles behind attributing delayed transfers of care (DTCs) to Local Authorities

7.4. The Care Act (2014) and the Care and Support (Discharge of Hospital Patients) Regulations (2014) set out the arrangements for discharging people from acute care, where they are likely to have ongoing social care and support needs; in particular they set out the process and timings for issuing assessment and discharge notices which must be applied to NHS patients in receipt of acute care.

7.5. DTC attribution is by ordinary residence. Irrespective of who is responsible for the delay, it is always counted under the Local Authority of ordinary residence, even where a patient is awaiting out

of area services. DTOC attribution helps to understand where patients are experiencing unnecessary delays and not to apportion blame.

Assessment and Discharge Notices

7.6. The Care Act (2014) outlines responsibilities of the NHS to provide its Local Authority partners with as much notice as possible of a patient's impending discharge, so they can assess, or reassess, care needs. To enable proactive planning, assessment notices should be sent well before a person is deemed medically optimised, once the patient has a proposed discharge date and patient consent has been obtained. The exception to this would be where a patient has a severe and unpredictable illness or injury, such as those admitted to critical care, in which case it will be appropriate to wait until their condition has stabilised and a longer-term treatment plan is clear. For elective admissions an assessment notice can be issued up to seven days before admission. The assessment notice must give at least two days' (48 hours') notice that patient may require support on discharge and ideally this notice would be issued within 24 - 48 hours of admission.

7.7. Where the NHS has issued an assessment notice to a Local Authority, asking them to assess, or reassess, a patient's care and support needs, it must also give written notice of the proposed date of the patient's discharge, in the form of a discharge notice, even though it is also included the assessment notice. The purpose of the discharge notice is to confirm the discharge date as it may not have been known when the assessment notice was issued, or it may have changed since the assessment notice was issued. However, where a discharge date is known at the point the assessment notice is sent, the assessment and discharge notices may be sent at the same time. The discharge notice must give at least one day's (24 hours') notice of the proposed discharge date.

7.8. The Local Authority must carry out a needs assessment for eligible patients and put in place any arrangements for meeting eligible patient (and/or carer) needs by the date upon which the NHS proposes to discharge the patient (as contained in the discharge notice). However, the NHS must issue assessment and discharge notices in a timely manner, at least two days (48 hours) in advance of the discharge date for assessment notices and at least one day (24 hours) in advance for discharge notices. Any notice which is given after 2pm on any day is treated as being given on the following day. If the Local Authority has failed to put arrangements in place, leading to the delayed discharge of a patient, then each day for which they remain in hospital from the day after their proposed date of discharge represents a DTOC and these are attributable to the Local Authority of ordinary residence. See also Figure 1.

7.9. Where there is a delay caused by an assessment or discharge notice having been sent to an incorrect Local Authority this is to be considered an internal delay and is NOT reportable.

7.10. Where an NHS organisation is considering issuing an assessment notice to a Local Authority under the provisions of the Care Act (2014), the responsible NHS organisation is required to consider whether or not to provide the individual with NHS continuing healthcare (CHC) before issuing such a notice. This does not necessarily mean a Checklist needs to be completed if it is clear to the professionals involved that there is no need for NHS CHC (see Paragraph 91 in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2018)).

7.11. If the proposed discharge date is delayed, for example where the patient has had a significant change of condition, such as following a stroke, a fall leading to a fracture or where the patient has an infection that is subject to infection control policies preventing discharge, then any assessment and discharge notices need to be withdrawn. Where the discharge date is changed because of a minor clinical reason or following a difficulty involving an internal process, and where the change of date is not for a significant length of time, then only the discharge notice need be withdrawn. In such circumstances, once a revised date of discharge is known, new notices must be issued, with the same timescales applying as those for other assessments.

With any Home First model, decisions about long-term care should not be made in hospital. Under such a scheme, fewer assessments will be undertaken in a hospital setting.

Recording delayed transfers of care (DTOCs)

7.12. Whilst the Care Act (2014) places DTOC counting for Local Authorities on a legal footing, the policy intention is that the same timescales and formal notices are to be applied to all transfers of care, including NHS transfers to non-acute care and between non-acute care settings. This requires similar robust processes and timings, to those already in place to alert Local Authorities of a likely need for support, to be established, which will prevent unnecessary hold-ups in meeting the ongoing care needs of patients. For example, the issuing of an assessment notice should not wait until the patient is deemed medically optimised. Whilst local arrangements may be agreed, these should be consistent with the timescales set out in the Care Act (2014). This will be particularly important, given the increasing number of referrals to short-term support, which allow assessments to take place after discharge from hospital.

