NHS Confederation NHS Providers
Community NETWORK

Discharge to assess: the case for permanent funding

Introduction

This briefing sets out the case for permanent funding to support the 'discharge to assess' model based on cost effectiveness for the taxpayer and improved outcomes.

There has been a welcome shift in recent years, and under the NHS Long Term Plan (LTP), towards a 'home first' approach in healthcare, with evidence of better outcomes and efficacy across the health and care system. This is reflected in proposals for the forthcoming Health and Care Bill, which seek to align the administrative requirements between acute hospitals and community and social care providers behind the discharge to assess approach for the longer term, with widespread support from across the sector.

The dedicated, additional funding to support the discharge to assess model during the COVID-19 pandemic delivered value swiftly as 30,000 acute beds were freed up in spring 2020 to support flow through the system. Providers are also clear that there is a strong case for embedding the discharge to assess model to benefit patients and their carers. They all agree that the government needs to make discharge to assess funding permanent if these positive and cost-effective improvements for patients and system capacity are to be retained.

Key points

- **Both acute and community providers are clear that withdrawing funding for the discharge to assess model will lead to a damaging 'cliff edge', increased length of stay, delayed discharges and avoidable readmissions.** All of these factors have a negative impact on patients and the public purse, and will be particularly detrimental to service delivery as we seek to recover and restore services following the pandemic.
- **Central, dedicated funding for the discharge to assess model improved patient care and proved cost effective by contributing significantly to a reduction in average length of stay during winter 2021/22 and facilitating patient flow from acute to community settings.** The National Audit Office showed that 30,000 acute beds were freed up in preparation for the COVID-19 pandemic, and data from NHS England and NHS Improvement (NHSEI) shows a 28% reduction in patients staying over 21 days in hospital between winter 2020/21 and winter 2021/22.
- **Discharge to assess funding helped providers to reduce avoidable admissions during the pandemic and reduced bed days improving quality and benefitting the public purse.** Emergency readmissions to hospital are distressing for patients and their families, often coming at a point of crisis. They are also costly to the public purse at an estimated annual cost of £1.6bn. Analysis by the charity Age UK shows that that the average excess bed day (the cost of a patient remaining in a hospital bed after their treatment has ended) costs £346. As the discharge to assess model reduces delayed discharges and therefore excess bed days, it is a proven, cost effective policy.
- **A permanently funded discharge to assess model will help acute trusts and community providers to manage the existing backlog of care through improved patient flow**. Maximising capacity will also help trusts tackle persistent winter pressures beyond the pandemic. Conversely, removing the funding puts this progress, and key national priorities at risk, particularly the commitment to clear the elective waiting list of 4.7 million people.

- **The discharge to assess model aligns with the broader strategic direction of travel for the health and care system** to deliver more care within and closer to home for the benefit of both patients and the wider health and care system.

Background

At the beginning of the COVID-19 pandemic, NHS England and NHS Improvement instructed trusts toinitiate COVID-19 preparations, including discharging all medically fit patients out of acute and community hospital beds. For community providers this meant designing and implementing a discharge to assess service within days, reprioritising services and redeploying staff to priority areas. As part of this effort, the new hospital discharge guidance (19 March 2020) suspended the bureaucratic and financial negotiations around NHS Continuing Healthcare (CHC) assessments and Care Act responsibilities for local government, which providers report had contributed to a large portion of delayed discharges previously.

The discharge to assess policy was developed on the principle, and clinical evidence, that most patients can go back to their own home, or into community-based provision, safely after a stay in hospital. The discharge requirements are adapted from Professor John Bolton's research, and state that 95% of patients can be discharged home with minimal support or some support from community/domiciliary care.

As the country moved into the second phase of the pandemic, NHSEI updated the hospital discharge guidance (21 August 2020), which instructed the health and care system to continue implementing the 'home first' discharge to assess model. However, the updated guidance confirmedthat NHS CHC assessments would resume in community settings from 1 September 2020 and introduced a different funding model, which provided up to six weeks of centrally funded care for new or additional needs on discharge from hospital. This central funding of £588m could also be used for rapid response services to prevent avoidable admissions.

