



HM Government

Hospital Discharge and Community Support: Policy and Operating Model

Published on 19 October 2021, this is a partially updated version of the document published on 5 July 2021. It has been updated to incorporate details of the national discharge funding settlement for quarters 3 and 4 of 2021-22 (1 October 2021 to 31 March 2022).



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1. Summary

This document sets out the Hospital Discharge Service operating model for all NHS trusts¹, community interest companies, and private care providers of NHS-commissioned acute, community beds, community health services and social care staff in England.

- 1.1 The Government has provided a national discharge fund via the NHS, for quarters 3 and 4 of 2021-22 (1 October 2021 - 31 March 2022), to help cover some of the cost of post-discharge recovery and support services, rehabilitation and reablement care following discharge from hospital. This policy is applicable for that time period.
- 1.2 The discharge to assess model has been implemented since March 2020 with an intention to support more people to be discharged to their own home. Health and social care systems are expected to build on this work during the second half of 2021-22 to embed discharge to assess across England as the default process for hospital discharge during the funded period.
- 1.3 Through a combination of embedding the discharge to assess model and utilising the national discharge fund, there is an expectation that performance continues to reduce the length of stay for people in acute care, to improve people's outcomes following a period of rehabilitation and recovery, and minimise the need for long-term care at the end of a person's rehabilitation.
- 1.4 We acknowledge and thank the Local Government Association, Association of Directors of Adult Social Services, the Academy of Medical Royal Colleges, British Geriatrics Society, British Red Cross and Carers UK for their involvement and support in developing this guidance.

¹Mental Health inpatient services are not within scope for this guidance. Separate funding for mental health discharges for 2021-22 is available and guidance on managing demand and capacity across mental health, learning disability and autism services has been developed [here](#).

2. Introduction

- 2.1. Through the introduction of the discharge to assess model and the Government's national discharge fund, health and social care systems have achieved significant gains but there still remains variation in the performance with the length of stay for people in hospital and the number of people being discharged on the day that they no longer meet the reasons to continue to reside in an acute bed.
- 2.2 Health and social care systems are expected to use the Government's national discharge fund to support the best outcomes for people leaving hospital, further reduce the length of stay of acute admissions and ensure a higher proportion of people are discharged on the day that it is determined they no longer need the support of an acute hospital.
- 2.3 Systems must ensure they provide adequate health and care discharge services, operating seven days a week during the second half of 2021-22 to improve people's outcomes as well as discharge performance. There is also a need to support hospital elective recovery plans and use available resources to fund usual discharge schemes.
- 2.4 Central to the delivery of effective discharge and timely discharge planning is professional and clinical leadership and good communication. This underpins regular reviews of the treatment and care for people, and ensures a consistent focus on the [principles of personalised care](#).
- 2.5 Daily morning board rounds to review every person and make decisions, informed by the criteria to reside, are the foundation for avoiding delays and improving outcomes for individuals. Transfer from the ward to a dedicated discharge area should happen promptly; for persons on Pathway 0 this should be within one hour of that decision being made, and the same day for people on all other pathways. Discharge from the discharge area should happen as soon after that as is possible - which will often be within two hours, or on the same day. The need for a timely discharge, however, should not result in discharges that are unsafe, such as happening overnight, or lead to people not being fully informed as to the next stages of their care.

- 2.6 The criteria to reside tool (see [Annex A](#)) was developed in March 2020 with the Academy of Medical Royal Colleges and has since been reviewed with the collaboration of the British Geriatric Society. The tool equips clinical teams to have discussions and make decisions whether a person needs to stay in an acute bed to receive care. This should then lead to a plan concerning the resources and services required to support a safe and timely discharge of that person if they no longer need the support and services of an acute hospital.
- 2.7 NHS commissioned (acute and community) hospitals must integrate the daily reviews into their electronic patient information systems during 2021-22. This will ensure live data is available for all agencies to work from and include those suitable for discharge, the number and percentage of people who have left the hospital, and reason of delay for those unable to be discharged in a timely way. This data forms part of national data performance reporting arrangements (see section 7).
- 2.8 The Government has provided a national discharge fund, via the NHS, for quarters 3 and 4 of 2021-22 (1 October 2021 - 31 March 2022), alongside existing Local Authority and Clinical Commissioning Group (CCG) budgets, to cover the cost of post-discharge recovery and support for the new or additional care needs of an individual following discharge from hospital. Therefore, an individual's new or extended care needs will be supported on discharge from hospital and delivered free for a time limited period. This will enable time for reablement, for assessment and, if needed, for the person to make decisions about their longer-term care and support. The scheme will end on 31 March 2022 and will not fund care delivered after this date – consequently no costs for care delivered in 2022-23 will be funded by this scheme. Further details of funding arrangements can be found in section 6.
- 2.9 Social care needs assessments and NHS Continuing Healthcare (NHS CHC) assessments of eligibility of finances and discussions about care planning and options should be made in a community setting. They should not take place during the acute or community hospital inpatient stay except where there are safeguarding concerns which need to be investigated and assessed prior to discharge.
- 2.10 The recovery and support provided post-discharge (including rehabilitation and reablement services) aims to help people return to the quality of life they had prior to their most recent admission. Many people will require a short period of support (i.e. two to three weeks) with no need for further, long-term support. For people with more complex needs, the period of recovery is likely to take longer. Where this exceeds the period of time paid for via the national

discharge fund (detailed in this guidance), local systems should follow agreed protocols for funding this care (see section 6).

- 2.11 Systems should work to be in a position where no one has to transfer permanently into a care home for the first time directly following an acute hospital admission - everyone should be offered the opportunity to recover and rehabilitate at home or in a bedded setting before their long-term needs and options are assessed and agreed.
- 2.12 It is essential that there is clarity about which CCG is responsible² for assessing each person's needs and paying the relevant organisation for any healthcare services provided to the individual.
- 2.13 To support full implementation of discharge to assess, a set of [hospital discharge staff action cards](#) has been developed to summarise responsibilities for key roles.
- 2.14 Local Authorities and NHS bodies should continue to work together to put this approach into practice in line with [top tips guidance on implementing a home first approach to discharge from hospital](#) and [the high impact change model](#).

² Please use NHS England's guidance [Who Pays?](#), to provide this clarity.

3. Discharge to assess arrangements

- 3.1 The [discharge to assess pathways model](#) is based on four clear pathways for discharging people, as shown below:

Discharge to Assess model - pathways³:

Pathway 0 - likely to be minimum of 50% of people discharged: simple discharge home; no new or additional support is required to get the person home or such support constitutes only:

- informal input from support agencies
- a continuation of an existing health or social care support package that remained active while the person was in hospital

Pathway 1 - likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.

Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.

Pathway 2 - likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home

Pathway 3 -for people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting*. Those discharged to a care home for the first time will have such complex needs that

³ Adapted from John Bolton model for persons aged 65+. When used across all 18+ age groups it is expected that a greater % than detailed here will be allocated to pathways 0 and 1, and a fewer than detailed % to pathways 2 and 3.

they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

* For national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0

Important considerations for all pathways

- 3.2 Upon discharge, all people should receive information about who they can contact if their condition changes, ranging from direct contact points within the clinical team who supported the person in an acute or community hospital, through to signposting to relevant voluntary or housing sector partners for help in day-to-day tasks. Please refer to the set of [hospital discharge staff action cards](#) for further details.
- 3.3 All persons leaving hospital should receive a holistic welfare check ⁴to determine the level of support, including non-clinical factors like their physical, practical, social, psychological and financial needs. Before discharge a determination must be made about the status and views of any carers who provide care, including that they are willing and able to do so. Discharge to assess arrangements do not change the entitlement for an unpaid carer to a carer's assessment where they are not able to care, and/or need help. A carer's assessment can be completed after discharge, but should be undertaken before caring responsibilities begin if this is a new caring duty or if there are increased care needs. If the assessment needs to take place prior to discharge it should be organised in a timely manner so as not to delay discharge from hospital.
- 3.4 Consideration must be given to identify where there are any children or young people in the household with caring responsibilities or may have some at the point of discharge. Children and young people may then be entitled to a young carer's needs assessment or benefit from a referral to a young carers service.
- 3.5 For people where new mental health concerns are considered in light of discharge, psychiatric liaison teams should be contacted by case managers in the first instance to review and assess as appropriate.

⁴ In line with recommendations from the [Healthwatch / British Red Cross report '590 people's stories of leaving hospital during COVID-19'](#).

- 3.6 A care coordinator or relevant mental health clinician should be involved in the discharge planning for people with a pre-existing mental health concern who are known to mental health services, to ensure their mental health needs are considered as part of duties under the Mental Capacity Act (2005).
- 3.7 If there is a reason to believe a person may lack the mental capacity to make the relevant decisions about their ongoing care and treatment, a capacity assessment should be carried out before a decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made, then there should be a best interest decision made for their ongoing care in line with the usual processes. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes and orders from the Court of Protection for community arrangements still apply. Further information about [mental capacity and deprivation of liberty during the pandemic](#) has been published.
- 3.8 For people identified as being in the last days or weeks of their life, the transfer of care hub will be responsible for overseeing communication with primary care, community services and, where required, community palliative care services to coordinate and facilitate rapid discharge to home or hospice.
- 3.9 All people who are homeless or at risk of homelessness should be determined on admission to hospital. During the hospital stay the person should be referred by acute hospital staff to Local Authority homelessness/housing options teams, under the requirements of the Homelessness Reduction Act (2017). This duty to refer ensures that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities. Further guidance on supporting people who are homeless when being discharged from hospital can be found in the [Local Government Association and ADASS high impact change model for managing transfers of care](#) and the accompanying [support tool](#).
- 3.10 Only a small number of individuals on the discharge to assess pathways will have needs that require assessment for NHS Continuing Health Care (NHS CHC). NHS CHC assessments should be undertaken when an individual's longer-term needs are clearer, following a period of recovery. In such circumstances where an extended period of recovery is required, this will need to be funded through local health arrangements.
- 3.11 NHS CHC teams must work closely with community health and social care staff in supporting people on discharge pathways 1, 2 and 3, to ensure appropriate discussions and planning concerning a person's long-term care options happen at the appropriate time on the discharge pathway.

3.12 There are some circumstances when it is not necessary to complete an NHS CHC checklist and these are set out in paragraph 91 of the [National Framework for NHS Continuing Healthcare \(NHS CHC\) and NHS Funded Nursing Care \(NHS FNC\)](#).

These include where:

- It is clear to practitioners working in the health and care system that there is no need for NHS CHC at this point in time. Where appropriate/relevant this decision and its reasons should be recorded
- The individual has short-term health care needs or is recovering from a temporary condition, and has not yet reached their optimum potential
- It has been agreed by the CCG that the individual should be referred directly for full assessment of eligibility for NHS CHC
- The individual has a rapidly deteriorating condition and may be entering a terminal phase. In these situations, the fast-track pathway tool should be used instead of the checklist
- An individual is receiving services under section 117 of the Mental Health Act that are meeting all their assessed needs
- It has previously been decided that the individual is not eligible for NHS CHC and it is clear that there has been no change in needs.

Pathway 0:

3.13 Acute hospitals are the responsible organisation for the discharge of all persons on pathway 0, ensuring that at least 50% of people, who can leave the hospital and only need minimal support, do so on time and safely.

3.14 People should be categorised as on pathway 0 when they do not require ongoing interactions with health or social care services to support recovery, although they may need a limited number of arranged follow ups immediately after discharge (for example, the removal of stitches in a clinic setting or at home). In addition, any person who is returning home and who had a home care package that is active and unchanged at the point of discharge should be recorded as being discharged on pathway 0.

3.15 Whilst a person classified as on pathway 0 does not require ongoing care, health and social care support to enable discharge and recovery, they can receive holistic wrap-around support, personalised to their needs in the days

immediately after discharge, such as low intensity or informal settling services or support from voluntary and community organisations. These services can help people regain their independence and prevent further re-admissions to hospital.

- 3.16 Support from and partnership with the voluntary sector and not for profit organisations on discharge is vital. National voluntary sector provision, commissioned by NHS England to support hospital discharge and admission avoidance over winter should be utilised and aligned with health and social care services within systems where this is operating.

Pathway 1:

- 3.17 Pathway 1 relates to people being discharged with home-based provision of health or social care support in line with home first principles. All persons needing new health and care support should be offered reablement and rehabilitation and, where necessary, time for assessment and future care planning post reablement. This pathway should also include people whose homecare package is being restarted after lapsing during their hospital stay.
- 3.18 To ensure systems can increase service capacity to support as many people to be discharged on pathway one, the following options are available:
- Utilise the national framework for independent sector providers for hospital at home services and reablement/rehab services (as set out in [20th January 2021 letter](#))
 - Use of hotel accommodation as a short-term measure (days, rather than weeks) where there are delays in arranging care at home support (as set out in [20th January 2021 letter](#))
 - Systems should engage with their local hospice(s) with the option to use the national discharge fund to extend the capacity in bed based and home visiting services beyond the existing commissioned service levels - as was successfully implemented during the pandemic.

