Background
At the NHS Confederation 13th June the NHS launched its plan to improve patient care by cutting long hospital stays.
The new drive aims to build on the success of the NHS and local councils in tackling delayed transfers of care (DTOCs). The number of DTOCs fell to 4,880 in January, 1,780 fewer than the baseline month of February 2017.
To meet the ambition NHS trusts will be expected to close the gap between the number of patients discharged during the week and those sent home at the weekend and make greater use will be made of alternatives to admission such as emergency day cases or therapy services.

The plan Guide to reducing long hospital stays is available at

Delayed transfer of care (DTOC) improvement tool
This tool has been developed to enable trusts, clinical commissioning groups and local authorities to understand where delayed transfers of care are in their area or system.
https://improvement.nhs.uk/resources/delayed-transfer-care-dtoc-improvement-tool/

What is a Delayed Transfer of Care?
A 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.
**HHFT SAFER Discharge Patient Flow Bundle**

In the SAFER process a **Predicted Date of Discharge (PDD)** is the date when the patient is expected to be **Clinically Fit** to leave our hospitals, as specified in the **Clinical Criteria for Discharge**. Time waiting for internal or external services should not be incorporated when setting this date. This date is set and reviewed on a daily basis by the multidisciplinary team and recorded on EPR. **If the PDD has been exceeded, the patient becomes a delayed transfer of care**, however, the PDD does not change on EPR whilst they are Clinically Fit.

**Clinical Criteria for Discharge (CCD)** is the criteria the patient has to achieve to be deemed Clinically Fit to leave our hospitals- this is the minimum physiological, therapeutic and functional status the patient needs to achieve before discharge, as determined by the multidisciplinary team. **The CCD should state specific parameters to be achieved, rather than non-specific goals (e.g. ‘back to baseline’)**. The CCD must be recorded on EPR.

http://trustnet/Directors-Management/Transformation/Non-Elective%20Transformation%20Team/Safer/Team%20Documents/PDD%20and%20CCD%20Definition_Final_V1.0_09_05_18.pdf

### Background reading

**Delayed transfers of care: a quick guide (king’s Fund)**

Why do delayed transfers of care occur? And what is the impact on the wider health system?

**Delayed transfers of care in the NHS (House of Commons 2017)**

This House of Commons Library briefing paper looks at policy and statistical trends on delayed transfers of care - patients who are well enough to leave hospital but are unable to do so - in the NHS.
https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7415

**What’s behind delayed transfers of care?   (Nuffield Trust 2017)**

An exploration what the data says about delayed transfers of care.

**How to reduce DTOC – examples**

**Ipswich Hospital NHS Trust**

This Trust uses a modified Red to Green day system. It has succeeded in reducing the average length of stay.
Data for July 2014 showed a length of stay for non-elective patients of over one day less than the same time in 2013 (6.07 days in July 2014 compared with 7.3 in August 2013). Since then the downward trend has continued, with an average length of stay of 5.3 in August 2015 and further decreases to 5 days in December. Accurate information within the trust’s delayed discharge database, and the development of an additional tracking system for patients receiving continuing healthcare, **operational managers, matrons and CCG colleagues all now have a greater awareness of the progress of the patient pathway** and any blocks to discharge.
https://fabnhsstuff.net/2016/06/21/ip/

**Lincolnshire Community Health Services NHS Trust : Reducing delayed transfers of care in community hospitals**

The trust has seen a significant reduction in community hospital DTOCs, down to 3.6 per cent from
16.2 per cent over the last 12 months. It has improved patient outcomes, with staff more proactive in recording the date of intended discharge, discharge planning and addressing issues that arise. The new pathways better support patients to be partners in their care and having a clear process helps to manage expectations. Care outcomes are now monitored against set standards and there is ongoing monitoring and audit through the ‘Safer’ tool. There is also improved accountability and responsibility among staff, with clear recognition that DTOC is a cause of harm. This is monitored through regular internal DTOC calls. Establishing the reasons for DTOC has allowed LCHS to identify gaps in ongoing care provision in the system and to raise them through appropriate channels. This has also improved relationships with other providers and third sector organisations.


Norfolk & Norwich University Hospitals Foundation Trust (NNUH)/Norfolk District council
725 bed days saved over 29-week extended pilot (average daily saving of 5 bed days). Improved efficiency in the System of around £180,000 by having a Resource a District Council Officer to work 5 days a week at the NNUH within the acute hospital’s integrated discharge team for a 12 week pilot to create bespoke action plan for housing and other lifestyle needs on discharge from the hospital.

Western Sussex Hospitals NHS Foundation Trust
A project which sets a scheduled date and time of departure has reduced length of stay
https://fabnhsstuff.net/2018/01/14/scheduled-on-time-departure-from-hospital/

Why Not Home? Why Not Today?
Preventing delays to patients being transferred from hospital settings is achievable. Done properly, not only are health and personal outcomes improved, but net savings for the system may also be generated.
Patients waiting in hospital beds for discharge to an appropriate setting is a symptom of systems not working – and can be tackled rather than accepted.
The challenge set for this piece of work was to ‘do something different’. So a new approach was designed by Newton and three areas in the North of England, resourced by regional Better Care Fund support monies.