The discharge to assess approach has been included in planning guidance for 2021/22, and £594m of funding for implementation has been announced for the first half of the financial year. This will fund up to six weeks of additional care post-discharge in Q1 and then up to four weeks in Q2 before being reviewed for the second half of the year. Acute and community health providers welcomed the continuation of the discharge to assess policy and the emphasis on reducing length of stay. They continue to advocate for permanent funding in support of this successful operating model. Creating a cliff edge at the mid-point in the year can only disrupt the service at a critical moment during its recovery.

The move to continue this funding for the first six months of 2021/22 also reflects the direction of travel in the government's recent white paper Integration and Innovation: working together to improve health and social care for all (February 2021), which sets out important proposals to remove the legislative barriers to discharge to assess policy so that patients can be assessed after they have been discharged from acute care (rather than in a hospital bed as current legislation states). This legislation will also remove the system of discharge notices and financial penalties, which increased friction and bureaucracy between NHS organisations and local authorities. As we understand it, there is widespread support from health and social care providers for this approach.

The case for making central, dedicated funding for the discharge to assess model permanent

Successive national policy initiatives have previously failed to solve the issue of delayed discharges from acute settings. A significant number of older inpatients who are medically fit for discharge often remain in hospital wards for an extended period due to the challenges of securing suitable care in the community. In recent years, various initiatives have been introduced to address this (for instance, the Better Care Fund in 2017 and the Reducing Length of Stay Programme in 2018), with some impact.

Alongside the imperative created by the pandemic, the critical difference for the discharge to assess model compared to previous initiatives has been dedicated national funding. It enabled community and acute providers to free up hospital beds for those who really needed them, manage capacity in the system and prevent delayed discharges. The six-week funding model, which paid for new packages of care to support people in their homes while their eligibility for ongoing support was assessed, has worked well on the ground, as is evident from the testimonials from provider chief executives and Integrated Care System leads. They also emphasise how the discharge to assess policy is much more cost effective than the patient waiting in an expensive hospital bed for the CHC assessment to take place, which can often be delayed due to pressures on both the NHS and social care teams involved in making those assessments. It has also reduced the delays caused by bureaucratic processes and funding negotiations between acute care, community health and social care teams prior to discharge.

The availability of central funding has brought about the following five key benefits.

1. Reduced length of stay in hospital

Before the COVID-19 pandemic, the health and care system faced significant challenges. Hospital admissions were rising, and delayed discharges were a barrier to patient flow, meaning there was insufficient acute capacity to safely meet demand. The impact of these problems was that the NHS was forced to suspend or cancel much of its elective care capacity to accommodate emergency patients during the winters of 2018/19 and 2019/20.

Both acute and community providers report that, during the COVID-19 pandemic, the implementation of national policy and central funding for discharge to assess helped local health and care services to rapidly increase the number of medically fit people being discharged in a timely way. This reduced delays and, critically, length of stays in hospital. Data from NHSEI shows that there was a 28% reduction in patients staying over 21 days in hospital between winter 2020/21 and winter 2021/22, alongside a 23% reduction in patients staying over 14 days and a 17% reduction in patients staying over seven days. Trust leaders note that, between these two winter periods, the key operational difference was the enhanced capacity and central funding provided by the discharge to assess model. Unnecessarily long stays in acute settings have a negative effect on both patients and public finances. Indeed, analysis by the charity Age UK (based on 2017/18 reference costs) shows that the average excess bed day costs £346.[1]

For example, Sussex Community NHS Foundation Trust reported that the average length of stay fell by 37% during the COVID-19 response, and this was directly attributable to the implementation of discharge to assess policies.[i] For providers, maintaining this type of reduction in average length of

[1] The latest data is from 2017/18 because the NHS is making a change to the way that comparative cost data is collected (moving from reference costs, as outlined here, to Patient Level Information Costing)

stay is essential not just for the COVID-19 response, but for the future sustainability of services, especially though winter and as they manage increased demand across all parts of the health and care system.

