The Kings Fund

Ideas that change health and care

Hospital discharge funds

Experiences in winter 2022-23

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About this report

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Key messages

- Delays in discharging people from hospital are a longstanding and serious concern. They affect both the quality of life of the individuals who experience delays and the efficiency and effectiveness of the wider health and care system.
- Delays have multiple causes, and the priorities for reducing delays vary widely from one area to the next.
- In recent years, it has become normal practice for government to provide additional short-term, ring-fenced money each winter to reduce delays as demand for hospital beds increases over the colder months. This funding approach has been criticised for potentially driving short-term, temporary fixes rather than long-term solutions that address the root causes of delayed discharge.
- In 2022, as the health and care system faced exceptional pressure, the government announced a £500 million Adult Social Care Discharge Fund. Shortly after, it announced a further £250 million hospital discharge fund.
- Our research with six sites in England found that they welcomed the Adult Social Care Discharge Fund, but had too little advance notice to develop the most effective plans and ensure value for money. The subsequent £250 million hospital discharge fund was announced with even less notice, and overlapped with the plans that had just been developed to spend the first tranche of funding.
- Most sites said that preventing avoidable hospital admissions was a key priority, but because the discharge funds could not be spent on that, they were in effect diverting efforts away from their strategies to reduce hospitalisations. Because the funds had to be spent rapidly, on services that were available at short notice, they were also in tension with sites' longer-term strategies to build up the home care market over time and reduce use of excess capacity in bed-based care.
- Where sites had invested effort in developing a deep and shared understanding of their performance and of local causes of delays, they appeared more able to manage those tensions and to use short-term funding effectively.

- However, while all the sites involved in this research described working together closely on hospital discharges, many interviewees went on to give inconsistent analyses of the reasons for delays and the actions needed locally to reduce them. They all spoke the language of integration, but this often lacked depth – for example, with NHS and local authority budgets nominally pooled but spent separately.
- The sites in our sample did not have a single set of metrics on their discharge performance that they could analyse together locally to drive improvement. Instead, the partner organisations had different data, reflecting historical practice and different accountabilities.
- Both sets of funding required bespoke data for monitoring how the funds were used, on either a fortnightly or daily basis. This was experienced as extremely burdensome and a top-down imposition. Many interviewees considered the monitoring to be focused predominantly on what had been purchased, rather than on outcomes for people or impacts on performance around delays, and they fundamentally questioned the value of this type of monitoring.
- To make best use of future funding for hospital discharge, we propose the following:
  - The Department of Health and Social Care should only use short-term, ring-fenced funding on an exceptional basis and should ensure sufficient notice to sites so that they can plan for it – as has now been done for funding in 2023/24 and 2024/25.
  - The Department should set funding criteria and develop guidance in ways that maximise places' flexibility to reflect local priorities.
  - The Department should work with NHS and local government representative bodies to ensure a low-burden, value-adding approach to monitoring.
  - Places should invest effort in developing shared understanding of discharge performance, causes of delays and priorities for action. This would require agreement on which metrics to use as well as joint analysis of those metrics, and better information-sharing.
  - Places should consider partnership working on discharge as an exemplar that can help them develop greater depth of integration.

1 Background

The Adult Social Care Discharge Fund was formally announced in September 2022 by the then Secretary of State for Health and Social Care as part of the government's 'plan for patients' (**Department of Health and Social Care 2022c**). Full details, including allocations, were outlined in November 2022 (**Department of Health and Social Care 2022b**).

The Adult Social Care Discharge Fund consisted of £500 million, split into two streams:

- £200 million distributed to local authorities, based on the Adult Social Care Relative Needs Formulae
- £300 million distributed to integrated care boards (ICBs), targeted at geographical areas experiencing the greatest number of discharge delays and the longest delays.

Local authorities and ICBs were expected to pool this funding via the Better Care Fund – a mechanism set up in 2013 to encourage local government and the NHS to join up service commissioning and delivery to achieve jointly agreed objectives (**NHS England undated a**). The £500 million funding for the Adult Social Care Discharge Fund was provided in two tranches: the first 40% in December 2022 and the remaining 60% (which was conditional on reporting requirements being met) by the end of January 2023. Expenditure against the Adult Social Care Discharge Fund was to be completed by 31 March 2023, though subsequently some carry-over of unspent funds into 2023/24 was allowed.

The Adult Social Care Discharge Fund could only be spent on two types of activity, but these were broadly defined and had no further prescription within them:

- interventions that best enable the discharge of patients from hospital to the most appropriate location for their ongoing care, prioritising those approaches that are most effective in freeing up the maximum number of hospital beds and reducing bed days lost (**Department of Health and Social Care 2022b**)

- actions to boost general adult social care workforce capacity, through staff recruitment and retention, where that will contribute to reducing delayed discharges.

Local authorities and ICBs were expected to work together to provide:

- a plan for spending the funding, additional to existing Better Care Fund plans
- fortnightly activity reports, setting out what activities had been delivered in line with commitments in the spending plan (spending plans were to be submitted by 16 December 2022, and the first activity report was to be on 30 December 2022)
- a final spending report alongside the wider end-of-year Better Care Fund reports by 2 May 2023.

Shortly after announcing the Adult Social Care Discharge Fund, in January 2023 the Secretary of State for Health and Social Care announced a further time-limited hospital discharge fund for NHS organisations, this time in the amount of £250 million (**Department of Health and Social Care 2023**; **NHS England 2023**). This had significantly more stringent conditions for what it could be spent on than the Adult Social Care Discharge Fund (**NHS England 2023**). Of the total amount, £200 million was provided to buy step-down bed capacity plus associated clinical support for patients who did not meet criteria to reside in hospital (sometimes described as 'medically fit for discharge'), for up to four weeks. The remaining £50 million was capital funding for activities such as expanding hospital discharge lounges (where people who are well enough to leave hospital may wait for medicines, transport or other arrangements, allowing the bed to be freed up for the next patient) and ambulance hubs. Each ICB was set a capped budget based on a weighted population formula and the budget was held centrally by NHS England. ICBs were required to report on key indices of activity, such as number of step-down beds purchased, with the majority of these collected daily.

Again, the focus of this additional funding was on speeding up discharge and improving flows through hospitals: the Department of Health and Social Care said the funds would 'free up hospital beds so people can be admitted more quickly from A&E [accident and emergency] to wards, reducing pressure on emergency departments and speeding up ambulance handovers' (**Department of Health and Social Care 2023**).

What problems were the discharge funds trying to solve?

Delayed discharges from hospital have been a concern for at least a quarter of a century. The national spending watchdog, the National Audit Office (NAO), reported that in 1998/99, 'delays in discharge from hospital affected an average of nearly 6,000 people over 75, costing [NHS] trusts about £1 million a day' (National Audit Office 2000b), and noted that 'delays in discharge from hospital can undermine people's quality of life and increase dependence on institutional care' (National Audit Office 2000a).

