Classification: Official

Publications approval reference: C1281

Hospital discharge and community support:

Finance support and funding flows

May 2021

This guidance is correct at the time of publishing. However, as it is subject to updates, please use the hyperlinks to confirm the information you are disseminating to the public is accurate.

Contents

1. Introduction

1.1. The government has provided a national discharge fund via the NHS, for quarters 1 and 2 of 2021/22 (1 April 2021 to 30 September 2021), 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 for patients discharged or using discharge services during that time period.

1.2 Systems must ensure they provide adequate health and social care discharge services, operating seven days a week during quarters 1 and 2 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 1 and 2. Systems should seek also to improve discharge performance and support hospital elective recovery plans.

1.3 The government has agreed to fund, via the NHS, new or extended packages of care on discharge from hospital starting on or before 30 September 2021 as set out in paragraph 3.1.

Duration of national discharge funded care

1.4 People discharged between 1 April 2021 and 30 June 2021 (inclusive) will have **up to six weeks** of funded care.

1.5 People discharged between 1 July and 30 September 2021 (inclusive) will have **up to four weeks** of funded care.

2. System budgets

2.1 From 1 April 2021 each integrated care system (ICS) is allocated a system budget. 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.

2.2 The amount each system can spend is capped at the level of ICS budget allocations as shown in Table 1.

2.3 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 30 September 2021. 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.

2.4 Budgets have been allocated to systems using a blended approach, which has regard to weighted population and actual spend on national discharge support Scheme 2 in 2020/21(from September 2020 to March 2021).

2.5 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.

3. Funding support

3.1 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.

3.2 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.

3.3 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.

3.4 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.

3.5 It is expected that, in straightforward cases, an assessment for ongoing health and care needs takes place within the six (or 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 six (or four) week period.

3.6 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 seven (or five for packages starting from 1 July) cannot be charged to the national hospital discharge budget and must be met from existing budgets.

3.7 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.

3.8 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 six (or four from 1 July 2021) 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.

3.9 The funding arrangements described in this guidance apply to care packages starting from 1 April 2021 and replace previous hospital discharge Scheme 2 funding arrangements introduced on 1 September 2020 as described in the Hospital Discharge Service: Policy and Operating Model dated 21 August 2020.

3.10 Where care packages started before 1 April 2021 and continue to be funded in 2021/22 under hospital discharge Scheme 2 arrangements, any costs arising in 2021/22 will need to be funded from the hospital discharge system budgets indicated in Table 1.

3.11 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 2021/22.[1]

[1] 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

4. Finance and contracting arrangements

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

4.2 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.

4.3 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.

4.4 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.

4.5 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.

4.6 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.

5. Reimbursement route

5.1 NHS England and NHS Improvement expect ordinary financial controls to be maintained with respect to invoicing, raising of purchase orders and authorising payments.

5.2 Table 1 sets out hospital discharge maximum budgets available to each system.

5.3 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.

5.4 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.

5.5 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.

5.6 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.

6. Monitoring of hospital discharge expenditure and activity

6.1 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.

6.2 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)
Northamptonshire	1,012
Birmingham and Solihull	4,487
South Yorkshire and Bassetlaw	5,800
Lincolnshire	3,446
West Yorkshire	11,827
Leicester, Leicestershire and Rutland	4,762
North West London	10,607
Gloucestershire	4,018
North Central London	10,144
Milton Keynes, Bedfordshire and Luton	6,454
Cumbria and North East STP	24,208
Staffordshire	8,592
Derbyshire	7,840
Lancashire and South Cumbria	14,462
Nottinghamshire	8,137
The Black Country	11,653
South East London	15,210
Coventry and Warwickshire	7,680
Frimley Health	5,629
Greater Manchester	26,450
Cheshire and Merseyside	27,103
Somerset	5,764
Cambridgeshire and Peterborough	8,159
Buckinghamshire, Oxfordshire and Berkshire West	15,581
Suffolk and North East Essex	10,382
Mid and South Essex	11,910
North East London	20,491
Norfolk and Waveney	11,019
Cornwall and the Isles of Scilly	6,366
Hertfordshire and West Essex	14,828
Shropshire and Telford and Wrekin	5,117
Surrey Heartlands	10,151
Kent & Medway	18,843
South West London	14,777
Devon	12,851
Bath, Swindon and Wiltshire	9,063
Humber Coast and Vale	17,635
Dorset	8,429
Herefordshire and Worcestershire	7,966
Sussex and East Surrey	18,091
Bristol, North Somerset, South Gloucestershire	9,623
Hampshire and the Isle of Wight	18,617
Total	**475,186**

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.