For patients on an NHS continuing healthcare (CHC) pathway, the policy intention is that screening (using a Checklist) and the full assessment of eligibility for NHS CHC should be at the right time and location for the individual and when the individual's ongoing needs are known. Where this is practicable and in the patient's best interests CHC assessments should be undertaken outside of a hospital setting. Where the individual has an existing care package or placement, which all relevant parties agree can safely and appropriately meet their needs, then they should be discharged back to this care package or placement under existing funding arrangements. In such circumstances any screening for NHS CHC should take place within six weeks of the individual returning to their home. In addition, for all patients on an NHS CHC pathways, the time between undertaking a screening (using a Checklist) and an NHS CHC funding decision being made should not exceed 28 days. If they meet the definition of a DTOC during either of these periods they should be reported, with the same timescales applying as those for other assessments.

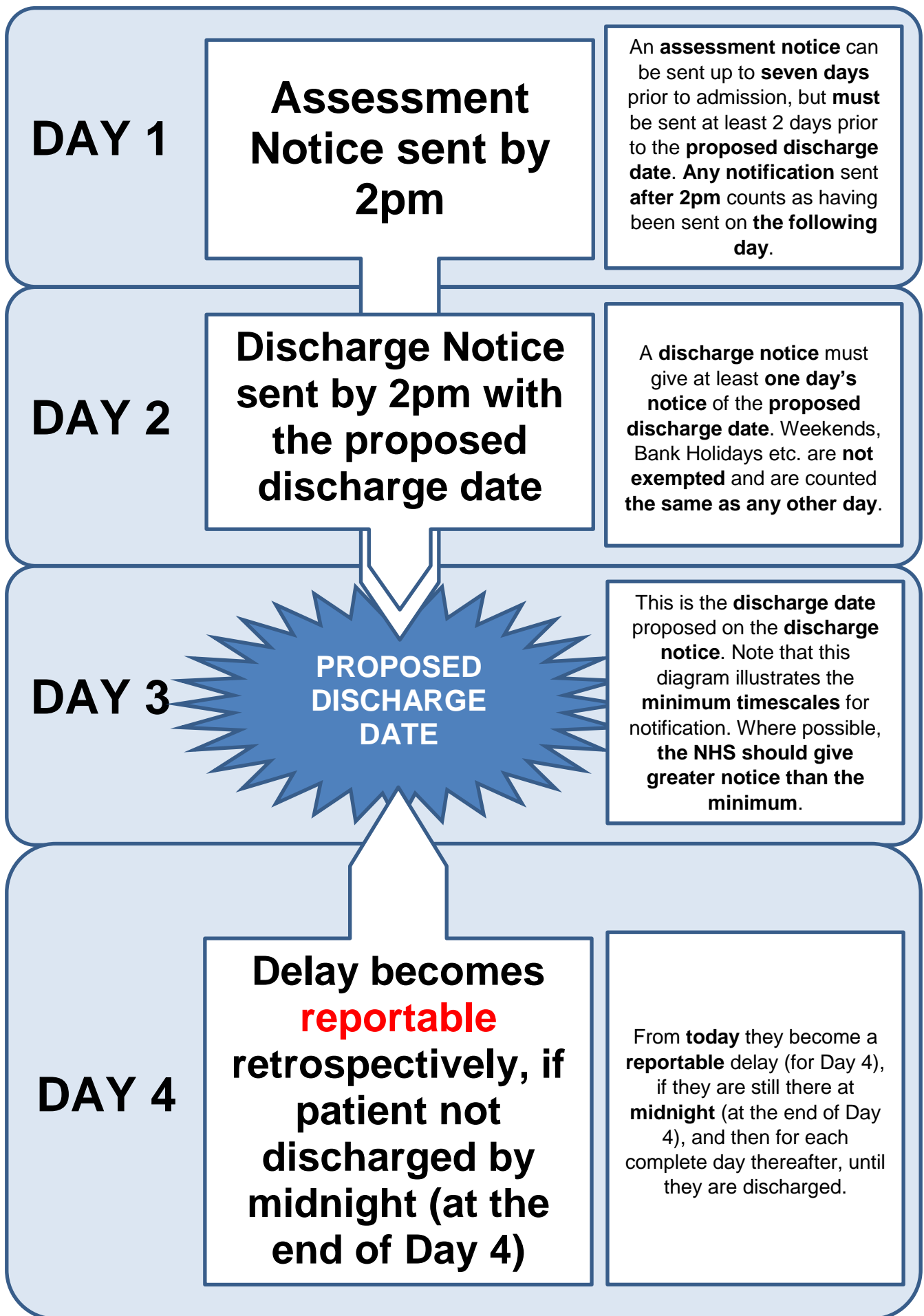


Figure 1 – The minimum timescales for issuing Assessment and Discharge notices

8. Reasons for Delayed Transfers of Care (DTOCs)

8.1. This table shows the list of available reason codes and indicates which are attributable to the NHS, Social Care or as Jointly owned.

	Permissible attribution		
	NHS	Social Care	Joint
A) Awaiting completion of assessment	✓	✓	✓
B) Awaiting public funding	✓	✓	✓
C) Awaiting further non-acute NHS care	✓	✗	✗
Di) Awaiting residential home placement or availability	✓	✓	✗
Dii) 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 the Care Act	✓	✗	✗
O) Other	✓	✓	✗

The Other category is ONLY to be used for patients covered by the Mental Health Services Data Set (MHSDS) DTOC collection (see Section 5 and Paragraph 8.19 for details).

8.2. A patient must only be counted in ONE category of delay each day. This category should be the one most appropriately describing their reason for delay and this category can change each day, as can the attribution. The total numbers allocated across the reasons for delay must equal the total number of delayed days.

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 category A (two days) and D ii (eight days).

Definitions

A) Awaiting completion of assessment

8.3. This category covers all patients whose transfer is delayed because they are awaiting completion of an assessment of their future care needs or the identification of an appropriate care setting. This includes any assessment by health and/or social care professionals of a patient's future care needs.