In another part of the country, Midlands Partnership NHS Foundation Trust implemented the discharge to assess process and reduced the average wait for pathway 1 (returning home with a short or longer term support care package) from 17 weeks to less than half a day. It has also led to increased effectiveness, with 83% of patients being discharged with no immediate support thanks to increased therapeutic interventions across pathways (up from 52% pre-Covid). It has also reduced average length of stay from 26 to 19 days.[2] Much of this improvement was facilitated by the removal of bureaucratic and funding negotiations during the pandemic.

Providers tell us that if funding for discharge to assess ceases after September 2021, there is a real possibility that the gains in reducing length of stay will be reversed to a pre-Covid level, which would reduce their capacity for elective procedures during the Covid recovery efforts in 2021/22 and in challenging winter months in future years.

As the examples in Sussex and the Midlands highlight, the discharge to assess model can free up acute bed capacity very quickly. Other options for creating additional acute capacity, such as building new facilities, can be time consuming and resource intensive. They not only require substantial capital costs but also new staff. Providers tell us that discharge to assess delivers additional capacity, which is fully staffed, at pace and without any additional capital costs.

2. Improved outcomes

We know that prolonged hospital stays (where not medically necessary) create poorer outcomes for patients, especially those who are elderly or frail. Long hospital stays and delays to discharges increase the risks of a patient becoming ill with a hospital-acquired infection (including COVID-19), losing independence or suffering from mental health issues or muscular deconditioning, which has a hugely negative impact on individual lives and increases demand on the social care system and unpaid carers. In turn, this creates a significant additional cost to public finances; the National Audit Office (2016) reported that the gross annual cost to the NHS of treating older patients in hospital who no longer need to receive acute clinical care is in the region of £820m.

In light of this, discharge to assess is viewed by NHS leaders as one of the key tools that can be used to reduce the length of stay in hospital, and ensure medically fit patients are discharged to receive ongoing care at home or in the community, which ultimately, benefits patients, families and wider public finances.

3. Reduced avoidable admissions to acute settings

Historic underinvestment in community and social care services plays a crucial role in increased emergency readmissions, which are similarly costly for the health and care system (an estimated annual cost of £1.6bn) and distressing for patients and unpaid carers.

Increased joined up working between acute, community and primary care colleagues during the pandemic contributed to a reduction in avoidable admissions. This was facilitated by the availability

[2] Details from a presentation by Midlands Partnership NHS Foundation Trust at NHS England and NHS Improvement's COVID-19 webinar for community health services, 18 September 2020

of discharge to assess funding, which could be used flexibly depending on where additional resources were required in local health and care systems, including rapid response services to prevent avoidable admissions. After patients are discharged from hospital, they can need complex rehabilitation care which necessitates a real focus on supportive discharge and integrated care planning. The discharge to assess model goes hand in hand with admission avoidance, ensuring people have access to six weeks of funded care post discharge.

At Anglian Community Enterprise (ACE), which is a Community Interest Company, the team developed a system-wide tracker and Situation Report (SitRep) of discharge capacity across health and social care settings at the start of the COVID-19 pandemic. The development of this tracker and the collaborative working has allowed ACE to provide early community sector input into discharge processes and support admission avoidance.[3]

Similarly, at the West Midlands Ambulance Service University NHS Foundation Trust (WMAS), the team used a quality improvement methodology to implement a model of working to divert patients over 70 years old, who would be clinically extremely vulnerable to COVID-19, from acute settings. Through an integrated, whole system approach, and the intervention of community services, the WMAS team managed to divert 92% of cases from conveyance to A&E.[ii]