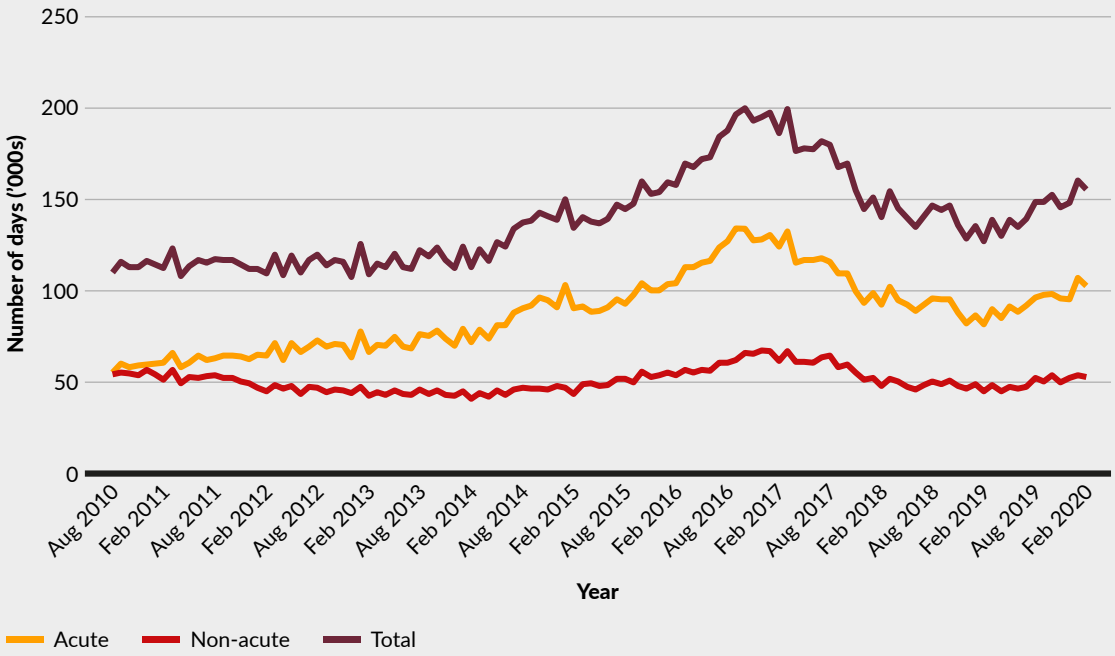
By 2016, the NAO was reporting that the cost of delayed discharge to the NHS was now around £820 million a year, noting that 'longer stays in hospital can have a negative impact on older patients' health as they quickly lose mobility and the ability to do everyday tasks' (National Audit Office 2016). In fact, 2016 may have been a peak for delayed discharges, as measured by days of delay, but they – and their negative impacts on patients and on costs – have continued to be a major concern every year since. In 2022, as the NHS faced a number of challenges – including the need to urgently reduce waiting times that had built up even further since the Covid-19 pandemic – there was significant concern that winter pressures that year could be among the most acute the NHS had ever faced. In that context, the government sought to re-double efforts to reduce delays, supported by additional funding (Foster 2023).

What does the data tell us about how the problems built up?

Data from NHS England on delayed transfers of care (NHS England undated c) gives a snapshot each month of the days patients spend in hospital awaiting discharge. The total increased steadily from 2010, reaching around 200,000 delayed days in autumn/winter 2016–17, and then subsided somewhat (*see* Figure 1). This data was last collected towards the start of the pandemic in February 2020, when there were just over 150,000 delayed days from acute and non-acute hospitals.

Efforts to reduce delayed discharges took on much heightened importance during the initial stages of Covid-19. With pressure to free up to 30,000 NHS hospital beds, government guidance directed rapid discharge of every patient who was clinically ready to leave hospital (Department of Health and Social Care 2020a; National Audit Office 2020). It required that patients be transferred off wards within one

Figure 1 Delayed days, August 2010 to February 2020



Source: NHS England undated c

hour of a discharge decision to a designated discharge area, and then discharged from hospital as soon as possible, normally within two hours. The government also provided special funding to pay for the first six weeks of social care required by anyone leaving hospital during the pandemic.

From April 2021, NHS England began to publish data on the number of patients remaining in hospital who no longer meet the criteria to reside in hospital (that is, who are medically fit for discharge), rather than the number of days of delayed discharge. This data is not comparable with the earlier data on delayed transfers of care. It showed that in December 2022, as the first funding from the Adult Social Care Discharge Fund reached local authorities and ICBs, an average of 13,440 patients per day remained in hospital despite being ready to leave. This was around 30% higher than the December 2021 daily average (NHS England undated b).

What causes delayed discharges?

There is no single, clear-cut reason for delays in discharge from hospital. Before Covid-19, NHS trusts were required to allocate responsibility for delayed discharges between the NHS, social care and other bodies. In February 2020, 60% of delayed days were attributed to NHS responsibility, 30% to social care responsibility and 10% to the responsibility of both. The most common reasons for delayed days were: 'awaiting care package in own home' (21%); 'awaiting further non-acute NHS care' (18%); 'awaiting nursing home placement or availability' (13%); 'awaiting completion of assessment' (13%); 'awaiting residential home placement or availability' (11%); and 'patient or family choice' (11%) (**NHS England undated c**).

The data published after April 2021 by NHS England used different categories. Analysis of the October 2022 data noted that just under a quarter of patients in hospital for seven days or more were delayed for reasons 'that can be broadly grouped as being about the discharge process in the hospital'. Another 25% were waiting for a care package at home, whether community health services, social care or both. A further 22% were waiting for a short-term bed, such as for rehabilitation, and a further 18% were waiting for a short-term package of care pending assessment of long-term care needs (**Schlepper *et al* 2023**).

Good practice in hospital discharge

Ensuring that patients are discharged effectively to the right place has real benefits for those individuals, as well as for hospitals. As a result, since 2016, places have attempted to introduce 'discharge to assess' or 'home first' models. These aim to discharge patients from hospital as soon as they no longer need acute care even if they still need care services such as short-term support in their own home or another community setting. Assessment for longer-term care and support needs is then carried out in the most appropriate setting and at the right time for the individual.

A note on terminology

For simplicity, we refer to discharge being managed and co-ordinated at 'place' level although in fact there are also a few ICBs that are coterminous with a single upper-tier local authority and do not have defined places (one of which participated in this research). NHS England divides the country into 42 systems (ICB level) covering geographical populations of 1 million to 3 million people; within these there are usually a number of defined places (typically at local authority level) covering 250,000 to 500,000 people.

Hospital discharge guidance published in 2020 (**Department of Health and Social Care 2020b**) set out the four pathways on which people might be discharged, and expected levels of use for each.

