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To:
- All ICB Chief Executives
- All NHS Acute, Mental Health and Community Foundation Trust and Trust Chief Executives
- Medical Directors and Directors of Nursing
- Chief Financial Officer of all Acute trusts

cc.
- NHS England regional directors

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21 March 2023

Dear all,

RE: Discharge Ready Date submission and Adult Social Care Discharge Fund

We wrote to you at the end of January with our delivery plan for recovering urgent and emergency care services. This set out our ambition to provide more and better care in people's homes, get ambulances to people more quickly when they need them, see people faster when they go to hospital and help people safely leave hospital having received the care they need.

We know that timely discharge of patients to improve patient outcomes and patient flow is key to being able to deliver on our ambition.

Good quality data is a powerful driver for improvement. The acute and community discharge SitRep data alongside the mental health Covid SitRep give valuable insight into the scale of the discharge challenge; but these do not allow for a full analysis to support local health and care systems to drive change. We are committed to developing a new metric that measures the time between a patient no longer meeting the Criteria to Reside (their "Discharge Ready Date") and their actual date of discharge, to be published for all systems ahead of winter 2023.

Today we are writing to remind you of two commitments that are set out in our Delivery plan for recovering urgent and emergency care services and require urgent action:

1.Submission of the Discharge Ready Date and improving data quality

- Acute and community ward teams to collect the Discharge Ready Date for all inpatients with a stay of one night or longer, and input it into their Electronic Patient Record (EPR) system, **from 1 April 2023**

- Acute and community trusts will need to ensure that this data item will flow from their EPR system into both national collections of Commissioning Data Sets (CDS) data via the Secondary Uses Service (SUS) and Faster Data Flows (FDF), **from 1 April 2023**

There is an equivalent metric for mental health called clinically ready for discharge, and mental health teams should continue to ensure this information flows via the mental health Covid SitRep.

2. Adult Social Care Discharge funding for 2023/24

- Local authorities and ICBs can start planning now for how the £600m of discharge funding could be used across the financial year 2023/24

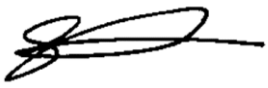
Further details are included in the appendix which sets out how trusts should go about collecting this data and the actions we need you and your teams to prioritise in regard to data collection and planning for the new funding.

Thank you for your efforts to improve discharge services for patients.

Yours sincerely,

Professor Sir Stephen Powis
National Medical Director
NHS England

Dame Ruth May
Chief Nursing Officer, England
NHS England



Sarah-Jane Marsh
National Director of Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Ming Tang
Chief Data and Analytics Officer
NHS England

Appendix

1. Submission of the Discharge Ready Date and improving data quality

In the short term we will need to continue the acute and community discharge SitReps. However, we anticipate that a move to adoption of the Faster Data Flow service will mean that these will stop in future.

To deliver the new metric, we need you to action the following data collection that Trusts will already be undertaking from 1 April. These actions will ensure that data is submitted from your Trust to be published as part of the metric.

For any acute providers that are still to confirm the start date for their Faster Data Flows submissions, please could they e-mail England.FDF@nhs.net confirming the date from which their submissions will commence.

Completing this new collection will require:

- **Ward teams to collect the Discharge Ready Date for all inpatients with a stay of one night or longer, and input it into their EPR system, from 1 April 2023**
- The Discharge Ready Date is the start date of the final period that the patient no longer met the 'Criteria to Reside' in a hospital bed for that episode of care.

See Annex A for Discharge Ready Date guidance and examples

This field should be collected and input into an EPR system for all admitted patients with a stay of one night or longer. Many Trusts are already collecting this field, which must be completed and submitted in the CDS from April 2023 as set out in the CDS v6.3 Information Standards Notice (ISN).

We will communicate via the Data Liaison Service in the week commencing 20 March to ask you to confirm that your EPR system is able to collect this data point, and that ward teams are aware of this requirement and are collecting and inputting this field.

- **Trusts will need to ensure that this data item will flow from their EPR system into both national collections of CDS data via the Secondary Uses Service (SUS) and Faster Data Flows (FDF), from 1 April 2023**

The source data included in CDS and FDF will be the same, as the data comes from your Trust's EPR / PAS. If you need support with the submission process for FDF please contact England.FDF@nhs.net and for CDS please refer to the CDS v6.3 guidance.

NHS England will share collated CDS and FDF data back with Trusts and regions and Regional Discharge Leads will examine these data weekly in the NHS Discharge Board, chaired by Lesley Watts. As well as supporting improvements in data quality that may be required, this information will be shared with DHSC, DLUHC and other government

colleagues to begin to explore and test the new metric. We plan to pilot this metric in a selection of Trusts over the summer before national publication in advance of winter.

2. Adult Social Care Discharge funding for 2023/24

In the planning guidance communicated on 23 December - PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk) – we outlined funding plans to support timely discharge.