4. Increased the number of timely discharges and supported patient flow

Delayed transfers of care were a significant issue for the health and care system prior to the discharge to assess model and associated funding. Many acute trusts were running hospitals at above 90% capacity prior to COVID-19, but with discharge to assess in place, some report bringing this down to 50-60% during the pandemic. For instance, Great Western Hospitals NHS Foundation Trust reported bringing bed occupancy down to 50% during the peak of the first wave of the pandemic along with a sustained reduction in the number of medically fit patients waiting for discharge and over 21-day stranded patients.[iii]

Additionally, the National Audit Office reports that at the start of the pandemic, around 30,000 acute beds were freed up in preparation for the anticipated surge in COVID-19 patients, and providers tell us that the discharge to assess policy played a crucial role. This demonstrates that when fully funded and supported to do so, community services can support the health and care system by supporting the timely flow of patients from acute to community settings, which can provide enormous benefits to services in their normal operations and more challenged periods such as winter.

Indeed, Surrey Downs Integrated Care is comprised of six partners including the county council, GP federations, community care provider, and acute trust. It has been operating a home first model since 2016, which supports patients over 65 at home as an alternative to hospital admission, and has seen a 6% reduction in acute admissions over three years, reiterating that the benefits can be sustainable and important beyond crisis response. With central funding in 2020, Surrey Downs Integrated Care managed to reduce community hospital capacity by 50% in preparation for the surge of COVID-19 cases.[4]

---

[3] Details from a presentation by Anglian Community Enterprise at NHS England and NHS Improvement's COVID-19 webinar for community health services, 18 November 2020

[4] Details from Annex 3, Community Network report on impact of COVID-19 on community health services, August 2020

As providers focus on the restoration and recovery of services, discharge to assess will continue to play an essential role in freeing up hospital capacity to manage the care backlog. With NHS waiting lists for care increasing to 4.7 million over the pandemic, and almost 400,000 people waiting over 52 weeks for surgery, being able to successfully manage the flow of patients through the system will be essential. The discharge to assess policy must be fully funded so that more complex medical care can be undertaken outside of hospitals to maximise acute capacity in hospitals.

5. Support for wider NHS ambitions

The discharge to assess policy and underpinning funding support the strategic ambitions of collaboration, system working and delivering more care in the community and help shore up a more sustainable health and care system. Fundamentally, the discharge to assess model promotes a home first approach, with rehabilitation and reablement teams supporting patients post-discharge in their own homes, reflecting the long-term plan ambitions to move more care within and closer to home for the benefit of patients and the wider health and care system.

Leaders across the NHS, local government and voluntary organisations want to be able to embed these changes permanently and see additional funding arrangements for hospital discharge made recurrent, so they can continue to provide these new services going forward. This cross-sector support for the discharge to assess model was demonstrated in a joint letter signed by Healthwatch England, the British Red Cross, Carers UK, Age UK, NHS Confederation, NHS Providers and the Local Government Association in April 2021.[iv] With a record number of people waiting for elective care, providers tell us that discharge to assess will play an essential role in addressing this backlog over the coming years.

In addition, acute and community providers welcomed the direction of travel outlined in the NHS white paper, which set out proposals to remove the legislative barriers to discharge to assess. Making funding for discharge to assess available on a permanent basis will complement these wider agreed goals, complement the forthcoming Health and Care Bill and support providers to achieve the ambitions laid out for them in national policy and guidance.

Conclusion

Ceasing central funding for the discharge to assess model risks undoing the positive improvements seen during the COVID-19 response by creating a funding cliff edge and forcing health and care systems to end the extra capacity created with this dedicated funding. Community and acute trusts are particularly concerned that this will reverse the reduction made in length of stay, which will create an additional barrier to addressing the backlog of care as the health service recovers from the pandemic.

The discharge to assess approach supports a financially sustainable system and provides benefits for patients. It is crucial that progress made during COVID-19 is maintained and developed through making this a mainstream approach with recurrent funding.