- Pathway 0 (50% of patients discharged) involves a simple discharge home, with input from health and/or social care.
- Pathway 1 (45% of patients discharged) involves patients able to return home with new, additional or a restarted package of support from health and/or social care.
- Pathway 2 (4% of patients discharged) involves recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.
- Pathway 3 (1% of patients discharged) involves patients needing bed-based 24-hour care, including those discharged to a care home for the first time and existing care home residents returning to their care setting.

The expected levels of use are adapted from an analysis for patients aged 65 and over. In practice, the number of all adult patients (aged 18 and over) discharged to each pathway has been quite different to these predictions. In June 2023, 84.9% of patients were discharged to pathway 0, 8.9% to pathway 1, 3.3% to pathway 2, and 2.9% to pathway 3 (**NHS England undated b**).

National guidance on reducing discharge delays, based on input from leaders of NHS and local government services, stipulates that NHS and local authorities should agree the discharge model that best meets local needs (**Department of Health and Social Care 2022a**).

What funding streams have been used to tackle delayed discharges?

In the past three years, there have been several separate streams of funding to ICBs and/or local authorities intended to reduce discharge delays. In addition to the £500 million Adult Social Care Discharge Fund and the £250 million hospital discharge fund, reducing delayed discharges was also at least one objective of the £1.08 billion adult social care grant for 2023/24 announced in the 2022 Autumn Statement, and of three workforce funds from January 2021 to March 2022. These have been criticised as 'piecemeal funding to tackle entrenched problems' (**Allen 2023**).

A focus on reducing delayed discharges has also been reflected in the Better Care Fund since its inception, and the government has now extended discharge funding with £600 million in 2023/24 and £1 billion in 2024/25, delivered through the Better Care Fund.

2 About this research

Our research explored two issues:

- how places planned for and used the winter funding
- whether any factors in the design or administration of the funding helped or hindered places' ability to make best use of it.

The focus was therefore on the process of funding, rather than evaluating spending decisions. The research aimed to inform any future national funding for hospital discharge, and to contribute to the Department of Health and Social Care's wider evaluation of its policy. The Department will publish analysis of spending decisions and their impact, which sits alongside this analysis of the experience of places using the funding.

We recruited six sites for the research, each based on a local authority area (in NHS terms, five were at 'place' level and one was at 'system' level). Recruitment criteria ensured sites with a range of characteristics and levels of discharge delays. We carried out semi-structured interviews with 29 people, including:

- local authority directors of adult social services (and/or other senior adult social care staff)
- senior NHS acute trust executives
- senior integrated care board (ICB) executives
- heads of local Healthwatch
- representatives of the local social care provider association.

All participants in the research spoke to us anonymously. We have included quotes from them throughout the report to illustrate our findings, but we identify the interviewees only by the type of organisation they represent.

We mainly focused on experiences of the Adult Social Care Discharge Fund. However, as we anticipated that there might be difficulty in looking at this fund alone, if it was integrated locally with the £250 million hospital discharge fund announced for 2022/23, we also asked about the place's experience of that fund too. (For further details about the research methods, *see* appendix.)

3 What sites told us about their local context

The sites we spoke to varied in significant but related ways: their underlying geographies, demographics and socio-economic factors were different and there were differences in their health and social care infrastructures. These differences reinforce the need, identified in the Department of Health and Social Care guidance, for discharge processes to be designed in response to the local context.

Interviewees described some of these geographic, demographic and socio-economic differences. They included:

- rurality
- size of local authority area
- coterminous hospital catchment areas or overlap with other local authorities
- size and characteristics of the labour market
- levels of deprivation
- quality of housing and levels of homelessness.

These factors affected issues impacting on hospital discharge – for example, travel times for staff and patients, the size of catchment areas for local hospitals, ability to recruit staff across health and care, the state of the population's health, and the likelihood that patients had decent homes to which they could be discharged.

> *Our population is sicker than a lot of other places. We have got a massive legacy of particularly respiratory disease in the city, so I think we are always going to be impacted heavily by… high admissions, longer length of stay, because people tend to be sicker.*
>
> Local authority

Characteristics of local health and care systems

At least partly in consequence of these differences, the six sites were also significantly different in how their health and care services were organised and how they performed. Some of the main differences were as follows.

- Some sites had simpler structures than others, particularly where the integrated care board (ICB) and the local authority were coterminous.
- Some sites had a much stronger focus on 'place' than others, which affected organisational structures and where decisions might be made.
- Some sites had greater issues with local NHS capacity and performance than others (for example, two sites had local hospitals that they had identified as having too few beds).
- Some sites had local authorities with greater financial challenges than others.
- There were differences in how joint hubs to co-ordinate discharges were organised, and differences in local capacity for residential care, home care and intermediate care.

Sites also reported differences in issues such as how long senior staff had been in post and in the strategies that were being implemented to tackle local issues. For example, in two sites, the local authority was attempting to build up its home care capacity because it felt it was too reliant on more residential and nursing care beds than were needed.

Finally, although all six sites acknowledged that delayed discharge was a significant issue for them, they were responding to somewhat different trajectories on it. Some had been performing poorly but felt they were now improving, while others were now struggling even more.

> *We weren't great in terms of flow and length of stay, pre-pandemic, it took a hell of a shock through the pandemic. We're still recovering from that.*
>
> NHS trust

Causes of delayed discharges

It was not surprising, then, that given their widely different starting points, the sites had identified different reasons for delayed discharge, and different priorities for, and approaches to, tackling them. We heard of more than 20 causes of delayed discharge across the six sites. These went across all of the discharge pathways, indicating the likely value of a 'whole system' view (*see* box).

Main reported causes of delayed discharge

- Lack of staff
- Poor hospital administration (eg, delays in discharge letters)
- Delays with hospital drugs/pharmacy
- Poor discharge planning
- Non-compliance with discharge protocols
- Risk aversion in hospital staff
- Lack of hospital physiotherapy and occupational therapy assessments
- Availability of transport
- Lack of intermediate care beds
- Lack of home support (eg, meals on wheels)
- Lack of specialised services for people with complex needs
- Poor care home handover
- Delays accessing home adaptations or equipment
- The need to discharge to a wide range of local authorities with different processes
- Homelessness
- Lack of responsibility for self-funders
- Patient choice

Within this range of causes, lack of staffing was a consistent theme. Difficulties in finding enough home care – often due to lack of staff – were mentioned by several sites but there were also concerns about lack of regulated professionals such as social workers and occupational therapists. There was also a concern about lack of NHS staff, which could cause pressure on wards and delays in completing discharge processes.

Cultural issues causing delayed discharge were also raised – in particular, a concern that hospital staff were 'risk averse' and over-inclined to believe that discharge to a residential or nursing home was required for some older patients.

Overall, we did not find that there was a common, shared understanding between all partners of the cause of delayed discharges in their system, nor a common, clearly understood set of priorities for tackling them.

