



Guidance on additional 2020/21 winter funding for post-discharge support for mental health patients

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1. Introduction – scope of the funding

- 1.1 **An additional £50 million is being allocated in 2020/21 to support mental health patients this winter. This is to be used to improve their journey through inpatient services and to ensure that patients who are ready to leave inpatient facilities have the community support they need to do so.**
- 1.2 This is new, ringfenced investment for mental health services in recognition of their vital role in responding to the pandemic and supporting some of the most acutely unwell and vulnerable patients. It is intended to reduce high bed occupancy levels, which are resulting in long waits in A&E and out of area placements – all of which adversely impact on patient safety and experience.
- 1.3 It is estimated that on any given day at least ~10–20%¹ of all mental health beds are occupied by people who are ready to leave hospital but do not have an agreed discharge package of support to do so. This equates to approximately 1–2 million bed days each year.
- 1.4 Some people remain in beds for excessive periods where clinicians feel they are ‘clinically well enough’ but do not yet feel comfortable to discharge to their previous level of community care. Some longer stays can result in people’s condition deteriorating resulting in the need for more costly long-term care. Crucially, this means people who urgently need admission to beds are sometimes unable to access them.
- 1.5 The funding is intended to **‘bridge the gap’ between inpatient care and community support to facilitate more timely and effective discharges** by providing enhanced support for people as they continue their recovery in the community.
- 1.6 While the pandemic clearly brought many challenges to mental health services, one benefit that was commonly referenced by providers in wave 1, was that they had the ability to commence post-discharge care as soon as people would benefit, without having wait for funding panels to agree packages, or resolve disputes over responsibilities. **This funding is intended to give mental health services the operational freedom to put in place**

¹ Figures based on recent engagement with a sample of mental health trusts. The percentage will vary between different wards. The RCPsych Commission on adult acute care estimated that on average 16% of people are clinical well enough to be discharged and this was as high as 38% in some wards.

packages as soon as patients are ready to continue their recovery outside hospital.

- 1.7 **We also know from wave 1, that people must be discharged with sufficiently robust support, given they may not have their usual support networks under COVID-19 restrictions** and mental health needs appear to be more complex as a result of the pandemic. For this reason the additional funding should in part be directed to local voluntary and community sector (VCS) services, which have been providing invaluable mental health support to many during the pandemic.
- 1.8 The funding is also intended to **encourage all mental health trusts to begin/continue to embed as routine some of the principles of the ‘discharge to assess’ or ‘home first’ ethos.** This is being implemented in acute and community health trusts but can be adapted for mental health care pathways.
- 1.9 Finally, **all systems are encouraged to use this funding to participate in multi-agency discharge events, where possible by the third week of December** (ahead of the peak winter pressure period) or as soon as possible thereafter.

2. What are the funding’s objectives?

- **Patient safety, support and suicide prevention:** People in contact with mental health services are at highest risk of suicide in the immediate days and months following discharge² (200-fold increased risk in the three months post discharge). While the number of suicides does not appear to have risen during the pandemic, its impact on people’s mental health remains a concern. Reports of increasing complexity of mental health need, compounded by people losing their usual support networks under COVID-19 restrictions, indicate a need for more robust post-discharge support – which has consistently been identified as a priority for suicide prevention. Improving flow through inpatient wards will also ensure that beds are available for timely admission of acutely unwell patients who may be at risk of suicide/harm.

² National Confidential Inquiry into Suicide and Safety in Mental Health, The University of Manchester - <https://sites.manchester.ac.uk/ncish/>

- **Improved access to mental health beds:** bed occupancy in mental health services is 93%³, well above recognised safe levels. In reality most systems are operating at or above 100% capacity as they are having to send people out of area. This is while a significant proportion of patients in inpatient wards no longer require hospital care but cannot be discharged because support is insufficient to enable them to continue their recovery at home or in another setting.
- **Reduced pressure on A&E and fewer out of area placements:** when pressure on beds is high, people with mental health needs may need to be admitted out of area or wait in A&E for extended periods, which can be distressing and unsafe for patients. Freeing up mental health bed capacity will ease these pressures. Avoiding A&E congestion is particularly critical this winter in view of the need for infection control and social distancing.