Before the end of this month, the government and NHS England will launch the planning process for the Better Care Fund for 2023-25. This will include £1.6bn of funding to reduce delayed discharge, with £600m being available for the period April 2023 - March 2024. The BCF programme will work with ICBs, local authorities and social care providers to ensure this funding as part of wider BCF plans will:

- Increase social care capacity – providing more care packages to more people – in ways that have the greatest possible impact in reducing delayed discharge from hospitals.

- Ensure local partners can plan services sufficiently far in advance and for providers to develop long-term workforce capacity plans.

- Be used in ways that build on learning from evaluation of the impact of previous discharge funding.

- Allow local authorities, the NHS and the social care sector to streamline discharge, assessment and placement processes and help to free up greater social worker time and capacity.

Local authorities and ICBs can start planning now for how the £600m of discharge funding could be used across the financial year 2023/24. The funding will be allocated 50% to local authorities and 50% to ICBs, with the local authority part of the funding distributed using the iBCF formula. The funding must be pooled into the BCF to allow joint planning and reporting. Detailed conditions and planning and reporting requirements will be published before the end of this month.

Annex A: Discharge Ready Date technical guidance and examples

The Discharge Ready Date will be the same as the Discharge Date if the patient is discharged on the day the patient first no longer meets the Criteria to Reside.

The Discharge Ready Date may be earlier than the Discharge Date if the patient does not meet the Criteria to Reside and their condition does not deteriorate but they remain in hospital or an inpatient unit.

Once it has been agreed that a patient no longer meets the Criteria to Reside, i.e. a Discharge Ready Date has been agreed, this should be reviewed each day to ensure that the patient continues not to meet the criteria.

A patient may again meet the Criteria to Reside in a hospital bed if their hospital stay is prolonged. Where this is the case:

i. For finished episodes of care, the **Discharge Ready Date** should record the start date of the final period that the patient no longer met the 'Criteria to Reside' in a hospital bed for that episode of care.

ii. For unfinished episodes of care, the **Discharge Ready Date** should record the start date of the current period that the patient no longer met the 'Criteria to Reside' in a hospital bed, if applicable for the current episode of care.

The **Discharge Ready Date** is a different data field from the **Discharge Date** which records the actual date of discharge from a Hospital Provider Spell (these may be the same date).

The settings from where the discharge may originate are a health service hospital or inpatient unit or an independent hospital in pursuance of arrangements made by an NHS body.

The above definition replaces the previous version based around the provisions of the Community Care (Delayed Discharges etc) Act 2003, which was repealed by the Health and Care Act 2022.

In order to reflect the changes described above, a Data Dictionary Change Notice (DDCN) will be published week commencing 20 March. The Data Dictionary itself will be updated week commencing 27 March.

Examples

Example 1: A patient in a hospital bed no longer meets the Criteria to Reside in hospital and is discharged the same day

Patient A is admitted into a hospital bed on 01/08/2023. At this point they meet the Criteria to Reside.

Two days later, on 03/08/2023, due to their recovery, Patient A no longer meets the Criteria to Reside. The Discharge Ready Date is completed with the date that day, 03/08/2023.

A short while later on the same day Patient A is discharged from their hospital bed. The Discharge Date should be completed with the date of discharge, which in this example is 03/08/2023.

Example 2: A patient in hospital bed no longer meets the Criteria to Reside in hospital and is discharged on a subsequent day.

Patient B is admitted into a hospital bed on 05/08/2023.

Two days later, on 07/08/2023, Patient B no longer meets the Criteria to Reside. The Discharge Ready Date should be completed with that date, 07/08/2023.

The following day Patient B is discharged from their hospital bed. The Discharge Date should be completed with the date of discharge, which in this example is 08/08/2023.

Example 3: A patient in a hospital bed no longer meets the Criteria to Reside in hospital but before they are discharged their condition deteriorates so they meet the Criteria to Reside once again. After a further period of recovery they no longer meet the Criteria to Reside and they are then discharged.

Patient C is admitted into a hospital bed on 10/08/2023.

Two days later, on 12/08/2023, Patient C no longer meets the Criteria to Reside. The Discharge Ready Date should be completed with the date that day, 12/08/2023.

However, later that day Patient C's condition deteriorates and before they have been discharged, they once again meet the criteria to reside. The Discharge Ready Date which was previous populated should be deleted and left blank.

Three days later, on 15/08/2023, Patient C has recovered sufficiently and no longer meets the Criteria to Reside. The Discharge Ready Date should be completed with that date, 15/08/2023.

Patient C is discharged from the hospital bed two days later on the 17/08/2023 and the Discharge Date is therefore recorded as 17/08/2023.

Note – Example 3 provides an example of a patient meeting the Criteria to Reside, then not meeting the Criteria, then meeting them again, then not meeting the Criteria, but for some patients this change between meeting and not meeting the Criteria to Reside could

happen multiple times. **Where this is the case, the Discharge Ready Date should record the start date of the final period that a patient no longer met the Criteria to Reside in a hospital bed.**