> *I've been sat with well-trusted health colleagues, who, when they are describing what they think the problem is, will say that it's our ability to get packages of home care in place is causing the delay from hospital. Whereas categorically that isn't [the problem].*
> ICB

Though we were typically told that relationships between partners were good, they were not always sufficient to develop a depth of shared understanding. In some cases, there were evident tensions between partners related to failures to turn these good surface relationships into meaningful action to reduce delayed discharges.

> *So it's been convenient for it to be our fault. We've not always managed our money well. And when I talk to my local authority colleagues, who we get on well with… you know, there's not a relationship issue. There's a, 'what are you going to do about it?' issue. And being told they've exhausted all their money, there's nothing else they can do… Okay, that's not an answer, is it? That's a statement of fact.*
> NHS trust

Sometimes, however, these issues did relate to fundamental differences of approach and emphasis between partners at each site, typically between those working in health and those working in social care.

> *The more we talk about acute beds, care home beds, people forget they're people that we're talking about, and they're probably in the most traumatic part of their lives… It is not a transaction just to get them out of the hospital.*
>
> Local authority

4 How sites reached decisions about the Adult Social Care Discharge Fund

Planning processes

Planning was usually driven by a small group involving the integrated care board (ICB), trust and local authority. Sites also created some significant joint planning structures such as task-and-finish groups, working groups and 'daily stand-ups' to draw up detailed plans and adapt them as necessary for rapid implementation. Health and wellbeing boards were used for oversight and sign-off.

Though most interviewees claimed that partners within their place were working closely together as one system, that was not always borne out by the details of the planning process. In particular, although the Adult Social Care Discharge Fund was pooled into the Better Care Fund, some NHS bodies and some local authorities still identified 'their' money within that and felt able to decide unilaterally how it should be spent.

> *I think one of the challenges when we first got that was the fact that there were two pots within the pot, if you see what I mean, so the social care pot and the ICB pot. And that did cause a few tensions at the very beginning, about, well, 'that's you, and you should be doing that and we'll do that'.*
> ICB

One site in our sample had carried out a notable depth of planning for winter earlier in the year, which meant it was better prepared to use the funding than the others. Its plans were underpinned by a shared understanding across the local authority and NHS about priority actions to improve discharge and refreshed procurement frameworks that allowed for expansion of services. This meant that when extra funding became available, the site was able to rapidly commission additional capacity and had a set of activities already scoped that could be developed and trialled if and when they had funding for them.

> *The majority of stuff that we funded were new initiatives, or we were trialling something different. And we tried to be a bit braver and bold… We felt that if we keep doing the same, we're going to get more of the same, so what can we do differently to result in something different?*
>
> Local authority

In general, in all sites, it was apparent that the maturity of relationships, trust, and levels of mutual understanding affected the extent to which plans were truly joint, and there was wide variation across the sites in this regard.

Involvement of other partners in planning

Social care providers, GPs, and voluntary and community sector (VCS) organisations were much less likely to be involved in planning. Even in sites where partners told us they had involved providers, we heard a more downbeat assessment from the providers themselves.

> *So it's not the culture of [place] to routinely involve either ourselves and certainly not [social care] providers in how the money is allocated.*
>
> Care provider association

Healthwatch sometimes had an overview of the local situation because of its *ex officio* attendance at ICB and other system meetings. However, typically, the organisation received relatively few concerns from the public about delayed discharge and more about discharges thought to happen too early, which was outside the scope of the Adult Social Care Discharge Fund.

Two sites felt that not including GPs fully was a potential risk, as they were not all considered to have sufficient capacity to manage patients who had been discharged early, with more complex needs.

All sites said that the short-notice timeframe and short-term nature of the funding effectively restricted meaningful collaboration on planning.

> *People go to, sort of the simple solutions with one or two partners, at most, because they haven't got the time to do the wider consultation.*
>
> Care provider association

In all places, health and wellbeing board members from various organisations were involved in overseeing the Adult Social Care Discharge Fund. In general, it appeared that engagement and governance structures across different services and sectors were more mature in some places than others. Where this was the case, those sites were able to engage more partners in their plans for winter funding. But overall, interviewees described communicating plans and progress rather than co-production.

> *So, we have regular working groups, which include all of the partners in the alliance. So, it wasn't just the ICB, it was the trust, it was the council. We involved also the GP Federation and the voluntary sector in some of the… discussions, and, obviously, mental health.*
> ICB

Several places found that it was particularly important to engage VCS organisations. This was because those organisations could often mobilise quickly, were often skilled at making use of relatively small amounts of money and – by dint of working closely with communities – were likely to have a good understanding of what would make a difference.

> *Actually, if you think about the community and voluntary sector, they are able to make a small amount of money generally go a really long way. So actually they're probably some of the most important partners in terms of making the best use of the funding and having that added… that value for money, added value type approach.*
> ICB

Learning from planning

Most sites reflected that the planning process had revealed a need for better collaboration.

> *But what I would say, at the moment for [place], it's not as joined up as it should be, and that's one of the things we're looking at changing.*
> Local authority

One site that had previously thought it had a reasonably well-integrated system found that working together to improve hospital discharge was leading to a qualitatively different level of shared understanding. Where there had previously

been assumptions that shared understanding was developing – for example, as a result of social care staff being physically located in the hospital alongside their NHS colleagues – working together intensively to plan across all the discharge pathways revealed how much more they had to learn about their different organisations' approaches, constraints and accountabilities.

It was also clear that some commissioners had learnt more about local needs and the drivers of delays in discharge through their experience of planning to use the Adult Social Care Discharge Fund. This probably also indicates gaps in data or a lack of data-sharing, which, once identified, can be addressed. For example, it was through this process that one site learnt about the number of bariatric patients facing lengthy delays in hospital and so could commission special arrangements in residential care as a result.

> *What we've learnt actually for next winter is we need some real complex social care beds, and that's where some of the delays are. So, it's about knowing your market really.*
>
> Local authority

5 How the Adult Social Care Discharge Fund was spent

Overview

All six sites told us that they managed to spend all or almost all of their Adult Social Care Discharge Fund allocations.

Overall, they mentioned very similar lists of services and activities when telling us what they were doing to reduce delayed discharges. But when we asked about what they were using the Adult Social Care Discharge Fund for specifically, the picture was totally different from one place to the next.

Spending on workforce

Overall, investment to extend the use of the existing social care workforce was the most frequent way that interviewees described using the funds they had been allocated.

> *Where possible, they looked at increasing existing staff's hours, and looking at different patterns of working, over the weekend and in the evening and things like that.*
>
> Integrated care board (ICB)

Two sites had increased funding to providers in order to bring forward planned increases in the national minimum wage, which were due to take effect in April 2023. This was felt to be successful in both sites; however, as the extra funding was only for places commissioned by the local authority, it also created challenges that had to be worked through in providers with a mix of funding from more than one council, self-pay and the NHS. None of the sites had used the allocated funds for staff bonuses.