Pathway 2:

- 3.19 A small proportion of people will need and benefit from short-term care in a 24-hour bedded facility for the purposes of rehabilitation/recovery where time is given to the assessment and consideration of options for longer term care. This could be in a rehabilitation facility, care home or hospice care.

- 3.20 Local health and care systems must ensure adequate rehabilitation is provided in relevant 24-hour bedded facilities and there is a focus on independence to (ideally) return to the person's own home.
- 3.21 Good practice would ensure all people discharged from an acute unit who may need a permanent care home placement, go home first and transfer to the care home from there or at the minimum enter a care home (as a short-term placement) supported by a rehabilitation support package. This will ensure the decision about their long-term care is taken in a care environment, once they have had time to recover from their acute episode of illness.

Pathway 3:

- 3.22 Systems should work towards an ambition whereby no person is transferred to a care home as a permanent placement for the first time straight from an acute hospital bed. Where this type of placement does occur, utilising the national discharge fund, this transfer cannot happen without the involvement and agreement of the Local Authority.
- 3.23 Any transfer into a care home must take into consideration published [guidance on testing prior to the person leaving an acute hospital for a care home](#).
- 3.24 Anyone who is likely to be infectious with COVID-19 being discharged into or back into a registered care home setting should first be discharged into a designated setting in line with [existing Government guidelines on designated settings](#) and [stepdown infection control guidance](#).
- 3.25 Pathway 3 should also be used to record the transfer of all people back to their care home if this was their usual place of residence prior to hospital admission. Data collection fields require systems to differentiate new care home placements from existing residents returning to their care home in order to maintain strong oversight of the proportion of new residents entering bedded care.

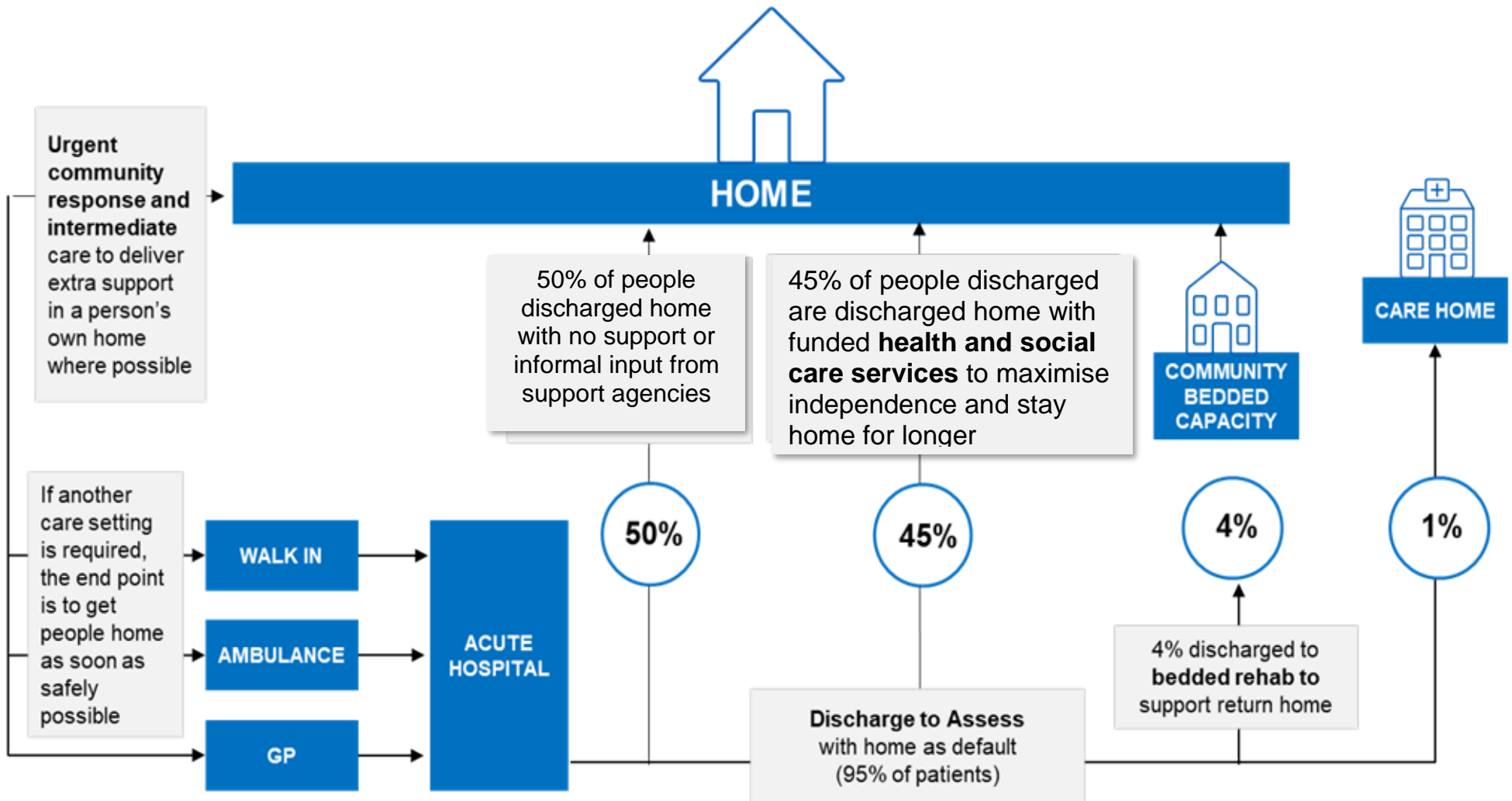
Discharge to assess governance

- 3.26 Health and social care systems based around an acute hospital should have an identified Executive Lead to provide strategic oversight of the discharge to assess process ensuring that there are no delays to discharge and that a home first approach is being used.
- 3.27 In addition, every system around an acute hospital should have a single coordinator, who has been appointed to act on behalf of the system to secure

safe, timely discharge on the appropriate pathway for the person concerned. They can be employed by any partner in the system. Their primary function will be the oversight of coordination of the discharge arrangements for all people from acute and community bedded units on pathways 1, 2 and 3; escalating any relevant issues to the executive lead. Please refer to the set of [hospital discharge staff action cards](#) for further details on the single coordinator role.