This funding's impact will be measured through monitoring improvements in the **following key metrics**, which are already a priority for all areas:

- reduction in length of stay in mental health wards (MHSDS)
- reduction in 6 and 12-hour waits for mental health patients in A&E (from attendance to departure) (ECDS)
- reduction in inappropriate adult acute mental health out of area placements (NHS Digital).

3. How will the funding be allocated and assured?

- 3.1 In view of the operational urgency, release of the funding should be expedited as far as possible. It is expected that it will go directly and immediately to mental health providers via nominated CCGs in each STP/ICS. Where CCGs or local authorities (LAs) are better placed to quickly commission additional capacity/support packages, eg through variations to existing contracts, mental health providers may agree that the funding remains with or can be transferred to them. However, this funding must be **ringfenced and additional**, and used for its intended purpose, not to cover what is/would have already been allocated to mental health services; systems will be expected to

³ Occupancy level for adult acute mental health beds, as at 20 November 2020 taken from Covid-19 Mental Health & Learning Disability Sitrep

provide regions with evidence of this (see template below listing the data/monitoring requirements).

- 3.2 Mental health providers and partners are asked to start spending the funding immediately to improve discharge support and step-down packages for mental health patients, working alongside LAs, VCS and other system colleagues to commission extra support from local services. Where possible, lengthy procurement processes and disputes about what constitutes LA/NHS responsibilities should be avoided to expedite having packages to meet patients' needs as quickly as possible this winter.
- 3.3 Indicative funding allocations will be set out on a fair share basis to NHS England and NHS Improvement regional teams, based on mental health weighted populations. We anticipate that regional teams will work with STPs/ICSs to largely allocate funding on an equitable basis to all the main CCG-commissioned NHS mental health providers within an STP/ICS, but will have discretion to weight allocations towards particular systems/providers if there is a reasonable case to do so.
- 3.4 NHS England and NHS Improvement regional teams will be encouraged to confirm allocations to local areas as quickly as possible, and will be accountable for:
- ensuring funding is ringfenced to achieve the stated aims of the fund
 - monitoring how the funding is being used and accounting for it by year-end
 - ensuring that the funding is **additional to** existing investments from CCGs and LAs and does not trigger any disinvestment by mental health trusts, CCG or LA partners.
- 3.5 Regions will be asked to inform the national team (using the return below, **with one return per NHS mental health provider**) of the amount of funding to release to the nominated CCG by no later than **close 7 December**, to allow it to be processed as part of the December CCG allocations run. All areas are asked to provide the names of executive-level leads from the mental health provider and the STP/ICS who are accountable for the appropriate use of the funding.

1. Region	
2. Name of ICS/STP	

3. Name and contact of accountable STP/ICS executive lead	
4. Lead CCG for transfer of funding to mental health provider and total funding to allocate	
5. Name and contact of CCG lead to confirm the funding allocation has been received and transferred	
6. Mental health provider(s) to which the funding will be allocated and total funding to allocate to each provider	
7. Name and contact details for the mental health provider(s) accountable executive lead	

3.6 It is expected that the funding will then be transferred immediately in December from the lead CCG to named providers, as per the agreed allocations. There is flexibility for mental health providers to agree locally where funding can remain with CCGs or, for example, in joint s.75 pots with LAs, because they are better placed to commission extra services most effectively (eg through variation to existing contracts). In all cases the fund is intended to encourage joint working between mental health providers and other NHS and non-NHS (in particular VCS and LA) partners.

3.7 Regions will be asked to inform providers of certainty of funding before the December allocations so that they can start mobilisation as soon as possible.

3.8 To account for the use of, and to meet conditions provided by Government on this new funding, NHS England and NHS Improvement regional teams will require the monthly reporting of the following data items, along with the previous month's data, by 10th of each month.