> *It [bringing forward the increase in the national minimum wage] was very well received, to the point where staff even wrote direct to the council to say, 'thank you, I was looking for another job, because I couldn't afford to stay here, but now I'm not'. So that did work, it's just that they didn't have enough money to make that possible for the entire workforce, they only did it for their own commissioned beds and CHC [NHS-funded continuing health care] didn't replicate it on their side.*
>
> Care provider association

The Adult Social Care Discharge Fund was also used to increase existing strategies to attract and retain staff. Examples included international recruitment initiatives, buying licences for an app that rewards referrals of job applicants, grants for providers' recruitment programmes, and hardship grants for individual staff.

Some sites described bringing people in on a fixed-term basis but said this tended to mean one of two things: use of agencies, or moving staff from one area to another, in a dynamic of 'robbing Peter to pay Paul' (local authority). Interviewees told us that although short-notice, short-term funding might be a solution to rising demand if there is a reserve workforce available that can be mobilised, that was not the situation in the NHS or social care, as there is no additional workforce capacity. They mostly also went on to say that although pressures were most acute in winter, they were essentially year-round, and that these factors combined to make a case for baselining the extra winter funding into annual allocations.

As a result, we heard few examples of places using the Adult Social Care Discharge Fund to employ additional staff. In multiple cases, initial plans had to be changed because of an inability to recruit staff.

> *We had three initiatives that would involve recruiting staff, and all three of those were delayed or scaled back because we couldn't get the staff.*
>
> Local authority

Where new staff were recruited, it was mostly in the voluntary sector – for example, for post-discharge check-ins, or for post-discharge support to specialist groups such as homeless people.

Most places had examples of managing to retain staff they had recruited or maintain changes in how they used staff after the funding period had ended. These were

funded either by securing resources from other budgets in the local authority, or by using resources that were available because services were carrying vacancies. In several cases, the Adult Social Care Discharge Fund was used explicitly to test the viability of new ways of using staff, enabling local authorities to make a business case for continued investment. In another case, a local authority used other funds to extend three-month fixed-term posts, financed by the Adult Social Care Discharge Fund, into 12-month fixed-term posts, to make them more attractive to applicants.

Spending on services

Similarly to the picture on workforce, interviewees told us that the Adult Social Care Discharge Fund was mostly used to provide more from existing services, rather than to create new ones. This was partly because of the difficulty of designing and mobilising new services in the time available, partly because of a concern about ongoing funding after March 2023, but also because fundamentally most places felt they already knew what services were needed and had them in place – they just needed more of them.

> *New money often doesn't result in somebody suddenly having a lightbulb go on in their head and think, 'oh goodness, we've never thought of this'. You know, what you need often is more bed base or you need more home care packages.*
>
> Local authority

Having said that, as mentioned earlier, one site had undertaken extensive planning for winter early in the year and had comprehensive plans in place, including new approaches they would like to develop if and when they had more funding. Other sites also had examples of new services, but they were much less common than examples of extending or reorganising existing ones. In the new services, as well as the challenge of mobilising services in the time available, there was also limited capacity for managing the process of change.

> *The biggest problem with that one wasn't accessing the capacity, the problem was influencing clinical behaviour and clinical decision-making… The clinical mindset and appetite for risk, or lack of, at [our hospital] was part of our problem.*
>
> NHS trust

Examples of extending existing services included:

- repurposing care homes to support people with greater needs, through higher staffing
- resources to support increased needs arising from more people discharged earlier (eg home care, out-of-hours GP care)
- resources to support more 'pathway 0' discharges to home (eg check-ins, cleaning, modifications)
- boosting services going over budget due to high need (eg home care, community equipment)
- addressing known bottle necks (eg occupational therapy assessments)
- additional beds in residential care (although this was sometimes over-estimated and scaled back)
- additional step-down and active recovery beds.

Although interviewees often gave positive examples of managing to maintain staffing changes after the Adult Social Care Discharge Fund had ended, they were notably more negative when we asked the same questions about maintaining services. There were positive examples, which tended to either be about how closely different staff worked together and the depth of their shared approach, or where experience with the Adult Social Care Discharge Fund had supported a business case to maintain progress in embedding 'discharge to assess' approaches. But there were also various cases of concern or regret about an expected 'cliff edge' when the funds ended, or of commissioners feeling 'bounced' into having to find unplanned funding for a service that, once started, could not reasonably be stopped.

> *You've then got a problem with what happens after March [2023]? Because, you know, the system hasn't really got any better. We've still got lots of pressure. And now there are things that we feel like we can't stop.*
> ICB

6 Issues with spending the Adult Social Care Discharge Fund

Short notice of funding

The announcement about the Adult Social Care Discharge Fund was generally welcomed across all sites, as they felt additional money was needed, but there was a sense of frustration around the late announcement (September 2022), the even later decisions on allocations (November 2022) and, even later still, the receipt of monies (December 2022):

> *… so I welcomed the [Adult Social Care Discharge] Fund because obviously we were expecting a really tough winter and that would have given us the opportunity, you know, we knew that that would have given us the opportunity to put schemes in place to support over the winter… At the same time, my reaction was slight frustration with the fact that it was a little bit late in the day.*
>
> Integrated care board (ICB)

Some sites felt that the lack of time to plan their interventions meant they were not as ambitious as they might have been in terms of how they spent the funds allocated, and they were not always confident that they delivered value for public money. This left at least one site feeling like they were patching up problems, rather than dealing with root causes.

> *And the timescales were ridiculous. We had to submit a plan – I think it was before Christmas – and then we were performance managed on the allocation of that money and the delivery and what impact it would be having.*
>
> ICB

All six sites had begun planning for the winter in spring or summer, but most sites described having to develop additional plans at short notice when the Adult Social Care Discharge Fund was announced. So while those sites welcomed the additional funding, they also found it frustrating in that it cut across their existing plans.

> *We had a winter plan, but if we had known that there was a fund that was going to be available when we were doing that planning, then we would have had so much more time to get things right to really consider what the best use of that money was.*
> ICB

However, one site described how it was more able to scale up its existing winter plan because it had invested effort in developing a common understanding of, and approach to, tackling delayed discharges. In some sites, the issues around short timescales were also reduced because commissioners had started spending 'at risk' before the funds were actually received. One place started spending in September, before even being notified of their allocation; another did not start spending until well into December, with consequently less time to develop and embed changes.

It was clear that commissioners' relationships with their finance and procurement teams – and the ability of their procurement frameworks to allow rapid extensions when additional funding arose – were important enablers.

> *We've got quite a substantial market because of the work that the local authority had done in increasing the framework of providers before September in anticipation that there was going to be increased demand.*
> ICB

Short-term nature of funding

As already noted, all interviewees welcomed the additional funding, but as well as frustration over the short notice, some also had fundamental problems with a model of short-term, ring-fenced funding.