- 3.28 Every person who is discharged on pathways 1 - 3 must have an allocated case manager who will closely monitor and review progress to ensure the individual receives appropriate care without delay and that there is no delay in assessing and planning for any long-term support as soon as it is possible to form an accurate picture of likely need and options following a period of recovery after discharge. This role can be undertaken by a variety of professions and/or organisations. They will not carry out the assessments, but they will coordinate with the relevant professionals involved in the person's care who have decision-making responsibilities in respect of providing any appropriate care.
- 3.29 Discharge to assess pathways 1-3 require NHS organisations to work closely with adult social care and housing colleagues, the care sector and the voluntary sector. At system level a 'transfer of care hub' should be in place (physically or virtually) to ensure all relevant services can be linked in order to provide appropriate care and support. Based on the description of the person received by phone or by referral the transfer of care hub will consult with the person and their advocates to decide which pathway is most appropriate.
- 3.30 Transfer of care hubs will also ensure information essential to the continued delivery of care and support is communicated and transferred to the relevant health and care partners on discharge (including the outcome of the last COVID-19 test for that person, where relevant).
- 3.31 Transfer of care hubs should not become a process that delays the discharge of an individual and should ideally be fully, or partially, co-located with acute partners to ensure ease of communication and enhance multidisciplinary working. The transfer of care hub will also support ongoing regular communication between health and social care partners during the period of recovery after discharge to ensure a shared understanding of what assessments are required and when it is most appropriate to carry these out.
- 3.32 [Annex C](#) provides a summary of discharge to assess accountability and escalation mechanisms that should be in place in each system.

Figure 1: Discharge to assess process



4. What does this mean for people being discharged?

- 4.1 People should expect to receive high quality personalised care including regular updates – for them or for their representative or advocate if they lack capacity to decide - and sharing of information about the next steps in their care and treatment. This must include joint decision-making processes and clarity on plans for the person's post-discharge care.
- 4.2 Leaflet A, describing these arrangements, is provided in [Annex B](#) and this (or locally developed equivalent materials) must be shared with all people on admission to hospital as part of discussions to develop a clear care plan for supporting the person after their hospital stay.
- 4.3 Conversations to ascertain family members' availability and capacity to care should take place during the hospital stay, recognise an entitlement to a carers assessment, including identifying whether there are children in the household. Staff involved in the care of people should gather this information in advance of discharge and, where possible, at the time of admission.
- 4.4 Hospital staff must make clear that discharge will be organised as soon as clinically appropriate and people will not be able to stay in a bed after the point where this is clinically necessary. For 95% of people leaving hospital this will mean that (where it is needed), the assessment and organising of long-term care will take place when they are in their own home.
- 4.5 Health and social care staff must always involve the person in the planning of the care needed on discharge from hospital and involve family, carers and any other professionals involved in their care, where appropriate. Leaflets B1/B2 in [Annex B](#) should be used as part of these discussions. Leaflet B3 can be used to provide information and advice for family or friends who will be providing care to people on discharge.
- 4.6 On the day a person is to be discharged, they will be asked to move from the ward to a dedicated discharge area, from where their discharge transport will be able to pick them up.

- 4.7 Any ongoing care and support required, including medication supply, transport home, any volunteer and voluntary sector support and immediate practical measures, such as shopping and turning heating on, will have been organised and co-ordinated by the case manager. For simple discharges (pathway 0), where minimal further support is required, people should expect to be discharged from a discharge area in around two hours. More time may be required for people with more complex care situations that need co-ordinating, though much of the support can be pre-planned during the person's hospital stay through early discharge planning (see the [Local Government Association/ADASS high impact change model for managing transfers of care](#) for further detail).
- 4.8 A lead professional or multidisciplinary team, as is suitable for the level of care and support needs, will visit the person at home on the day of discharge or the day after to co-ordinate what support is needed in the home environment. If care support is needed on the day of discharge from hospital, this will have been arranged prior to the person leaving the hospital site by a case manager.
- 4.9 Any new or enhanced care package and support on discharge from hospital will be funded for a short period of time to allow for a period of recovery and rehabilitation. Further details on the national discharge fund for care and support packages can be found in section 6.
- 4.10 Anyone needing a long-term package of support in their own home or a care home will have an assessment and care planning undertaken following discharge from hospital and this will also include a financial assessment, if social care is needed which will be undertaken by the Local Authority.
- 4.11 For people whose needs are too great to return to their own home, short-term care and recovery / rehabilitation in a 24-hour bedded care facility will be arranged through the case manager. This also enables more effective personalised care and support planning, to better inform the person's future support requirements. Any assessment of care needs will happen, where appropriate, towards the end of the recovery/rehabilitation period in most cases, to determine what ongoing package of support will be needed.

5. What are the responsibilities of different organisations?

- 5.1 This section provides a summary of responsibilities for principal organisations involved in hospital discharge. A separate set of [hospital discharge staff action cards](#) has been developed to summarise responsibilities for key roles within the hospital discharge process.

System-wide priorities

- 5.2 The system as a whole should:

- Agree expected levels of performance for the following areas, including the establishment of performance management mechanisms to monitor and improve outcomes:
 - Daily discharge rates following the application of the ‘criteria to reside’;
 - Numbers and proportions of people being discharged on each discharge pathway;
 - Reductions in the average length of stay for people with hospital stay of 7, 14 and 21 days and over; and.
 - Improvements in the outcomes of recovery and rehabilitation services and associated reductions in the long-term care package costs for individuals
- Undertake an analysis of current demand and capacity plans, including for additional assessment and care planning time in dispersed locations and implement agreed plans to meet expected growth in the use of services throughout the next 12 months
- Use agreed, reliable and shared data to inform daily decision making, address issues and improve outcomes for people being discharged

- Agree an Executive Lead and a Single Coordinator for the system
- Establish and implement a joint vision and ambition for a home first approach; maximising the numbers who are discharged home.
- Implement mechanisms to monitor the effectiveness of local discharge and recovery/rehabilitation arrangements
- Identify joint commissioning responsibilities and leadership
- Establish how shared risk and resources will be managed in order to deliver improved outcomes for people being discharged from hospital

Acute health providers

5.3 Acute providers need to ensure their processes and ways of working have been fully adapted to deliver the discharge to assess model.

Ward level:

- Clinically led review **of all people** at morning board round. If the person does not need an acute bed, as per the criteria to reside prompt (see [Annex A](#)) but cannot be safely discharged, use an improvement approach to identify the gaps in services requiring development.
- **Twice daily review of all people** in acute beds to agree whose care needs can be provided in an alternative facility (including home), safely and with confidence.
- Ensure professional and clinical leadership between nursing, pharmacy, medicine and allied health professions for managing decisions and reducing delays in discharging people.