This category **includes**:

- Delays awaiting assessment by social care.
- Delays awaiting assessment by mental health services.
- Delays awaiting assessments for NHS continuing healthcare (CHC) that are being undertaken in an acute setting, where these assessments are reliant on a team that is external to the trust. Delays are attributable to whoever is funding the assessment bed. Where there is an integrated discharge team, delays are Jointly attributable.
- Delays awaiting assessment by residential or nursing home, in which case delays are attributable to the NHS, for NHS-funded or self-funded care, and to the Social Care, for social care-funded care.
- Delays awaiting assessment by an external service provider, in which case delays are attributable to whoever is funding the placement.

This category **excludes**:

- Delays awaiting assessments undertaken by a service solely funded and managed internal to where they are also receiving their care, such as that provided by an occupational therapist, physiotherapist, palliative care, specialist nurse, or ward action on NHS CHC, in which case they are not be reportable as a DTOC.

B) Awaiting public funding

8.4. This category covers all patients whose assessment is complete but whose transfer has been delayed while waiting for Local Authority funding, such as for residential or home care, or NHS funding, such as for NHS-funded nursing care or NHS continuing healthcare (CHC).

This category **includes**:

- Where the Local Authority and NHS have failed to agree funding for a joint package of care.
- Where the patient is awaiting panel process approval of funding for package of care (POC) and placements, including decisions relating to very high cost packages of care.
- Where the patient is awaiting Mental Health resource panel approval.

This category **excludes**:

- Disputes with a patient or their family, in which case delays are counted under category G "Patient or family choice".
- Delays due to arranging other NHS services (residential or community), in which case delays are counted under the care package for which they are waiting, such as category Di "Awaiting residential home placement or availability" or Dii "Awaiting nursing home placement or availability".
- Those rare situations where there is an exceptional level of contention between the NHS and the Local Authority, in which case delays are counted under category H "Disputes".

C) Awaiting further non-acute NHS care

8.5. This category covers all inpatients whose assessment is complete but whose transfer has been delayed while waiting for further non-acute care, including in mental health and community health inpatient settings.