> *All non-recurrent money is effectively useless in my view. Unless you want to pilot something quite whizzy with an uncertain outcome, kind of prove the concept before you then make a case for long-term investment… Non-recurrent money for four months is very hard to use.*
> NHS trust

This short-term nature of the spending also created the risk of an inflationary effect on costs. We were told of increases in the fees charged by providers and staffing agencies, and in the salaries that providers had to pay to secure or retain staff.

> *Because there's money nationally all at the same time that could be spent on anything on discharge, that agency workforce could really name their price.*
>
> Local authority

Providers were also aware of the potential for price increases as a result of the additional funding.

> *The provider reaction is always, money coming down, will they increase pricing? Will they increase hourly rates? Will they increase bed rates? That's 99% of the time. What are you giving to us? What are you keeping for yourself to spend on yourselves, and what are you giving to us?*
>
> Care provider association

Conditions of funding

One of the key concerns reported by interviewees was that they would have liked the conditions attached to the Adult Social Care Discharge Fund to be broader. In particular, all sites said that their strategic approach was to reduce avoidable hospital admissions, and that the Adult Social Care Discharge Fund's focus on discharge without admission avoidance distracted from this more up-stream approach. To some, this felt like treating the symptom of a problem rather than the root cause, and there was a sense of disappointment at some sites that when they tried to make this point to the Department of Health and Social Care they felt they were not listened to.

> *And we did raise this a number of times… We just couldn't seem to get that kind of message across. So, you know, we were told very clearly that we couldn't use the funding in that way [on prevention].*
>
> Local authority

Interviewees also told us that framing the purpose of the additional funds as improving discharge in order to speed up the flow of patients out of hospital could skew investment away from and potentially undermine longer-term strategic directions for market-shaping. We heard that where sites were seeking to rebalance

social care provision through a reduction in bed-based care and building up more home care, the need to spend to improve patient flow out of hospitals could result in them investing even more in residential care, because that was all the capacity available at the time. We also heard examples where short-term commissioning was felt to be in tension with local authorities' approaches to stabilising the local market and building resilience.

However, some sites did seek to 'work around' the funding conditions and spend the money in (as they saw it) the most effective way. This often meant scaling back pre-existing winter plans (thereby releasing funds), using the Adult Social Care Discharge Fund to put new, enhanced plans in their place and reallocating the released funds to something else that was not eligible for funding under the Adult Social Care Discharge Fund – in other words, shifting spending between different pots of money.

> *So, we wanted to invest much more in community urgent response, carers' crisis support, but we couldn't use the [Adult Social Care] Discharge Fund for that. So, we ended up moving some of our schemes to sit in different winter pots with less criteria. So, a depressing amount of effort was put into playing the game of, 'oh well, I can put that £100 against that because they don't mind me spending it on that, but I couldn't put that £50 so I'll move that over there'.*
>
> NHS trust

> *So using some local funding that we've got… we combined the Adult Social Care Discharge Fund… alongside what we called the winter fund. So what we tried to do was obviously use the Adult Social Care Discharge Fund targeted at discharge, but use the opportunity of the winter fund to do some of that admission avoidance work.*
>
> ICB

Other sites successfully made a case for more liberal interpretation of the criteria, and said they did not experience any negative pushback from the centre or locally.

> *We did get questions from the BCF [Better Care Fund] team about a couple of our schemes because they weren't strictly within the criteria, but they did accept them.*
>
> ICB

Variable depth of integration

Though most interviewees claimed that sites were working closely together as one system, that was not always borne out when we probed for further details. In particular, although the Adult Social Care Discharge Fund was pooled into the Better Care Fund, in some cases it was only nominally a joint pot.

> *Although we pulled the two funding allocations together and we did everything jointly, did the work together jointly, the council spent their bit and we spent our bit.*
>
> ICB

All sites told us they felt that two distinct funding allocations (one to the local authority, one to the ICB) created a sense of separateness rather than integration.

> *Where the local authority held the money, they wanted to go through a bit of an internal process that looks a certain way, and where the ICB held the money, they wanted a slightly different process. Because fundamentally, they were each going to be held accountable by their executives and through their respective structures. So, sitting on top of it we had an aligned approach, but beneath that each organisation then had slightly differential approaches to what they then chose to do.*
>
> Local authority

7 Monitoring and reporting

While there was broad recognition of the need for 'a high level of assurance' (local authority) to be attached to the Adult Social Care Discharge Fund, all six sites reported significant concerns with its monitoring and reporting processes.

The fortnightly reporting template required places to report on:

- the number of discharges to social care and number of beds or hours of care funded
- the number of packages of care (beds or hours of care) booked, showing overall total and those funded by the Adult Social Care Discharge Fund
- actual spend on different types of social care, with percentage confidence that this was sufficient capacity to meet people's needs
- free text on progress against the plan, impact on reducing delays, innovations and challenges.

All sites found the granularity and frequency of the information being asked of them to be excessive, and demonstrative of a lack of understanding about what kinds of information are routinely being collected by local systems.

> *One of the things that I think is poorly understood by the centre is the things they ask us to report on are not there in the database.*
> Local authority

As a result, there were reasons to question the quality of the data that ended up being submitted, as much of it had to be 'guesstimated' (integrated care board (ICB)) and was the product of different parts of systems scrambling to collect and combine disparate sources of information.

The granularity and frequency of monitoring and reporting requirements caused ill feeling. There was a sense that the level of detail requested by the centre revealed a fundamental lack of trust in them as systems, which some interviewees experienced as infantilising.

One Director of Adult Social Services described the process as:

> *...an annoyance and a distraction for people that should be doing other things that were more important.*
>
> Local authority

Another said:

> *The reporting was onerous, it was death by Excel. I think it created a feeling that we, as directors of adult social services, didn't know what we were doing and we needed somebody on our shoulder checking our homework constantly. So, it felt like there was an element of mistrust.*
>
> Local authority

Because the reporting focused on what the Adult Social Care Discharge Fund monies were spent on (eg, packages of care, purchase of equipment) rather than outcomes for people or performance of the local system, some began to question what the purpose of the process was.

There was a general view that sites were reporting on things that would tell very little to the centre about what the situation on the ground really was, and that it would be very hard to understand what the data they were submitting would mean once it was stripped of a place-specific context.

As one Director of Adult Social Services put it:

> *Isn't it more about reducing the length of stay in acutes and what we're doing there rather than saying, 'well, did you buy 20,000 hours or 25,000 hours?' What does that mean? I could put any figure down on the paper, what does it mean to you? It doesn't mean anything at all.*
>
> Local authority

Interviewees also reported feeling frustrated that there was no feedback given in reply to submissions, adding to a sense that reporting was simply happening for reporting's sake.