Sheffield Teaching Hospitals
Sheffield (one of the Trusts in the report Why Not Home? Why Not Today) are using a variant of Red to Green days with a RED BRONZE SILVER GOLD approach

Their principles are
1. That people come to hospital to receive acute medical treatment. When that treatment is over, we aim to get them out as quickly as possible.
2. We want people to be as independent as possible. We always aim to get people home first.
3. Assessments regarding long-term care are not made from hospital.

ASSESSMENT AT HOME
A service that feels like one, seamless service to people.
A better, more efficient, fit for purpose service with joint effort and ownership.
Flexible, accessible MDT services.
Support people at home as soon as they are no longer benefitting from acute care, utilising the discharge to assess approach.
Support people to remain at home, manage crisis and reduce avoidable admissions.
“Hide the wiring” – make discharges simpler for the wards.


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<th>Research</th>
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| **Discharge planning from hospital (2016)**
This systematic review looked at 30 trials (11,964 participants) and concluded that a discharge plan tailored to the individual patient probably brings about a small reduction in hospital length of stay and reduces the risk of readmission to hospital at three months follow-up for older people with a medical condition. Discharge planning may lead to increased satisfaction with healthcare for patients and professionals. There is little evidence that discharge planning reduces costs to the health service.


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<th>Health and social factors associated with a delayed discharge amongst inpatients in acute geriatric wards: A retrospective observational study.</th>
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<td>Moore, G. et al Geiatrics &amp; gerontology international; Apr 2018; vol. 18 ( 4); p. 530-537</td>
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This study sought to analyze whether clinical frailty was a significant and independent risk factor for having a delayed discharge when the data were controlled for potential health and social confounders. It was a retrospective observational study in an English NHS teaching hospital. We analyzed all first hospitalization episodes to the Department of Medicine for the Elderly between 1 May 2016 and 31 July 2016. A delayed discharge was operationally defined as a patient being discharged more than 24 h after his/her last recorded clinically fit date. The independent risk factors for having a delayed discharge were: needing a new package of care, new institutionalization, living alone delirium and frailty. The results are consistent with previous reports that delayed discharges in older hospitalized patients are mainly related to new formal social care requirements in survivors of acute illness. **Frailty was an independent risk factor for delay**, but its effect might have been confounded by the unmeasured variable of informal care requirements. (Full text of this article is available from library.basingstoke@hhft.nhs.uk) |

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<th>The High Impact change model for managing transfers of care,</th>
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| Developed by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS), national partners and the sector in 2015, offers a practical approach to managing patient flow and hospital discharge. The model identifies eight system changes that will have the greatest impact on reducing delayed discharge.
This resource supplements the model by bringing together examples of work being undertaken across the country, for each of the eight system changes. It references a range of initiatives where there is already evidence of impact, points to examples of emerging practice that are starting to make a difference and includes links to published guidance, and further information. |


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<th>The role of expected date of discharge in the significant reduction in length of stay.</th>
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<td>East Midlands Academic Health Science Network emahsn.org.uk (2015)</td>
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This review examined whether there is evidence that effective use of Expected Date of Discharge (EDD) leads to a significant reduction in Length of Stay (LOS). Whilst only sparse quantitative |
Evidence is available to show that EDD directly reduces LOS, case study and qualitative examples show that a relationship does exist between EDD and LOS. An EDD can be used as an audit tool to evaluate patient flow through the organisation and at the ward level an EDD has been shown to be appreciated by multidisciplinary teams (MDTs) in that it provides a useful target for teams to work towards. Effective team working and better staff relations are linked to staff engagement and staff engagement is linked to implementation. Recognition that the setting of an EDD as a decision made purely on clinical need may be counterproductive in relation to the use of an EDD as a tool to reduce LOS as in many instances delays to discharge (EDD not being met) are due to non-clinical issues.

http://emahsn.org.uk/images/Section%208%20Resource%20hub/Sparks%20and%20Sparklers/SPARKLER_9_v3_FINAL.pdf

Summary:
The examples and research show that DTOC can be reduced by establishing good practice in hospitals for setting discharge dates and criteria for discharge. There needs to be a culture within a Trust so that everyone is working towards the target of meeting the predicted date of discharge but crucially involvement from Adult Services and Community providers is key to ensuring care packages are available.

However there must be some caution.

• In 2017 the Care Quality Commission’s chief inspector of social care warned that the focus on short-term targets for reducing delayed transfers of care from hospital could put elderly people at risk, and cause tension between councils and local NHS organisations. (https://www.lgcplus.com/services/health-and-care/interview-chief-inspector-warns-of-dtoc-target-risk-to-elderly/7021680.article)

• The National Audit Office in its report Reducing Emergency Admissions (March 2018) identified an increase (10.2% between 2012-13 and 2016-17) in the number of people being readmitted in an emergency shortly after an initial inpatient stay. They say that readmissions can serve as a warning indicator that local practices may not be providing the required quality of acute care and discharge planning and it raises questions about the appropriateness of some decisions to discharge and/or the support provided to help people recuperate. (https://www.nao.org.uk/wp-content/uploads/2018/02/Reducing-emergency-admissions.pdf)

• A recent study ‘Incidence and cost of medication harm in older adults following hospital discharge: a multicentre prospective study in the UK’ in the British Journal of Clinical Pharmacology found that the incidence of medication-related harm (MRH) associated hospital readmission was 78 per 1000 discharges. Post discharge MRH in older adults is estimated to cost the National Health Service £396 million annually, of which £243 million is potentially preventable. https://bpspubs.onlinelibrary.wiley.com/doi/abs/10.1111/bcp.13613