Reporting measure – one return per provider	Value	Comments/reason for asking
Please confirm the total amount of funding that has been released to the provider(s) to date		It is expected that all funding should be released immediately in December to mental health providers, unless otherwise agreed by the mental health provider
Average weekly cost of new additional discharge packages in the reporting period using share of new funding		This will enable regional and national monitoring of average cost per discharge package and may inform future policy/ investment

Number of new additional discharge packages in the reporting period using share of new funding		As stated above, this funding is to increase investment in mental health discharge support, and not to cover costs that were already being met
Total costs of other discharge support or enablers of discharge packages using new funding, e.g. MADE events, discharge co-ordinators, housing contracts etc		This section can be used to set out other reasonable costs that support the aims of the funding but are not directly related to discharge support packages for patients but may enable them
Total number of discharges in the reporting period from the provider		The total should be more than the additional, ie the new funding should only be funding a proportion of total discharges – with most funded through existing funding
Optional narrative: how has the additional funding helped to support patient flow – has there been any learning or challenges that would be helpful to share?		

4. What types of support can this funding buy?

- 4.1 Mental health providers will be expected to stratify patients to identify who is ready for discharge, and what types of support can be put in place rapidly to address the most significant mental health and A&E system pressures.
- 4.2 While there are no particular limitations on what type of discharge support package can be purchased with the funds where there are services available locally, it is likely that in many places some types of lower level/medium intensity step-down support can be put in place relatively quickly and used to support the discharge of the significant proportion of people who are typically delayed on inpatient wards. For example:
- temporary enablement in-reach support package into someone’s home on their discharge from hospital – to help people cope with things like daily routines, tenancy, finances, personal care, employment
 - step-down supported housing/beds, working with local providers to commission additional capacity
 - personalisation funds to help ‘think outside the box’, agreeing with patients and carers what might facilitate their discharge

- agreements with local private/social landlords, potentially with offer of greater support from Home Treatment Teams (HTTs), VCS, allied health professionals (AHPs) and social workers
 - using local crisis house capacity
 - deep clean, house adaptations, new mattress purchase, etc – one-off costs that can be met quickly once funding is agreed
 - care home placements
 - temporary B&B or similar accommodation while medium-term housing solutions are found, eg for people who may have been rough sleeping or are awaiting home adaptations
 - additional capacity in HTTs and inpatient wards, including social work and housing input.
- 4.3 While the funding is primarily to be used to improve post-discharge care, it can be used for step-up care to help avoid admissions. Covid-19 testing upon discharge must be carried out in line with the latest [NHSE/I guidance](#).
- 4.4 There is flexibility to use the funding on services for all ages and patient cohorts that help patients move through the system. It should be kept in mind that a priority for this winter funding is to ensure it is spent on support that will best help to alleviate A&E and mental health bed occupancy pressures, and which can feasibly be put in place relatively quickly.

5. Multi-agency discharge events and embedding home first/discharge to assess (D2A) principles

Multi-agency discharge events for mental health

- 5.1 Many areas have instigated local multi-agency discharge events to bring system-wide focus to supporting discharge. A brief guide and example agenda can be found [here](#).
- 5.2 We recommend that, supported by this funding, all areas **complete one of these events by the third week of December if possible, ahead of the busiest winter period from late December**. It is acknowledged that such events require preparation, so if this timing is not feasible, systems are encouraged to hold their next event as soon as they can and to repeat them periodically.

- 5.3 Some patient groups have worked with their trusts to push for 'home for Christmas' initiatives for patients who are currently placed out of area. MADEs in December may also work towards supporting this.
- 5.4 While the expectation is already that MADEs **include local VCS partners, this is particularly important in the context of mental health patients and the pandemic**, when many people may not have their usual support networks.

