Digital Transfer

Whitepaper

A guide to planning and deploying digital solutions to support timely transfer of care

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Who this guide is for

This guide is written for NHS Trusts, Integrated Care Boards (ICBs), and system partners responsible for improving patient flow, reducing delayed discharges, and strengthening collaboration between acute, community, mental health, and social care services. It is particularly relevant for organisations that have already established, or are planning to establish, Transfer of Care (ToC) Hubs and are seeking to improve their effectiveness through better process design and digital enablement.

Introduction

Transfer of care is a strategic priority for the NHS in England. Every day, there are 13,000 people in England whose treatment has been completed who are still in hospitals, plus a further 4,000 across the rest of the UK. This means that approximately one in eight beds is occupied by someone who does not clinically need to be there. Supporting patients to leave hospital and complete treatment at home or in another community setting helps free up staff time, reduce costs and improve patient experience.

Within the past 2 or 3 years, ToC Hubs have been set up across England with new staff roles to support patients to leave hospital sooner. And yet, as things stand, delayed discharge figures remain stubbornly high.

In this whitepaper, we explore why this is the case and outline practical considerations for NHS organisations looking to establish effective, region-wide transfer of care, supported by digital solutions that enable coordination rather than simply digitising existing fragmentation.

The power of the pilot: Starting small to scale big

Implementing a region-wide transfer of care solution is a complex undertaking. To avoid becoming bogged down, successful projects often begin by perfecting a single, high-impact pathway before expanding to the full Integrated Care System (ICS) footprint.

- **The "micro-pathway" strategy**: Start with a focused handover, such as the transition from an acute trust to a local care home group.
- **Proof of concept**: By digitising this specific link, providers can iron out data-sharing protocols and handover checklists in a controlled environment.
- **Creating the blueprint**: Once the 'Acute-to-Care Home' model is proven to reduce delayed discharges, it serves as a standardised template that can be rolled out across other providers in the region.

Why this matters now

Despite the rollout of ToC Hubs, delayed discharges remain high. This suggests that new roles and structures alone are not enough. The limiting factors are increasingly coordination, shared visibility, and the ability to manage handovers consistently across organisational boundaries.

Digital enablement is no longer about replacing paper - it is about providing the operational tools that allow ToC Hubs to function as intended.

Aligning with the national strategy: *Fit for the future*

The move toward integrated Transfer of Care Hubs isn't just a local efficiency drive; it is a fundamental pillar of the NHS national strategy, *Fit for the Future*. This strategy emphasises shifting healthcare provision away from hospitals as a default, and back into the heart of the community, where appropriate.

1. Integration via Integrated Care Boards (ICBs)

The goal of the national strategy is to erase the 'digital borders' between organisations. An effective transfer of care process acts as an interface between care settings across an ICS. Ensuring that whether a patient is in an acute bed or a community setting, their data, and the responsibility for their care, is always visible.

2. Empowering 'Neighbourhood Teams'

A core element of the Fit for the Future model is the creation of Neighbourhood Teams; multi-disciplinary groups (GPs, social care, district nurses, and mental health professionals) that manage care at a local level.

Effective digital solutions ensure that when a patient is discharged, the relevant Neighbourhood Team is alerted instantly, receiving the clinical and social context needed to prevent avoidable readmission.

3. Proactive vs. reactive care

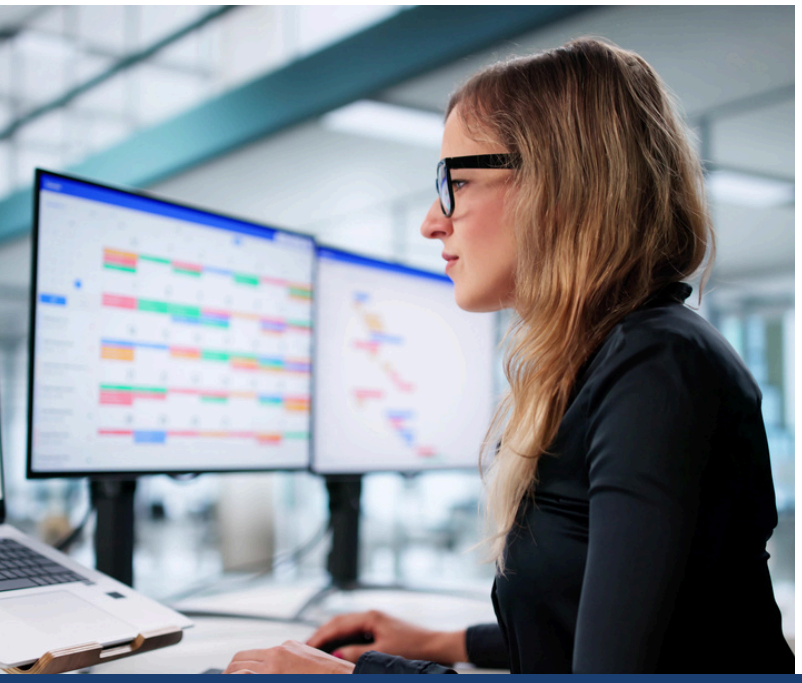
By aligning with the national focus on proactive care, regions can use digital transfer of care solutions to move from simply 'reacting' to a discharge crisis to 'managing' a patient's journey through the community. This reduces the 1 in 8 beds currently occupied by patients who have completed treatment but lack a safe community-based option for step-down care.