This category **includes**:

- Delays awaiting a decision to be made concerning NHS continuing healthcare (CHC) eligibility, where NHS-funded care (in a care home, the patient's own home or other settings) is continuing until an eligibility decision has been made.
- Delays awaiting a specialised mental health placement, for example in secure care services.
- Delays awaiting community bed rehabilitation, intermediate care or other purpose, including rehabilitation services for people with complex mental health needs.
- Delays awaiting an end of life care (EOLC) hospice or other NHS CHC fast-track-funded bed.
- Delays awaiting long term NHS CHC placement.
- Delays awaiting an interim health placement for NHS CHC assessment, where the discharge to assess bed is solely NHS-funded.
- Public Health England (PHE) must be consulted for any reportable diseases (eg tuberculosis (TB), severe acute respiratory syndrome (SARS)) and, where specialist provision is available, delays are attributable to the NHS. Where no such provision is available, a patient may not be deemed safe for discharge, and so are not reportable as a DTOC.
- Delays where a conscious decision has been taken to defer consideration of eligibility for NHS CHC.

This category **excludes**:

- Delays awaiting an interim health placement for NHS CHC assessment, where the discharge to assess bed is jointly-funded or solely Social Care-funded, in which case delays are counted under the care package for which they are waiting, such as category Di "Awaiting residential home placement or availability" or Dii "Awaiting nursing home placement or availability".
- Delays in providing NHS-funded care in the patient's own home, such as that provided by community health services, in which case delays are counted under category E "Awaiting care package in own home".
- All home-based health or social care packages of care, including intermediate care, in which case delays are counted under category E "Awaiting care package in own home".

D) Awaiting residential/nursing home placement or availability (Di/Dii respectively)

8.6. These two categories cover all patients whose assessment is complete but whose transfer has been delayed while waiting for a residential or nursing home placement, including long-term or intermediate, either because of lack of a suitable place to meet their assessed care needs, or because a placement has been made available but the patient is awaiting confirmation from the home, for example following assessment.

This category **includes**:

- Residential care pathways that are jointly-funded.

This category **excludes**:

- Delays where Local Authority funding has been agreed and two or more choices have been offered, but the patient or their family are exercising their right to choose a home under the Care and Support and After-care (Choice of Accommodation) Regulations (2014), in which case delays are counted under category G "Patient or family choice".

E) Awaiting care package in own home

8.7. This category covers all patients whose assessment is complete but whose transfer is delayed while waiting for a package of care in their own home or housing with care.

8.8. The delay is attributable to the organisation responsible for providing the service that is delayed. These attributions can still be determined, even where organisations operate in partnership, as statutory responsibilities for care do not change under partnership arrangements. Where integration is progressing and services are jointly commissioned and/or provided to support short term reablement and rehabilitation at home any delays into these jointly commissioned and/or provided services are recorded as a Joint delay.

This category **includes**:

- Delays awaiting intermediate or other NHS-funded care in their own home, or community.
- Delays awaiting social care-funded reablement or home care, in which case delays are attributable to Social Care.
- Delays awaiting jointly-funded home care, in which case delays should be Jointly attributable unless agreement cannot be reached, at which point delays are attributable to the part of the system (NHS or Social Care) with the statutory responsibility to meet the patient's needs.
- Delays where there is no NHS-funded intermediate care available (or such care is not provisioned at all), but where this would best meet the patient's needs, in which case delays attributable to the NHS, to identify this as a service gap.
- Delays awaiting extra care housing pathways.
- Delays awaiting Mental Health supported housing.
- Delays awaiting social or community health provided services.

F) Awaiting community equipment and adaptations

8.9. This category covers all patients whose assessment is complete but whose transfer has been delayed while waiting for items of community equipment or minor adaptations.

8.10. The delay is attributable to the organisation responsible for providing the equipment or adaptation that is delayed. This attribution should be possible to ascertain even where equipment is provided via a service delivered in partnership between the NHS and the Local Authority, by identifying the cause of any delay. The delay is Jointly attributable only where both NHS and social care services are delayed. The provision of short-term equipment is usually the responsibility of the NHS. The provision of beds addressing health needs, either short-term or long-term, is usually the responsibility of the NHS. The provision of long-term equipment is usually the responsibility of the Local Authority and attributable to Social Care. Such long-term equipment includes items that support daily living where there is no clinical need, such as specialised beds addressing functional needs that, for example, assist with manual handling.

This category **includes**:

- Delays for patients leaving acute or non-acute care who are awaiting major home adaptations or alternative housing arrangements.
- Delays awaiting manual handling equipment, such as hoists.
- Delays awaiting living equipment.
- Delays awaiting a bed.
- Delays awaiting house deep cleaning.
- Delays awaiting house decorating.
- Delays awaiting house decluttering.