Hospital discharge teams:

- Arrange dedicated staff to support and facilitate hospital discharge. This will include:
 - Making arrangements to transport people home from hospital. This should be via family/carers, voluntary sector, or taxi and, only as a last resort, non-emergency patient transport services (NEPTS).

- Local voluntary sector and volunteering groups helping to ensure people are supported (where needed) actively for the first 48 hours after discharge,
- Ensuring people have full information about the next steps of their care
- Ensuring 'settle in' support is provided where needed.
- In conjunction with local care home providers, develop trusted assessment arrangements to facilitate the prompt return of their own residents after a hospital stay.

Hospital clinical and managerial leadership team:

- Create safe and comfortable discharge spaces for people to be transferred to from all ward areas.
- Maintain timely and high-quality transfer of information to Primary Care and all other relevant health and care professionals on all people discharged.
- Maintain provision for senior clinical staff to be available to support ward and discharge staff with appropriate risk-management and clinical advice arrangements.
- Engage with Integrated Care System (ICS) and regional colleagues to support clinical and medical leaders in implementing discharge to assess processes and culture
- Closely monitor hospital discharge performance data to ensure discharge arrangements are operating effectively and safely across the system, and a high proportion of people on the discharge list achieve a same-day discharge to the most suitable destination for their needs.
- Ensure that, as part of daily ward rounds, timely and accurate data is collected and submitted to the Acute Daily Discharge Situation Report, as described in Section 7. It is important this is a clinically driven data collection.
- Ensure a live list is available for all agencies to work from and include those suitable for discharge; the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way.

Community health service providers

5.4 Providers of community health services should work closely with other system partners to facilitate timely discharge of people, particularly for pathways 1, 2 and 3. As part of this they should:

- Have an easily accessible contact within the transfer of care hub who will always accept referrals from staff in the hospital and source the care requested, in conjunction with local authorities.
- Deliver enhanced occupational therapy and physiotherapy 7 days a week in a person's home; rehabilitation ward or care home in line with the persons care plan
- Monitor the effectiveness of reablement and rehabilitation, with Local Authority partners as appropriate.
- Use multi-disciplinary teams on the day a person goes home from hospital, to assess and arrange packages of support.
- Ensure provision of equipment to support discharge.
- Ensure people on pathways 1-3 are closely tracked and followed up regularly to ensure their care support is appropriate.
- Take part in assessing the long-term needs of an individual at the end of the period of recovery.
- Maintain a focus on supporting timely onward transition of care for people receiving care in community beds (rehab and short-term care) and support them with reablement and rehabilitation packages in home settings following their discharge from a 24-hour bedded unit.
- Collect and submit data on the delivery of services to the [Community Services Data Set \(CSDS\)](#).
- Use the Capacity Tracker tool for identifying the bed capacity in community rehabilitation bed providers.
- For people identified as being in the last days or weeks of their life, the transfer of care hub will be responsible for coordinating liaison with primary care, community services and community palliative care services to coordinate and facilitate rapid discharge to the persons home or a hospice.

- Community Palliative Care teams will continue to coordinate and facilitate prompt discharge to home or hospice. End of life care, including palliative care, must continue to be personalised and planned in a holistic way involving the person themselves and their families, social care, community nursing, general practice, occupational therapy, and others.

Adult social care services

5.5 As part of implementing the discharge to assess model, local authorities are asked to:

- Agree a single lead Local Authority or point of contact arrangement for each hospital site, ensuring each acute trust and single local coordinator for local discharge to assess pathways has a single point to approach when coordinating the discharge of all people, regardless of where that person lives.
- Work with partners to coordinate activity with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery.
- Care packages for those discharged (including commissioning of care home beds) should be jointly commissioned; and the Local Authority should be the lead commissioner unless otherwise agreed between the CCG and the Local Authority.
- As outlined in the Care Act, take the lead on local care market shaping, including contracting responsibilities (e.g. expanding the capacity in domiciliary care, and reablement services in the local area).
- Work with CQC and other regulators to ensure safeguarding and quality of care, advising NHS colleagues where action is needed to make provision safe or alternatives are needed.
- Engage Local Housing Authority services to provide housing support and advice for persons requiring housing assistance on discharge from hospital.

Specific responsibilities for Adult Social Care:

- Identify an Executive Lead for the leadership and delivery of the discharge to assess model.

- Make provision for Care Act assessments of need, financial assessments and longer-term care planning to take place following discharge, after a period of recovery and rehabilitation.
- Ensure expert social work staff can contribute to hospital based multidisciplinary discussions and decision making occurring before discharge.
- Ensure social care expertise is a central part of the process to determine the long-term care needs of and with people following a period of recovery and rehabilitation and that they are fully aware of their options and the implications of each choice
- Safeguarding activities should continue to take place in a hospital setting if necessary.
- Provide social care capacity to work alongside local community health services via the transfer of care hub.
- Support real time communication between the hospital and the single point of contact, not just by email.
- Provide capacity to review care provision and change if necessary, at an appropriate point in line with good practice and legal responsibilities.
- Organise any needed isolation capacity for people who do not meet the criteria to remain in hospital, in the event that they require to be discharged to a care home but are unable to be isolated - in line with [designated settings guidance](#).
- Where it appears to a Local Authority that a carer may have needs for support (whether currently or in the future), the authority must assess to identify needs to be considered.
- Work closely with community health providers and local resilience fora over the provision of equipment, such as PPE.
- Where possible, support 7-day working for community social care teams (commissioned by local authorities).
- Deploy adult social care staff flexibly to support best outcomes for people. This can include support to avoid any immediate bottlenecks in arranging step down care and support in the community, and at the same time focus on maintaining and building capacity in local systems.

- Work with system partners - CCGs, Trusts and ICSs/STPs - to ensure appropriate data collection and that its use supports the best outcomes for individuals.