Quotes from provider leaders in support of permanent discharge to assess funding

Quote from Daniel Elkeles, Chief Executive, Epsom and St Helier University Hospitals NHS Trust

From my role as both a hospital Chief Executive providing acute care to two London Boroughs and a County Council, as well as a provider of community health services for 500,000 people, I am absolutely sure that discharge to assess has made both a big improvement in patient care and will also lead to significant financial benefits for the taxpayer over time. In my view we can already see this in the hospital and I think we will be able to see it in social care over the next year or two.

The benefits to the patient are clear in relation to assessments taking place in familiar surroundings, and they are much more likely to lead to outcomes that are appropriately based on an individual's needs and likely to reduce the over provision of care. I think that there are so many different variables that impacted on placements into nursing and residential care during COVID-19 that it is hard to quantify the impact on reducing cost for social care so far.

However, it is much easier to see the impact on the hospital bed base because the consequence of discharge to assess processes is that assessment processes are streamlined and shortened and time spent in acute settings when there is no added value to someone being there is reduced. In all the work we have done over several years to look after more people at home we are crudely saving the best part of £100 per bed night looking after someone at home compared to looking after them in the hospital (assuming a hospital bed night cost of £350 and a community / home bed night cost of £250). Over the last three years at Epsom and St Helier we have closed four medical wards by investing in community services generating an overall financial saving to the system of c.£500,000 per ward closure and also freeing up bed capacity to do more elective care because we now rarely have medical patients in surgical beds.

Quote from Richard Kirby, Chief Executive, Birmingham Community NHS Foundation Trust

During the COVID-19 pandemic, introducing and funding discharge to assess pathways has made a significant impact for patients. In the Birmingham and Solihull system, for example, the numbers of medically fit for discharge patients in acute hospital beds has reduced from c. 650 in early 2020to a sustainable 250-275 at any given point. At the same time the system has gone from one of the worst performing system on the delayed transfer of care measure to better than the England average.

Lots of what has been delivered has been the result of operational changes, of multi-agency teams working together and of improved information systems and co-ordination hubs.

The commitment to a clear offer of 6 weeks NHS-funded post-discharge care, has also been an important part of this. This is because it has enabled systems to invest in the additional capacity needed to support the discharge to assess model. It is also because it has removed the need for decision-making about responsibility for funding care at the point of discharge from the acute hospital bed simplifying the complexities of the relationship between free-at-the-point-of-use NHS care and means-tested social care.

Quote from Dame Jackie Daniel, Chief Executive, Newcastle-upon-Tyne Hospitals NHS Foundation Trust

The Discharge to assess scheme has supported the timely discharge of 3,840 patients from our hospitals at a time of significant pressure – relieving bed pressures and freeing up scarce staff time to focus on the patients who clinically need to be here. As we plan to maximise recovery and reduce waiting list backlogs caused by the pandemic, the continuation of discharge to assess will help us to maintain increased elective volumes through winter. Should the scheme end we estimate that increased lengths of stay caused by the return of delayed discharges waiting for care assessment will result in £2.3m of costs a year.

Quote from Sir Jim Mackey, Chief Executive, Northumbria Healthcare NHS FT

The discharge to assess model is an excellent example of patient centred care, with acute and community teams working closely together, and it supports the integrated approach that health care systems locally, and across the country, are currently working together to achieve.

Following our trust's principle of 'home first', there are significant patient benefits of this model as patients don't need to stay in hospital any longer that they need to, encouraging independent living and enabling the early identification of any complex needs patients may have. All of which results in speedier patient recovery and reduced dependence on the NHS.

The model frees up precious time for ward staff who historically may have had to visit a patient at home and it also, crucially, frees up beds and improves patient flow. This has a significant impact on the quality of patient care and patient experience, especially during times of increased pressure on health systems. Having to fund the additional beds that would be required without the discharge to assess model would run into tens of millions of pounds and remove an element of integrated working which is having such a positive effect on all involved.