This category **excludes**:

- Delays awaiting the self-purchase of smaller items of living equipment, which are no longer available to support discharge, in which case delays are counted under category G "Patient or family choice".

G) Patient or family choice

8.11. This category covers all patients whose assessment is complete and who have been made a reasonable offer of care to meet their assessed needs as far as practicable, but who have refused this offer. In such circumstance, local choice policies should be implemented but any delays, during any waiting period for the patient or their family to make another choice, are still reportable as a DTOC.

8.12. Where social services are responsible for providing services and a person's preferred home of choice is not immediately available, they should offer a reasonable interim package of care. All interim arrangements should be based solely on the patients assessed needs and be designed to sustain or improve their level of independence. Local agreements for interim packages and placements should be in line with national guidance, as outlined in the Quick Guide for Supporting Patients' Choices to Avoid Long Hospital Stays (2016).

This category **includes**:

- Delays for patients who are funding their own care, such as those opting for a residential or nursing home with no immediate vacancies, or delays incurred by patients who want a residential or nursing home where the costs (fees) exceed the amount agreed by the Local Authority to meet eligible care and accommodation needs.
- Delays where no alternative is provided that can meet the patient's needs, in which case delays are attributable to Social Care.
- Delays where a reasonable alternative service has been offered, either on an interim or more permanent, long-term basis, by the Local Authority, which the patient is refusing, in which case delays are attributable to the NHS, since the Local Authority has discharged its statutory duty to meet their assessed needs and, because their offer has been refused, responsibility has reverted to the NHS.
- Delays where patients or their families are holding up the discharge, such as those not attending planning meetings or refurbishing a house during the hospital stay.

This category **excludes**:

- Delays where a package of care is not available, and the patient does not consider the offer of care home to be reasonable, in which case delays are counted under Category E "Awaiting care package in own home", because the underlying issue concerns the package of care on offer.

Patients are typically given seven days, within which to make a decision concerning an offer of support, as outlined in the Quick Guide for Supporting Patients' Choices to Avoid Long Hospital Stays (2016), which contains a link to template policy and patient letters to be adopted locally. However, if they meet the definition of a DTOC during this period they are reportable, with the same timescales applying as those for other assessments.

H) Disputes

8.13. This category covers all patients whose assessment is complete and those rare instances where there is a dispute between statutory agencies, either concerning responsibility for the patient's onward care, or concerning an aspect of the discharge decision, such as a patient's readiness for discharge or the appropriateness of the care package being offered.

8.14. Disputes should only occur infrequently, where there is an exceptional level of contention between the NHS and the Local Authority. NHS organisations and councils are expected to operate within a

culture of problem solving and partnership, where formal dispute is a last resort, and high numbers of disputes should trigger a review of local partnership working.

8.15. Disputes cannot be recorded as Joint. Whilst awaiting the arrangement of an interim package of care, delays are attributable to the organisation that is taking interim responsibility for the patient's care.

This category **excludes**:

- Disagreements between the NHS and a Local Authority concerning the details of a reportable delay, such as attribution or reason code, does not mean this should be counted under category H "Disputes", and the category to be used should be the one most appropriately describing the reason for the delay.
- Disagreements with patients or members of their family, in which case delays are counted under category G "Patient or family choice".

I) Housing – patients not covered by the Care Act

8.16. This category covers all patients whose assessment is complete and where there are housing delays that relate to people who are not eligible for funded care and support, such as asylum seekers, patients from overseas, single homeless people or those with no fixed abode, and therefore are not within the remit of social services, because the Local Authority has no responsibility under the Care Act (2014).

From October 2018, there is a duty on specified public services to refer people they consider may be homeless or threatened with homelessness to a local housing authority, under the Homelessness Reduction Act (2017). Even where the duty to refer applies, this does not mean any DTOCs are necessarily a consequence of this status, so should not automatically be counted under Category I "Housing – patients not covered by the Care Act", because this category only relates to people who are not eligible for funded care and support.

8.17. In some cases, people in these groups may be still the responsibility of a Local Authority housing service, as opposed to social care, although this is not universal and is limited to meeting certain eligibility criteria, including immigration status. Therefore, it is essential to identify the postcode from where people were admitted into hospital.

8.18. All delays under this category are attributable to the NHS, because it covers patients who have been assessed by social care but who do not meet the eligibility criteria for care and support. For this reason, where patients do not meet the eligibility criteria for care and support, or the Local Authority housing priority criteria, it may be necessary to discharge them back onto the street.