Summary: Success in the *Fit for the Future* era requires a 'think big, start small' approach. Whilst by no means a panacea for challenges such as a lack of funding or staff shortages, by mastering a single pathway and scaling it to meet the needs of Neighbourhood Teams, Trusts can make genuine inroads against the **13,000 to 17,000 delayed discharges** currently stalling the system.

The starting point: Mapping transfer of care

The success of **Transfer of Care (ToC)** Hubs depends on more than just new staff or software; it requires a clear understanding of the current 'as-is' state. Healthcare transitions are inherently fragmented, and without mapping the existing journey, critical information (medication lists, social care requirements, and equipment needs) will continue to fall through the cracks of manual handovers.

Mapping is essential for identifying the structural shortfalls in your region's discharge and transfer protocols. By visualising the current process, Trusts can achieve several critical goals:



1. Eliminating fragmented data silos

Mapping reveals exactly where data is trapped in silos. ToC Hubs function best when they act as a 'single point of truth.' By identifying these bottlenecks, regions can streamline digital workflows, ensuring that the receiving team, whether in social care or a community hospital, has a clear view of care needs when a patient arrives.

2. Standardising clinical pathways

Discharge shouldn't be a postcode lottery. Mapping allows regions to synchronise their **Discharge to Assess (D2A)** models across different sites. This ensures patients receive timely reminders for recovery and that homecare is organised before the patient leaves the ward, rather than as an after-the-fact emergency.

3. Operational efficiency and bed flow

Trusts can significantly reduce 'failed discharges' by identifying exactly where protocols are being ignored or bypassed. Clear mapping allows hubs to move from reactive firefighting to a managed flow. This limits unnecessary bed days, reduces the risk of avoidable readmission, and ensures that clinical interventions happen when they are needed, not just when a bed finally becomes available.

Summary: ToC Hubs are designed to provide integrated, proactive care. However, they can only succeed if the underlying process is understood and optimised. Mapping isn't just an administrative exercise, it's the essential tool for a healthy, connected NHS system.

Why digital tools are essential to support transfer of care

Healthcare is complex by nature, especially when transitions of care occur. During a transfer between departments or organisations, patients and providers must exchange a vast amount of critical information regarding conditions, risks, and follow-up requirements. Too often, essential pieces of information are lost in the shuffle of manual handovers or fragmented systems.

Digital transfer of care solutions are designed to eliminate these gaps, ensuring that medical data follows the patient seamlessly and securely. By digitising and standardising the transfer process, healthcare providers can ensure continuity of care and better patient engagement.

Optimising your transfer process with digital tools benefits the relationship between patient and healthcare provider in several key ways:

1. Streamlined clinical workflows

By automating the collection and sharing of patient data during a transfer, hospitals can reduce the administrative burden on staff. Real-time data availability allows receiving providers to intervene immediately when necessary or adjust care plans without waiting for paper files to catch up.

2. Empowered patient participation

Transitions are less intimidating when patients and their next-of-care providers are fully informed. The updated Care Act (2014) indicates that patients and unpaid carers should be involved as soon as it is feasible in discharge planning, where appropriate. Digital transfer of care solutions can help ensure that everyone involved has the knowledge needed for shared decision-making, from medication adjustments to post-transfer recovery exercises and homecare organisation.

3. Reduced operational costs and delays

Inefficient transfers often lead to postponed procedures or redundant testing. By facilitating clear communication throughout the transfer process, hospitals can minimise errors, limit the duration of stays, and reach out to patients based on actual clinical needs rather than just scheduled appointments.