Health care commissioners

5.6 CCGs supported by Integrated Care Systems (ICSs) need to support the coordination of activities set out in this framework. Specifically, they must:

- Work in partnership to plan and commission sufficient provision to meet the needs of the population based on home first discharge to assess principles.
- Work in partnership to coordinate local financial flows for post-discharge care and support, including monitoring all local spend and coordinating local funding arrangements.
- CCGs should follow processes under the D2A arrangements, detailed in sections 3.10 - 3.11, to identify when it is necessary to complete an NHS CHC checklist.
- Continue to build on recent learning and commissioning arrangements for community palliative care services optimising the best use of all available financial resources including those currently allotted to CHC Fast Track. Enabling community palliative care services to provide palliative and end of life care for those people transferring to, or already in, the community requiring care and support within their own home or a hospice.
- Continue to promote the use of the Capacity Tracker tool for care homes, hospices and community rehabilitation bed providers. They should ensure that the operational potential of domiciliary and residential capacity trackers is realised, by their use in health and care system wide discharge planning and that their effectiveness of reablement and rehabilitation is monitored
- Ensure that providers of relevant community services are submitting data to the Community Services Data Set (CSDS) on a monthly basis, as they are legally and contractually mandated to do.
- Work with system partners - CCGs, Trusts and ICSs/STPs - to ensure appropriate data collection and that its use supports the best outcomes for individuals.

Social care providers

5.7 As part of implementing the discharge to assess model, social care providers are asked to:

Residential and nursing homes:

- Please refer to separate specific guidance for care home providers on [admission and care of residents in a care home during COVID-19](#).
- Accept people only when they have been discharged with a COVID-19 test result and when it safe to do so. People being discharged to a care home (except those with a historical positive test within the previous 90 days) must be tested for COVID-19 within 48 hours prior to discharge. The result will determine transfer to either a designated setting (if positive and within 14 days of first positive test result) or care home (if negative) and will be communicated prior to discharge. For isolation requirements for care home residents returning from hospital please see guidance on [admission and care of residents in a care home during COVID-19](#). Further guidance on designated settings is available [here](#), alongside [stepdown infection control guidance](#)
- Maintain capacity and identify vacancies that can be used for hospital discharge purposes, utilising the Capacity Tracker tool to share information with partner organisations.
- Where Trusted Assessment relationships and arrangements are not in place with acute providers, rapidly work with the discharge team to implement these approaches.
- If providing reablement or rehabilitation, then monitor and share the effectiveness of that service.

Domiciliary care providers:

- Identify capacity to adult social care contract leads that can be used for hospital discharge purposes or follow on care from reablement services.
- Ensure sufficiency of PPE and COVID-19 testing, the ability to isolate and that assessment and care planning for the future are in place (for example, by ensuring all providers know who to contact to get help, and that robust workforce contingency plans ensure continuity of care).
- If providing reablement or rehabilitation, then monitor and share the effectiveness of that service.

6. Finance support and funding flows

- 6.1 [The government](#) has provided a national discharge fund via the NHS, for quarters 3 and 4 of 2021-22 (1 October 2021 to 31 March 2022), to help cover some of the cost of post-discharge recovery and support services / rehabilitation and reablement care following discharge from hospital. These financial arrangements apply to care delivered to people up to and including 31 March 2022. The scheme will end on 31 March 2022 and will not fund care delivered after this date – consequently no costs for care delivered in 2022-23 will be funded by this scheme.
- 6.2 Systems must ensure they provide adequate health and social care discharge services, operating seven days a week during quarters 3 and 4 of 2021-22, to ensure people receive the most appropriate care at home where possible. The national discharge fund can be used to fund discharge services covered by the hospital discharge programme seven days a week in quarters 3 and 4. Systems should seek also to improve discharge performance and support hospital elective recovery plans.
- 6.3 The government has agreed to fund, via the NHS, **up to four weeks** of care for new or additional needs of an individual on discharge from hospital, where care is delivered up to and including 31 March 2022. The needs of the individual will determine the availability and the period of funded support, which may be less than four weeks depending on when it is appropriate for post-discharge recovery and support services to cease because the person has recovered or long-term care has been put in place following relevant assessments.

System budgets

- 6.4 Each integrated care system (ICS) is allocated a system budget for quarters 3 and 4 of 2021-22. The budget will continue to be held centrally by NHS England and NHS Improvement, with clinical commissioning groups (CCGs) being reimbursed based on their actual spend.
- 6.5 The amount each system can spend is capped at the level of ICS budget allocations as shown in [Table 1](#).

- 6.6 Where a system uses its allocated discharge budget in full it will need to fund and maintain hospital discharge services from its core system budgets up to 31 March 2022. This is to ensure that there is no reduction in activity on discharge pathways, performance is maintained and delays in discharging people are minimised during all of these six months.
- 6.7 Budgets have been allocated to systems using a blended approach, which has regard to weighted population and reported national discharge fund expenditure.
- 6.8 Where extant patterns of legitimate expenditure indicate a risk against allocations, the national discharge team will work with local systems including local authority partners to understand the reasons for this, and support them to sustain the operational benefits of the scheme while appropriate controls are introduced.

Funding support

- 6.9 The national discharge fund is available to fund the additional costs of:
- Services that support the new or additional needs of an individual on discharge from hospital. This will include recovery and support services, such as rehabilitation and reablement to help people return to the quality of life they had prior to their most recent admission.
 - Designated care settings for those discharged from acute care who are COVID-positive and cannot return directly to their own care home until 14 days of isolation has been undertaken.
- 6.10 The additional funding available to support delivery of hospital discharge should only be used to fund activity arising from the programme that is over and above activity normally commissioned by CCGs and local authorities.
- 6.11 CCGs are expected to ensure that an appropriate rate is paid for care funded under the national discharge funding arrangements, working with their local authority commissioners. This agreed rate may need to reflect the actual cost of care, particularly where some care provider capacity being utilised would previously have been self-funded from the point of hospital discharge.
- 6.12 CCGs and local authorities should ensure they undertake joint planning at health and wellbeing board (HWB) level, in line with the wider funding allocation for the ICS footprint to ensure equitable distribution. This should include agreeing budgets at the HWB level where possible, as well as operational

planning. ICSs will need to manage their budgets for hospital discharge to support planning at this level. Should there be concerns about the ICS allocation of funding to a HWB level, including that the funding may be exceeded, decision making to address the situation should involve both health and social care partners.