This category **includes**:

- Delays for patients who have no care needs under the Care Act (2014) and have no right of recourse to public funds, such as those who are homeless but have no eligibility for housing.
- Delays for patients who need rehousing.

This category **excludes**:

- Housing delays for all other patients, namely those who are eligible for funded care and support, who are waiting either for an interim or more permanent long-term housing solution, including those awaiting long-term adaptations to be made, in which case delays are attributable to Social Care and are counted under the care package for which they are waiting,

such as category Di “Awaiting residential home placement or availability”, category Dii “Awaiting nursing home placement or availability”, or category E “Awaiting care package in own home”.

O) Other

8.19. The reason codes, specific to the Mental Health Services Data Set (MHSDS) (see Section 5), do not easily map to those used in the monthly SitRep (MSitDT) return. This category is to be used for those patients included in both returns, who are not covered by that mapping. Conversely, this category is ONLY to be used for such patients, who should be included in returns both to the MHSDS and the strategic data collection service (SDCS), whilst the data quality of the MHSDS is being improved.

This category **includes**:

- Those who are Awaiting care coordinator allocation (A2), in which case such delays should be attributed to the NHS
- Child or young person awaiting social care or family placement (L1), in which case such delays should be attributed either to the NHS or to social care
- Those who are Awaiting Ministry of Justice agreement/permission of proposed placement (M1), in which case such delays should be attributed to the NHS
- Those who are Awaiting outcome of legal requirements (mental capacity/mental health legislation) (N1), in which case such delays should either be attributed to the NHS or to social care.

8.20. The MHSDS uses an additional attribution, namely “Housing (including supported/specialist housing)”. All DTOCs attributable to Housing within the MHSDS are to be attributable to the NHS within the monthly SitRep (MSitDT) return.

MHSDS attribution	Monthly SitRep (MSitDT) attribution
NHS, excluding housing	NHS
Social Care, excluding housing	Social Care
Both (NHS and Social Care), excluding housing	Both
Housing (including supported/specialist housing)	NHS

Table 1 – Mapping between the MHSDS DTOC attributions and those used within the monthly SitRep (MSitDT) return

Appendix A. Patient snapshot

A1. Prior to April 2017, a patient snapshot count was reported in the monthly SitRep (MSitDT) return. This patient snapshot recorded the number of patients whose transfer was delayed at midnight on the last Thursday of the calendar month. In other words, the snapshot was taken at the end of Thursday / start of Friday. Being a snapshot, it will only include patients that are currently delayed at that point in time (midnight on Thursday). Although this element is no longer required in the monthly SitRep (MSitDT) return, the historical data are available in the relevant publication files.

Appendix B. Supporting resources

- B1. ageUK Homelessness [Factsheet 89](#) eligibility criteria for Local Authority housing service
- B2. Applications to the Court of Protection: a Guide for Council Staff ([2017](#))
- B3. Care Act ([2014](#))
- B4. Care and Support and After-care (Choice of Accommodation) Regulations ([2014](#))
- B5. Care and Support (Discharge of Hospital Patients) Regulations ([2014](#))
- B6. Care and Support Statutory Guidance ([2018](#))
- B7. Deprivation of Liberty Orders ([2018](#))
- B8. Deprivation of Liberty Safeguards - Code of Practice ([2008](#))
- B9. Guide to Reducing Long Hospital Stays ([2018](#))
- B10. Homelessness Reduction Act ([2017](#))
- B11. Mental Capacity Act ([2005](#))
- B12. Mental Capacity Act Code of Practice ([2016](#))
- B13. Mental Capacity Act Deprivation of Liberty Safeguards ([2007](#))
- B14. Mental Health Act ([1983](#))
- B15. Mental Health Services Data Set (MHSDS) attribution codes ([2017](#))
- B16. Mental Health Services Data Set (MHSDS) reason codes ([2017](#))
- B17. MHSDS to MSitDT Guidance and Mapping ([2017](#))
- B18. National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care ([2018](#))
- B19. Quick Guide for Supporting Patients' Choices to Avoid Long Hospital Stays ([2016](#))
- B20. Quick Guide to Deprivation of Liberty Orders ([2017](#))
- B21. Rapid Improvement Guide: Red2Green Bed Days ([2017](#))