Summary: Digital transfer of care solutions enable hospitals to provide more personalised and proactive care by bridging the gaps between care settings. This results in improved health outcomes, higher patient satisfaction, and a truly connected healthcare ecosystem.



Stakeholder mapping and engagement



Any successful digital healthcare project involves a blend of people, process and technology. When implementing tools and processes across multiple organisations, it becomes more important than ever to define the people involved in that process and ensure strong lines of communication and understanding of needs, if the project is to succeed.

For transfer of care, the following people are important to consider:

Patients and carers
Patients and their families are the only ones who experience the transfer from start to finish. Including them in feedback loops or focus groups is vital to identify where communication breaks down once they leave the ward and often enter the 'nowhere space' between hospital and home.

The Multi-Disciplinary Team (MDT)
This includes the 'sending' team (ward nurses, discharge coordinators, and consultants) and the 'receiving' team (GPs, community nurses, and pharmacists). Their input ensures that the clinical handoff is not just about transferring patient notes, but a meaningful transition of responsibility.

Social care and community partners
In a **Transfer of Care Hub** model, these stakeholders are non-negotiable. Local authorities and social care providers must be involved to align discharge timelines with the availability of homecare packages or intermediate care beds.

A digital partner
Companies which work with and alongside the NHS to develop digital solutions can often provide both technical and process / mapping advice and guidance. **Digital transfer of care solutions** guide the mapping process by providing a framework to standardise how information is shared, ensuring that changes to the workflow are technically feasible and sustainable.

Summary: For a transfer of care project to succeed, every stakeholder must have a seat at the table. Without active participation from both the acute and community sectors, the map will have missing links which lead to delayed discharges and poor patient outcomes.

Mapping the transfer of care process

The entire process of mapping your transfer of care might typically take between 4 and 8 weeks, depending on the availability of key stakeholders across the Trust and the wider region.

Preparation for transfer mapping

To ensure a successful transition from hospital to community, the following steps are essential:

1. Define the transfer pathway

Decide which specific pathway you'd like to map first (e.g., Pathway 1: Discharge to home with support). It is recommended to start with a high-volume, standardised pathway before moving on to more complex multi-agency transfers.

2. Define the clinical and operational steps

From a provider perspective, what are the specific milestones a patient must reach to be ready for discharge? (Of course, there is an important difference between a patient who has No Criteria to Reside and a patient who is ready for discharge. What information (medication, mobility status, social care needs) must be communicated at each stage?

3. Identify handover steps

Handover steps are where the responsibility for patient care passes between teams. These can be digital (e.g., updates in digital transfer of care solutions), physical (e.g., MDT ward rounds), or external (e.g., phone calls to community providers or families).

4. Apply a continuity perspective

Determine how the 'receiving' end experiences the transfer. Does the GP or social care provider receive the information they need in time to act? Is the patient clear on where they are going and who is responsible for their next stage of care?

5. Identify system bottlenecks

Identify where the process stalls. Whether it's waiting for a pharmacy TTO, transport delays, or a lack of visibility in the Transfer of Care Hub. You will quickly see which touchpoints are failing to support a timely discharge.

The goal of this process is to gain a system-wide view of patient flow, providing real-time visibility for the Hub while aligning acute and community workflows.



Your mapping sessions

Your transfer process can be mapped in as little as two targeted sessions. It is vital that stakeholders from both the sending and receiving sides are present to ensure the map reflects the reality of the entire journey.

- **Session 1: Conceptualise the transfer flow**

Understand the movement of the patient and how it intertwines with the digital workflow of the medical and social care staff. Determine what data is vital at each handover point.

- **Session 2: Feedback and finalisation**

Involve community partners and patient representatives to provide feedback on the proposed flow. Use this to finalise a process that satisfies clinical safety, operational efficiency, and patient comfort.

Summary: Too often, Trusts map their internal processes in isolation, without involvement from all organisations in the transfer of care pathway. By using this time to collect real feedback from both the ward and the community, you can eliminate the gaps in your current flow and build a truly integrated transfer of care experience.

Tips & Tricks for mapping your transfer of care progress

Optimising your **Transfer of Care** process doesn't have to be an administrative burden. Digital transfer of care solutions have helped healthcare organisations across Europe bridge the gap between acute and community settings, improving system flow and patient safety.

Optimising your **ToC** process doesn't have to be an administrative burden. Digital transfer of care solutions have helped healthcare organisations across Europe bridge the gap between acute and community settings, improving system flow and patient safety.