Quote from Rob Webster, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust and Lead Chief Executive, West Yorkshire and Harrogate Integrated Care System

As a result of the discharge to assess model:

- The one pathway approach supported the implementation of a single referral process/form which has brought systems together to focus on the needs of the individual and in many systems led to the development of discharge hubs.
- Designated (Covid+) care home bed capacity to ensure compliance with national isolation guidance minimising the risk of outbreaks in care homes.
- Workforce has been increased and reconfigured into the community, e.g. therapist/social workers to support community based assessment supporting system flow whilst moving care closer to home.

Quote from Tracy Taylor, Chief Executive, Nottingham University Hospitals NHS Trust

The discharge to assess model is significantly better for patient outcomes. If a patient is assessed for long-term care and support requirements in an acute or bed-based setting then it is likely that their long-term reliance on care will be at an increased level of input. This is because they are being assessed in an unfamiliar environment and too early in their recovery journey. A period of time back in their own home and familiar surroundings allows time for rehabilitation and recuperation and means that there is a more accurate assessment of their ongoing capabilities and support requirements. This often leads to a reduced reliance on care and an increase in independence.

Quote from Siobhan Melia, Chief Executive, Sussex Community NHS Foundation Trust

The discharge to assess model has been rapidly expanded over the past year with funding from the Hospital Discharge Programme (HDP). Sussex Community Foundation Trust was originally commissioned for 107 discharge pathways per week in 2019/20, and demand is now 241 per week. For H1 this is funded through HDP, but for H2, this level of demand represents a funding gap in H2 of £2.8m

Additional care hours funded by the HDP has without doubt had a hugely positive impact. Sussex Community Foundation Trust has c.320 community beds and average length of stay has reduced from 25 to 19 days over the past year due to more rapid and available domiciliary packages of care. Clarity around funding arrangements has meant that delays associated with confusion about who will fund care have been totally mitigated or removed. In all, this has created improved flow and capacity, with the trust treating 17% more patients per week since 22 March 2020 compared to the 11 months prior to that.

However, we are already experiencing care providers withdrawing because of the uncertainty over funding, and the Adult Social Care placements team are also experiencing major issues with staffing, which is also related to this insecurity. This means the hospital discharge teams are at risk. Further uncertainty, or a funding cliff edge would have a significant and negative impact on flow.

Quote from Andrew Burnell, Chief Executive, City Health Care Partnership (Community Interest Company)

The national funding for discharge to assess has significantly helped the local health and care system to deliver care closer to home or at home; an ambition that the NHS Five Year Forward Viewand the NHS Long Term plan heavily featured but struggled to deliver due to funding constraints.

Locally, the discharge to assess model, supported by the additional funding, has enabled c.50% per day not spending time in a hospital bed awaiting discharge. The additional funding has allowed community services to ensure essential community rehabilitation and recovery support is available for people at home seven days a week and more importantly on the same day of discharge orwithin 24hrs.

We have supported voluntary sector organisations to enhance their input and contributions to the local community in support frail elderly patients at home. We have invested in clinical qualified workforce but also non-qualified care staff and supported local home care services with the additional funding to enhance support for patients at home.

The demand on community services has increased by up to 30% compared to pre-COVID-19 baseline as a result of discharge to assess. Not receiving sustainable funding will result in further system pressures and will see hospital length of stay increasing and will significantly impact on system recovery. Removing the need for means testing for social care support for up to six weeks post discharge (we are aware of review to bring forward to four weeks) has helped systems to achieve ourbiggest goal ever to bring health and social care services together to deliver integrated care and this has been by far the greatest benefit.

---

[i] Annex 1, Presentation from Sussex Community Foundation Trust on Urgent Community Response Service, August 2020

[ii] Annex 2, West Midlands Ambulance Service University NHS Foundation Trust report, September 2020

[iii] Annex 3, Community Network report on impact of COVID-19 on community health services, August 2020

[iv] Annex 4, Healthwatch letter to the Chancellor in April 2021 on the extension of hospital discharge funding