8 The hospital discharge fund

As we have seen, there was concern from sites about the short notice, criteria and reporting requirements for the Adult Social Care Discharge Fund. When we asked interviewees specifically about the hospital discharge fund, some (other than those from acute trusts and integrated care boards (ICBs)) had limited experience and were unable to comment. However, for those that did, their concerns about the hospital discharge fund were even stronger than for the Adult Social Care Discharge Fund.

All sites, regardless of whether they successfully spent the money, felt that this winter's hospital discharge fund process should not be repeated in its current design. They welcomed the willingness to invest additional funding, and recognised that it reflected significant concern about managing winter pressures in 2022. But there were very strong negative feelings across all sites about this pot of money, and a sense of cynicism from the interviewees, who found it 'ridiculous' (local authority) or a 'joke' (ICB). These negative views were based on the pressure and difficulty of spending effectively in the two-month timescale available for planning and using the hospital discharge fund, and the disproportionate burden of reporting on what was a small percentage of their overall budget. Some said these concerns had caused them to not even bid for the £50 million capital funding.

Having said that, we did identify positive examples of how the hospital discharge fund had enabled extra capacity and improved patient flow. Sites that managed to spend the money successfully mainly attributed this to existing relationships and collaboration. One interviewee said:

> *It [the hospital discharge fund] did help in the end, but I think it was in spite of the guidance that came with it, not because of.*
> ICB

Despite the overall criticisms of the hospital discharge fund, it was also notable that one site used the monies for a significant change to its discharge lounge. This had been turned into a short-stay, 24-hour staffed discharge ward, with positive results that had been sustained after the initial pump-priming.

The concerns described to us by interviewees cover four main themes.

First, there was irritation that while the Adult Social Care Discharge Fund had cut across their existing winter plans, the hospital discharge fund then cut across their plans for using the Adult Social Care Discharge Fund by coming just a few weeks later and without advance notice. Overall, the requirement for another extremely rapid plan and implementation before the Adult Social Care Discharge Fund plans had even bedded in put sites under pressure, and was, in the words of one interviewee:

> *An unnecessary distraction from being able to actually deliver the schemes.*
> ICB

Second, there was concern about the timescale, with just two months available to plan and spend monies under the hospital discharge fund.

> *How did they expect us to mobilise schemes in two months? Two months. We were shocked when it came through.*
> Local authority

Third, interviewees described restrictive criteria that overlapped with those of the Adult Social Care Discharge Fund. Some reported already having fed back their difficulties with spending the £500 million on bed-based care and felt it was unrealistic to then spend another pot of money on bed-based schemes with tighter conditions and timeframes.

> *Why did it have to be beds, with buying more beds? We were reporting back that we're struggling to buy the beds, so why are we so blinkered to going down one road?*
> Local authority

> *So, we were a bit like, 'oh, we need to block-book more beds or buy more beds or do something else that we've already done'.*
> ICB

Fourth, all sites were frustrated with the level of daily reporting expected and having two separate, different reporting systems for the Adult Social Care Discharge

Fund and the hospital discharge fund. One interviewee felt that the excessive reporting was not an accurate reflection of their place's system, and another reported that the level of reporting was not worth the amount of money that had been given.

> *When the NHS funding came in after Christmas, the level of reporting became truly ridiculous, where we were having to report against two systems in two different ways. I would defy anybody to use the data that we produced to tell us anything about [our place's] performance. I would just say that the level of reporting on the NHS scheme, having to do a daily report on everybody, this is when we get the madness. What the hell can NHS England either regionally or nationally do with that data? They can't react to it. What they're really asking you is, do you know what's going on in your system, but they're not trusting you to understand your own system.*
>
> Local authority

Sites reported requiring 'whole armies of people every week' (NHS trust) just to fill in the forms, and in one case even had to get new people in just to manage the process – a reality that interviewees felt was 'absolutely crazy' (local authority).

Some sites also questioned whether the late timing of the hospital discharge fund was genuinely designed to enable the NHS to spend it effectively, or to get positive media headlines.

> *And the danger is it creates the impression of an announcement to be seen to make an announcement, not an announcement that's actually going to have an impact on the real problem that we've got.*
>
> NHS trust

9 Conclusions and recommendations

We now summarise our key findings and make recommendations based on them. They are grouped according to the actors involved: national funders (Department of Health and Social Care and NHS England), and local health and care systems (integrated care systems (ICSs) and places).

Department of Health and Social Care and NHS England

Timescales

Finding: The short timescales made it difficult for places to plan effectively and to engage wider partners such as voluntary and community sector (VCS) organisations, GPs and social care providers.

Recommendation: Any future funds should allow more time for places to plan and spend the discharge funding. It is welcome that the Department has already allocated funding for 2023/24 and 2024/25. This should also allow time for deeper engagement with systems about issues such as criteria and allocation method (as discussed below).

Conditions of funding

Finding: Sites varied widely in their socio-economic conditions and health and care infrastructure, as well as their approaches to reducing delayed discharge. Places already had an overall strategic direction to reshape the local social care market (eg to increase its stability or reduce over-provision of bed-based care) and these also varied depending on their specific circumstances.

Recommendation: Funding conditions need to work with this high level of variation and avoid undermining local, long-term strategic approaches. Funding conditions and guidance should maximise places' flexibility to design activities and spend

funding in ways that best respond to local circumstances. This may in turn require higher-level monitoring of outcomes and system-wide performance (*see* below).

Finding: We heard strong views and frustration that funding conditions did not allow for expenditure on prevention.

Recommendation: The conditions of funding should allow expenditure not just on reducing delayed discharges but on preventing avoidable admissions in the first place. This was such a strong finding that although criteria for 2023/24 have already been set, additional guidance should be issued to clarify the scope for spending on preventing avoidable admissions.

Allocation

Finding: We heard that having separate funding streams for integrated care boards (ICBs) and local authorities increased their administrative burden and reinforced separateness rather than integration as 'one system'.

Recommendation: Allocation mechanisms and guidance should clearly present future funding as one pot for the local system and not as separate allocations to individual organisations. There should be a single approach to authorising and monitoring spends, even if it is fed data from multiple organisations.

Monitoring

Finding: Sites experienced the level of monitoring for both funds, but particularly the hospital discharge fund, as disproportionate to the amount of funding provided. They felt it created an opportunity cost whereby time and money were spent on reporting that could have been used for planning and delivery. Having two different and unco-ordinated monitoring systems added to this feeling.

Recommendation: Any future funds should have more proportionate levels of reporting, with a clear statement of why information is required and how it will be used, and be designed to fit with existing information flows. The Department of Health and Social Care should work with the Local Government Association,

the Association of Directors of Adult Social Services, NHS Providers and the NHS Confederation to consider whether monitoring could be more focused on ensuring that places have an adequate strategy and plan for spending funds and/or measuring the outcomes achieved by those plans.

One-off funding

Finding: Funding for winter pressures, delayed discharge and/or workforce recruitment and retention have, in effect, become 'recurring non-recurrent funding' in recent years. Unforeseen funds that need to be spent quickly create a risk of price inflation.