Below are a few tips to ensure your first mapping sessions result in a seamless transition for every patient:

1. Adopt the 'receiver's' perspective

While the patient's experience is central, a transfer involves a handoff. Analyse the process from the perspective of the receiving party, be it a GP, a care home, or the patient's family. If they receive a wall of clinical text, vital information gets missed. Ask: *What does the next provider need to know right now to keep this patient safe?*

2. Standardise information, minimise jargon

Delayed discharges often happen because of 'information overload' or confusing terminology. Use a digital transfer of care solution to standardise handover data. Limit medical jargon so that community providers and families can easily understand the care plan. Only communicate what is relevant to the immediate post-discharge period.

3. Use visual aids for complex care

Images aren't just for aesthetics; they are clinical tools. Use photos to demonstrate wound care progress or equipment setup. This reduces the anxiety for patients moving to a home setting and

provides community nurses with a clear visual baseline.

4. Leverage video for home recovery

Video has huge potential for reducing readmissions. Use short clips to introduce the community care team or demonstrate specific physiotherapy exercises. For patients with low health literacy, seeing a 'how-to' video on managing their medication or mobility aids is far more effective than a printed leaflet.

5. Bridging the gap post-discharge

The transfer isn't finished the moment the patient leaves the ward. Use digital touchpoints – like integrated apps or automated check-ins – to maintain engagement during the first 72 hours at home. This ensures the transfer has stuck and allows the Transfer of Care Hub to intervene before a minor issue becomes a readmission.

Continuous improvement: Keeping the flow moving

Mapping your transfer of care is not a 'once only' exercise. To sustain a reduction in delayed discharges, the process must be refined as community resources and hospital pressures evolve.

- **Multi-agency focus groups:**

Regularly host sessions with 3-5 representatives from social care, primary care, and patient advocacy groups. Run through a recent 'live' transfer and collect honest feedback. What information was missing? Where did the delay occur?

- **Annual flow audits:**

Once you have perfected your transfer pathway, host yearly mapping sessions with all stakeholders. Use this time to identify new blind spots or bottlenecks that have emerged in the regional system.

Summary: By involving both the senders and receivers in your mapping process, you move away from a fragmented discharge model toward a truly integrated healthcare ecosystem. Digital transfer of care solutions can then help transform these maps into a much-improved workflow.

Things to consider when mapping a transfer of care process

Involve the right stakeholders

Patients and carers
Involve them in post-discharge feedback to identify communication gaps and improvement needs.

Sending and receiving teams
Include staff working across Acute, Community and Mental Health settings, as well as patients and carers.

System partners and digital solution providers
Industry partners can help advise on how to successfully design, implement, and integrate digital solutions to support the patient pathway.

Map your transfer flow

I. Define the transfer pathway
Start with a straightfoward, high-volume pathway.

II. Define clinical and operational steps
Identify specific milestones for discharge-readiness and vital information (medication lists, mobility status) that must be shared.

III. Identify handover
Trace every handover step between teams - digital, physical or phone - for data, transport and equipment.

IV. Apply a continuity perspective
Assess how the receiving end experiences the transfer. Does the GP or social care have the information in time to act?

V. Identify system bottlenecks
Locate where the process stalls (e.g. pharmacy delays, transport issues, or lack of visibility in the ToC Hub) and causes delays.

Mapping sessions

Session 1: Conceptualise the transfer flow

- Understand patient movement intertwined with staff digital workflows.
- Determine vital information for each handover point.

Session 2: Feedback and finalisation

- Involve community partners and patient representatives to provide feedback on the flow.
- Finalise a process that satisfies clinical safety, operational efficiency, and patient comfort.

Continuously improve

Multi-agency focus groups
Regularly test the journey with a diverse group (3-5) of social care, primary care and patient representatives.

Annual flow audits
Host yearly mapping sessions with all the stakeholders to identify blindspots and bottlenecks as the regional picture evolves.

Collect feedback

Improve Transfer

About Enovation

The Enovation Platform is the leading platform for connected care. Our software supports digital care and collaboration throughout the patient journey. This gives (healthcare) organisations all the tools they need to function as one well-oiled multidisciplinary network, close to the client.

Is your organisation ready to take the next step in digitalisation? Or would you like to know more about implementing digital solutions? We would be happy to tell you more about the possibilities and how you can approach this.

Would you like to know more about Enovation Platform? Go to enovationgroup.com or contact us:

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