- 6.13 It is expected that, in straightforward cases, an assessment for ongoing health and care needs takes place within four weeks of discharge and that a decision is made about how ongoing care will be funded by this point. CCGs will not be able to draw down on national discharge funding in respect of care provided after the four week period.
- 6.14 On the rare occasion that a decision on ongoing care requirements and funding route is not reached within this timeframe, the parties paying for the care should continue to do so until the relevant care assessments are complete. Whatever arrangements are agreed, costs from week five cannot be charged to the national hospital discharge budget and must be met from existing budgets.
- 6.15 Where an existing local arrangement is in place to agree who funds care while assessments are taking place, then the local authority and the CCG, if they both agree and it is affordable within existing envelopes, may choose to continue with this local funding arrangement beyond the national discharge-funded period.
- 6.16 In the absence of an existing locally agreed approach to funding care provided after the national discharge-funded period, it is suggested as a default that the following approach is adopted:

The costs are allocated according to what point in the assessment process has been reached by the end of the four weeks of care, as follows:

- Where the NHS continuing healthcare (CHC) or funded nursing care (FNC) assessments are delayed, the CCG remains responsible for paying until the NHS CHC/FNC assessment is done.
 - Where there is no NHS CHC or FNC assessment delay, responsibility for funding sits with the local authority in line with existing procedures until the Care Act assessment is completed, after which normal funding routes apply.
- 6.17 The funding arrangements described in this guidance apply to post-discharge care delivered from 1 October 2021 and replace previous hospital discharge funding arrangements introduced on 1 April 2021 as described in the Hospital

Discharge and Community Support: Policy and Operating Model dated 5 July 2021.

6.18 The national discharge funding will **not** pay for:

- Long-term care needs following completion of a Care Act and/or NHS CHC assessment.
- Social care or NHS CHC packages that are restarted following discharge from hospital at the same level as that already delivered prior to admission to hospital.
- Pre-existing (planned) local authority or CCG expenditure on discharge services.
- Admissions avoidance schemes, as separate NHS funding is available for these services in 2021-22⁵.

Finance and contracting arrangements

6.19 Procurement and contracting rules continue to apply. Local commissioners should agree the most appropriate route to deliver hospital discharge services in their area.

6.20 Additional national discharge funding may be pooled locally using existing statutory mechanisms. Under section 75 of the NHS Act 2006 and associated regulations, CCGs and local authorities can enter into partnership agreements that allow for local government to perform health related functions where this will likely lead to an improvement in the way these functions are discharged.

6.21 Where systems decide that an enhanced supply of out-of-hospital care and support services will be commissioned via the local authority, the existing section 75 agreements can be extended or amended to include these services and functions and the local authority should commission the health and social care activity on behalf of the system. Similarly, where a CCG is already acting as a lead commissioner for integrated health and care, partners can agree that existing section 75 arrangements can be varied to allow them to commission social care services.

⁵ Funding will be available in 2021-22 through Service Development Funding for transforming community services, [including for accelerating the rollout of the two-hour crisis community health response at home](#)

- 6.22 Where CCGs and local government agree, Better Care Fund (BCF) section 75 agreements can be extended or varied for this purpose. A model template was developed for the COVID-19 Discharge Service Requirements for areas to adapt locally to vary existing BCF Section 75 agreements and this document can be used as the basis for implementing these arrangements.
- 6.23 National discharge funding provided should be separately identified within the agreement and monitored to ensure funding flows correctly. It should be pooled alongside existing local authority and CCG planned expenditure on discharge support – the funding is intended to meet additional costs arising from the national discharge fund only. Support provided and agreed budgets from this funding should be recorded at individual level. CCGs should continue funding (through their existing budgets) existing intermediate care support services on discharge from hospital. Where the enhanced care services are most appropriately commissioned directly by NHS commissioners, these should be placed under existing contractual arrangements with providers but invoiced separately to ensure that national discharge funding is identifiable.
- 6.24 The additional funding available to support delivery of hospital discharge should only be used to fund activity that is over and above the activity normally commissioned by CCGs and local authorities. Expected contributions from CCGs and local authorities to the pooled budget should be agreed accordingly.

Reimbursement route

- 6.25 NHS England and NHS Improvement expect ordinary financial controls to be maintained with respect to invoicing, raising of purchase orders and authorising payments.
- 6.26 [Table 1](#) sets out hospital discharge maximum budgets available to each system.
- 6.27 It is expected that all systems carry out an upfront planning exercise to determine equitable indicative allocation of budgets to all CCGs in the system.
- 6.28 As part of oversight of the national discharge funding arrangements by NHS England and NHS Improvement, collections of data on indicative budgets at CCG level may be undertaken, in which case details will be communicated separately.
- 6.29 CCGs, local authorities and other system partners should maintain a record of their additional hospital discharge costs, and associated activity, so that CCGs

can submit a claim for reimbursement for this from NHS England and NHS Improvement from their hospital discharge system budgets.

- 6.30 NHS England and NHS Improvement will reimburse CCGs for their hospital discharge actual spend, capped at the level of the ICS budget allocations. If the total of requests for reimbursement from CCGs in a system reaches the system maximum budget shown in [Table 1](#) no further reimbursements will be available for the CCGs in that system.

Monitoring of hospital discharge expenditure and activity

- 6.31 Reimbursement of hospital discharge expenditure will be based on the non-Integrated Single Financial Environment (ISFE) submissions and up to the maximum budgets noted in [Table 1](#) below.
- 6.32 CCGs will be required to submit via non-ISFE monthly reporting templates cost and activity data for the following care settings or services:
- a) Pathway 1
 - b) Pathway 2
 - c) Pathway 3
 - d) Designated care settings
 - e) Hospice
 - f) Other care accommodation
 - g) Other (please specify).

Table 1: ICS budget allocations

ICS name	Amount (£'000)
Bath, Swindon and Wiltshire	11,393
Birmingham and Solihull	11,627
Bristol, North Somerset, South Gloucestershire	9,014
Buckinghamshire, Oxfordshire and Berkshire West	14,080
Cambridgeshire and Peterborough	7,853
Cheshire and Merseyside	26,045
Cornwall and the Isles of Scilly	6,271
Coventry and Warwickshire	5,663
Cumbria and North East STP	28,648
Derbyshire	8,456
Devon	14,224
Dorset	8,889
Frimley Health	4,966
Gloucestershire	5,023
Greater Manchester	28,780
Hampshire and the Isle of Wight	21,251
Herefordshire and Worcestershire	7,485
Hertfordshire and West Essex	13,878
Humber Coast and Vale	16,568
Kent & Medway	17,642
Lancashire and South Cumbria	13,541
Leicester, Leicestershire and Rutland	5,817
Lincolnshire	1,785
Mid and South Essex	11,151
Milton Keynes, Bedfordshire and Luton	8,067
Norfolk and Waveney	11,169
North Central London	11,461
North East London	17,938
North West London	16,080
Northamptonshire	2,826
Nottinghamshire	9,520
Shropshire and Telford and Wrekin	4,480
Somerset	5,558
South East London	16,872
South West London	12,937
South Yorkshire and Bassetlaw	9,748
Staffordshire	6,663
Suffolk and North East Essex	9,739
Surrey Heartlands	9,881
Sussex Health and Care Partnership	15,837
The Black Country	9,042
West Yorkshire	12,502
Total	490,369

Note: Where extant patterns of legitimate expenditure indicate a risk against these allocations, the national discharge team will work with local systems to understand the reasons for this, and support them to sustain the operational benefits of the scheme while appropriate controls are introduced.