'Home first' or D2A principles in all mental health trusts

- 5.5 Current NHS England and Department of Health and Social Care [national guidance on application of D2A during covid-19](#) focuses on acute and community trusts. Further helpful tips and [guidance from the Local Government Association can be found here](#).
- 5.6 The following principles from the D2A approach are likely to apply and benefit discharge from mental health care equally to physical health:
- Longer-term care and support needs to be assessed in the most appropriate setting and at the right time for the person. This is not just about increasing service capacity, but also identifying where care can be continued in a non-acute setting with extra benefits from doing this in someone's home or a more recovery focused step-down placement.
 - Instigating discharge packages as soon as someone is ready to leave hospital, doing what is right by patients, and crucially removing delays and disputes over funding and responsibilities (and if needed resolving these after the discharge support has started).
 - In mental health and particularly in the current context of lost usual support networks, D2A or home first will likely need to instigate more supportive care packages than usual. These must be person centred and planned in conjunction with patients and families.

Annex A: Short case studies and examples

Central and North West London: Step-down project and whole pathway reviews

Like many others, the trust experienced increased pressures after the first lockdown ended, compounded by a number of bed closures due to COVID-19. This resulted in a spike in out of area placements and long waits in A&E for mental health patients.

In November the trust started a pilot to review and stratify all inpatients to identify who could benefit from continuing care in a more recovery-focused environment.

The trust commissioned eight 'step-down' 24-hour supported accommodation beds across two properties, where people can stay for up to 12 weeks while they work towards recovery with daily activities and, if needed, ongoing health and care assessments. The step-down service has been implemented together with local authorities and has multi-disciplinary input, with oversight from urgent care clinical leads, input from social workers and support workers to support with activities of daily living, and from home treatment teams who monitor mental state and administer medication.

The trust has also given increased focus to community services with regular 'whole pathway' meetings. These are chaired at VSM executive level. Inpatient and community teams together review what level of community input patients have received prior to admission, to continuously identify whether the operation of community teams can be improved to keep people well, and prevent needs escalating to the point of admission.

The trust also held multi-agency discharge events in February and June alongside LAs, CCGs, VCS, patient/carers reps and housing, and intends to repeat these every three to four months, with the next planned for early December.

Promising early progress has been made, including significant reduction to zero out of area placements in recent weeks, although pressures remain high and maintaining this position will likely continue to be a challenge.

Sussex Partnership NHS Trust D2A approach for mental health

Sussex has adapted and piloted a D2A approach in adult mental health services; specifically, broadening the range of immediately available supported discharge options for patients who have been deemed 'medically fit for discharge', to smooth their transition from inpatient care back to the community. Options include transitional accommodation and support in people's homes.

- Ward staff are responsible for identifying and referring patients who are ready for discharge to a D2A placement.
- Early cross-agency working to identify placements/packages.
- Encourage 'outside the box' thinking and person-centred approach, including a small personalisation fund.
- Part of a local mental health and housing strategy, including brokering tenancy agreements with local landlords.

West Sussex D2A pilot

Four units of supported accommodation (via block contracts) with four provider organisations consisting of:

- a supported housing provider delivering two rooms with on-site 24/7 monitoring/support
- a mental health residential care home delivering one room
- a mental health residential care home with nursing delivering one room.

A specialist community mental health provider delivering:

- up to 160 hours of community support per week
- pathway co-ordinator responsible for operational co-ordination of the D2A service, including managing referrals, allocation of D2A resources and administration.

A mental health housing co-ordinator who oversees a housing support service based on the working age wards.

1 x social worker – leads on all social care activity.

P/T placement finding resource (funded from separate internal WSCC source) to support the pilot.

A personalisation fund available to people using the service.

The project has so far seen:

- reductions in length of stay and DTOC
- a number of positive patient testimonies
- that the home-based support has as much impact as step-down housing placements.

This quote from a service user illustrates the service's impact:

“I will be forever grateful to Venture People for housing me at Cogden House, straight from Millview Hospital. It was a lovely place to recover, offering all amenities and was fully staffed with support workers. I had support for an hour each day with paperwork and IT help. This led to me finding secure accommodation for the future. They also supported me through two appeals and have given me back my freedom and independence.”