Recommendation: There is a strong case for periodically reviewing longer-term funding to ensure that ICBs and local authorities have adequate underlying funding so that one-off, ring-fenced additional funding is only needed exceptionally for urgent, unanticipated issues. If there is more than one one-off funding stream addressing similar issues – as happened with the Adult Social Care Discharge Fund and the hospital discharge fund in 2022–23 – the Department of Health and Social Care should, as a minimum, ensure that the funding streams have co-ordinated approaches so that the objectives, criteria and monitoring are aligned, and they avoid creating a need to re-work existing plans.

ICSs and places

Planning

Finding: Only one site really demonstrated a mutually agreed, deep understanding of the main drivers of delayed discharge in their place and what, as a consequence, their priorities for action should be. Despite several years' experience of short-notice, short-term, ring-fenced winter funds, the other five sites described having to revise winter planning when new funding arrived and often questioned the effectiveness and value for money of these rapidly devised plans.

Recommendation: It should be a priority to agree between all partners in a place (including frontline staff) an analysis of the main causes of delayed discharge and a strategy outlining the most effective actions to address these. This should be developed in partnership with the wider health and care sector, including social

care providers and GPs. It will need to be underpinned by partners investing effort in developing depth of understanding of each other's drivers, constraints and obligations in relation to discharge.

Information

Finding: Sites did not have a single, place- or system-wide view of performance on hospital discharge and its drivers.

Recommendation: Places should further develop and share data on hospital discharge, so that there is a genuinely shared view of performance and areas for improvement.

Finance

Finding: Sites that were prepared to spend at risk, and which had reviewed their procurement frameworks, said they were better able to use the Adult Social Care Discharge Fund.

Recommendation: Places should review their preparedness to spend short-notice, short-term funding effectively and quickly – for example, through appropriate spending 'at risk' and procurement frameworks that allow them to commission extra capacity rapidly.

Integration

Finding: The six sites were clearly at different stages of maturity in integration and in their working relationships. Although all places had told themselves that they worked in a closely integrated way, working intensively on hospital discharge enabled some to gain new levels of mutual understanding and identify ways to deepen integration.

Recommendation: Places should review lessons learnt from the first round of the Adult Social Care Discharge Fund with a view to using joint work on hospital discharge as an exemplar to deepen integration.

Appendix: Research methods

This research explored experiences of the Adult Social Care Discharge Fund, in order to inform any future national ring-fenced funding arrangements for hospital discharge and to contribute to the Department of Health and Social Care's wider evaluation of its policy. The focus was on the processes for making the funding available, spending it, and reporting on it, rather than evaluating the effectiveness of funding decisions. Because we expected it to also be in participants' minds, and there was a possibility that interviewees might not always be clear in distinguishing between the two funds, we allowed discussion of the hospital discharge fund in interviews and prompted interviewees to talk about it if they wished. The hospital discharge fund was not, however, a main focus of the research.

An overview of the research protocol was submitted to the University of York research ethics committee, which confirmed that it would fall within the NHS Health Research Authority definition of service evaluation and would therefore not require NHS ethical approval.

Our research questions were as follows:

- How did places plan for and use the Adult Social Care Discharge Fund?
- What factors in the design and administration of the Adult Social Care Discharge Fund helped or hindered places' ability to make best use of it?

We focused on six sites, which were selected to ensure a mix of the following characteristics:

- urban or rural
- relatively high or relatively low numbers of delayed discharges, and relatively longer or shorter length of delays
- coterminous or complex fit between hospital, local authority and 'place' or integrated care system (ICS) areas

- in the perception of Department of Health and Social Care officials, sites with relatively mature relationships and extent of integration, or sites with relatively less depth of integration and developing relationships.

In each of the six sites, we invited the following to interview:

- the director of adult social services (DASS) or their nominated senior executive
- the senior executive of the integrated care board (ICB) with responsibility for the Adult Social Care Discharge Fund
- the senior executive of the acute trust with responsibility for the Adult Social Care Discharge Fund
- the leader of the local care provider association
- the leader of the local Healthwatch.

To prepare for these interviews, we reviewed the relevant Department of Health and Social Care and NHS England policy documents and guidance on delayed discharges. We also held exploratory discussions with a range of national stakeholders. The purpose was to help us understand the issues and concerns around delayed discharge from the perspectives of NHS and social care organisations' membership bodies, including the NHS Confederation and the Association of Directors of Adult Social Services, and Healthwatch England. We also had a 'teach-in' with officials from the Department of Health and Social Care, to explain to us the mechanics and processes of the Adult Social Care Discharge Fund.

In total, we interviewed 29 people between 24 May and 28 June 2023. All interviewees were provided with information sheets and offered opportunities to discuss the research before consenting to participate. We offered interviewees the choice of being interviewed individually, in pairs or small groups, and as single organisations or jointly with interviewees from partner organisations. Most interviews were on an individual basis, and those that were pairs or small groups were from the same organisation in each instance. However, in one site, the local authority, ICB and NHS trust chose to be interviewed together.

Interview participants were:

- local authority interviewees in all sites
- ICB interviewees in all sites
- Healthwatch interviewees in all sites
- care association interviewees in five of the six sites
- acute NHS trust interviewees in three of the six sites.

Interviews were semi-structured, and covered the following issues:

- local context and history of delayed discharges, including overall approach or plan, perceived challenges and opportunities, and use of data
- a history of what happened, what the interviewee's role was and how organisations worked together, at every stage from announcement of the Adult Social Care Discharge Fund, putting together a plan, and spending the funds allocated (including adapting plans as needed)
- the specifics of what was funded through the Adult Social Care Discharge Fund allocation
- what the local priority objectives were, which the site tried to achieve through its approach to using the funds allocated
- key challenges faced
- experiences of monitoring and reporting on use of the allocated funds
- learning from experience of the Adult Social Care Discharge Fund locally and suggestions for improvements to the Department of Health and Social Care
- experiences of the separate hospital discharge fund, including processes and reporting
- learning from experience of the hospital discharge fund.

Interviews were transcribed and coded using MAXQDA software, for descriptive analysis. The coding framework was tested for comprehensiveness and consistency by comparing all team members' coding of a sample of interviews. Coding was then carried out by three team members.

Code excerpts were reviewed to identify key messages and themes, illustrated with quotes. These were synthesised into a presentation of findings, which we reported back to officials from the Department of Health and Social Care.

We held a workshop to present these findings to the national stakeholders who had assisted us at the outset of the project, and senior leaders from three local authorities and three ICB places (none of which had participated in the research). The purpose of the workshop was to advise us on whether findings from our sites were atypical or likely to resonate with others, and what recommendations might be of value.

We have written up our findings and recommendations, which are contained in this report. It was subject to both internal and external review before being finalised.

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