7. Reporting and performance management

- 7.1 Since April 2020 NHS providers have been required to provide daily and weekly reporting on hospital discharges through the Strategic Data Collection Service (SDCS). These arrangements identify the numbers of people leaving hospital and where they are discharged to, and the reasons why people continue to remain in hospital.
- 7.2 This information is required to allow us to track the effectiveness of the policies described in this document. We are working on further refining situation reporting and will notify providers of new requirements as and when appropriate.
- 7.3 Local systems should ensure that data and intelligence about the sufficiency, suitability and sustainability of care and health services are shared, so as to maximise the effectiveness of services, outcomes for individuals and populations and the overall use of resources.
- 7.4 Health and social care partners should ensure governance arrangements are in place to allow all relevant organisations to access, review and, where required, verify, data gathered in relation to hospital discharge.

Data collection guidance

- 7.4 NHS England has published [technical specifications and FAQs relating to EPRR Acute Daily Discharge Situation Reports](#). These specifications will be regularly reviewed and updated as appropriate through the hyperlink provided above.

8. Additional resources and support

- 8.1 For queries relating to this guidance, please contact england.d2a@nhs.net
- 8.2 This document should be read alongside the 2015 [NICE guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs](#).
- 8.3 Discharge to assess also forms part of the [Local Government Association/ADASS high impact change model for managing transfers of care](#).
- 8.4 For further detail on discharge to assess, please see the [quick guide](#).
- 8.5 [Guidance to Local Authority commissioners](#) is available from the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Care Provider Alliance (CPA).
- 8.6 For further information on coronavirus and adult social care please see the [COVID-19 action plan for adult social care](#).
- 8.7 Newton Europe publications: [Why Not Home, Why Not Today?](#) and [People First: Manage What Matters](#).
- 8.8 [Community health and care discharge and crisis care model: an investment in reablement](#).
- 8.9 For more information on designated settings for care homes please refer to the [designated settings guidance](#)
- 8.10 The Local Government Association/ADASS (LGA) have produced two 'tops tips' guides: [Top tips guidance on implementing a home first approach to discharge from hospital](#) and [Top Tips guidance on implementing a collaborative commissioning approach to home first](#).

Annexes

Annex A: Criteria to Reside - Maintaining good decision making in acute settings

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made.

Requiring ITU or HDU care?
Requiring oxygen therapy/NIV?
Requiring intravenous fluids?
NEWS2 > 3? (clinical judgement required in persons with AF and/or chronic respiratory disease)
Diminished level of consciousness where recovery realistic?
Acute functional impairment in excess of home/community care provision?
Last hours of life?
Requiring intravenous medication > b.d. (including analgesia)?
Undergone lower limb surgery within 48hrs?
Undergone thorax-abdominal/pelvic surgery with 72 hrs?
Within 24hrs of an invasive procedure? (with attendant risk of acute life- threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review/challenge questions for the clinical team:

- Is the person medically optimised? - (Don't use 'medically fit' or 'back to baseline').
- What management can be continued as ambulatory - e.g. heart failure treatment?
- What management can be continued outside the hospital with community/district nurses? e.g. IV antibiotics?
- Persons with low NEWS (0-4) scores - can they be discharged with suitable follow up?
 - If not scoring 3 on any one parameter - e.g. pulse rate greater than 130
 - If their oxygen needs can be met at home
 - Stable and not needing frequent observations every 4 hours or less
 - Not needing any medical/nursing care after 8pm
 - People waiting for results - can they come back, or can they be phoned through?
 - Repeat bloods - can they be done after discharge in an alternative setting?
 - People waiting for investigations - can they go home and come back as outpatients with the same waiting as inpatients?

Criteria-led discharge:

- Can a nurse or allied health care professional discharge without a further review if criteria are well written out?
- Can a junior doctor discharge without a further review if criteria are clearly documented?
- How can we contact the consultant directly if criteria are only slightly out of range and require clarification?

Annex B: Discharge choice leaflets

Where there are ongoing health or social care needs after discharge with different care options available, individuals (with their family or advocates) should be empowered and supported to make the best choice for their individual circumstances. The leaflets hyperlinked below have been produced to support the communication of this message and are [available for download](#). They are available in 12 languages and in Easy Read.

- Leaflet A -to be shared and explained to all persons on admission to hospital
- Leaflets B - to be shared and explained to all persons prior to discharge:
 - Leaflet B1 -for persons who are being discharged home
 - Leaflet B2 - for persons moving or returning to further non-acute bedded care
 - Leaflet B3 - for family or friends who will be providing care to people on discharge

Annex C: Overview of decision making and escalation

Overview of Discharge Decision Making & Escalation to ensure hospital and community beds are freed up

Key Steps	Decision Points & Responsibilities	Route of Escalation
Morning Ward Round	<p>Medical decision to discharge - discharge pathway confirmed</p> <p>(Lead: Senior Doctor in ward)</p>	Executive Director in Acute
Waiting in discharge area in hospital	<p>Case manager agreed</p> <p>(Lead: Local coordinator in acute)</p>	Executive Director in Acute
	<p>Discharge activities agreed incl. transport and medication</p> <p>(Lead: Single coordinator in acute)</p>	
Patient leaves hospital or community bed	<p>Transport to home or bedded setting</p> <p>(Lead: Single coordinator in acute)</p>	Executive Director in Acute (for acute issues) and Director of Community Services (for community health issues)

Overview of Discharge Decision Making & Escalation to ensure assessment and support is provided



Key Steps	Decision Points & Responsibilities	Route of Escalation	
Assessment at home	<p>Trusted assessor visit for those on pathway 1 - acute or community health care professional</p> <p>(Lead: Single coordinator in acute)</p>	<p>Executive Director in Acute (for acute issues) and Executive Director of Community Services (for community health issues) and Director of Adult Social Services (for social care issues)</p>	<p>Gold Command EPRR Team</p>
Care provided as needed	<p>At home support provided as needed by health and/or social care</p> <p>(Lead: Single coordinator in acute)</p>	<p>Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)</p>	<p>Gold Command EPRR Team</p>
Review post short team support	<p>Ongoing short-term support as needed by health and/or social care or discharge from all support</p> <p>(Lead: Single coordinator in acute)</p>	<p>Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)</p>	<p>Gold Command EPRR Team</p>



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