# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Health and social care directorate

## Quality standards and indicators

## Briefing paper

| **Quality standard topic:** Transition between inpatient hospital settings and community or care home settings |
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| **Output:** Prioritised quality improvement areas for development. |
| **Date of Quality Standards Advisory Committee meeting:** 11 February 2016 |

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# 1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for transition between inpatient hospital settings and community or care home settings. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

## *1.1 Structure*

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

## *1.2 Development source*

The key development source(s) referenced in this briefing paper is:

Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline 27 (2015).

[No review schedule presented.]

# 2 Overview

## *2.1 Focus of quality standard*

The quality standard will cover both admissions into, and discharge from, inpatient hospital settings for adults with social care needs. It will not include inpatient mental health settings because a separate quality standard will be produced on this topic.

Social care needs are defined as need for personal care and other practical assistance because of the person's age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances. This is based on the definition of social care in the Health and Social Care Act (2012) (section 65).

## *2.2 Definition*

A range of health, social care and other services are involved when adults with care and support needs move into or out of hospital from community or care home settings. Families and carers also play an important part.

Problems can occur if services and support are not integrated, resulting in delayed transfers of care, readmissions and poor care. Examples of poor transitions include discharge problems when people are kept waiting for further non-acute NHS care, or for their home care package to be finalised, uncoordinated hospital admissions and avoidable admissions to residential or nursing care from hospital.

## *2.3 Statistics*

NHS England's Delayed transfers of care statistics for England show that in 2014/15, on a daily basis an average 3.7 adults per 100,000 population had their transfer of care delayed. This compared with 3.1 in 2013/14. For 2014/15 this is equivalent to over 1,500 delayed transfers each day throughout England.

Healthwatch England's Safely home: what happens when people leave hospital and care settings? report highlighted that poor hospital discharge practice leads to unnecessary patient suffering and millions in wasted resources.

A 2015 YouGov poll found that nearly a fifth of people who were discharged from hospital in the previous 3 years did not feel they received the social care support they needed afterwards. In addition, 1 in 8 felt they were unable to cope in their own home after being discharged. These issues are likely to lead to people being readmitted to hospital following discharge, or potentially admission to residential or nursing care.

In 2012-13 there were more than a million emergency readmissions within 30 days of discharge. This cost the economy more than £2.4 billion (Emergency admissions to hospital: managing the demand, National Audit Office).

## *2.4 Current policy*

In May 2013, a national collaboration, including the Department of Health, co-produced 'Integrated Care and Support: Our Shared Commitment', a framework document on integration. This continues a policy direction towards better partnership and integrated working. The document sets out how local areas can use existing structures such as health and wellbeing boards to make further steps towards integration. National Voices, a national coalition of health and care charities, developed a person-centred 'narrative' on integration with Think Local Act Personal. A further partnership created a Memorandum of Understanding to support joint action on improving health through the home, setting out a shared commitment to integrated working across health, social care and housing.

The August 2013 Spending Review established the Better Care Fund: a local single pooled budget to encourage the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services. Following on from the framework document the Integrated Care and Support Pioneers Programme was set up in December 2013 to test new ways to join

up people's care around their needs. The first annual report sets out the experiences of the first 14 areas to take part in the programme – many of them seeking to provide integrated care and support at the interface with general hospitals.

While some localities have 'pioneer' status, all local systems are faced with tackling the challenges presented through better joined-up working across an increasingly diverse market for care and support. New models of practice are emerging, involving the independent sector as well voluntary and community services, with the aim of enabling older people to remain at home for longer. Some aim to ensure that, where care and treatment in a hospital environment is really needed, people are admitted for the shortest possible episodes. Anticipatory and advance care planning, used particularly to ensure people at the end of life can exercise choice, may also be used for people in the early stages of dementia, or who have other forms of cognitive impairment, or who are considered at greater risk of avoidable hospital admission.

## *2.5 National Outcome Frameworks*

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

**Table 1 The Adult Social Care Outcomes Framework 2015–16**

| Domain | Overarching and outcome measures |
|---|---|
| 1 Enhancing quality of life for people with care and support needs | ***Overarching measure***<br>1A Social care-related quality of life**<br>***Outcome measures***<br>**Carers can balance their caring roles and maintain their desired quality of life**<br>1D Carer-reported quality of life** |
| 2 Delaying and reducing the need for care and support | ***Overarching measure***<br>2A Permanent admissions to residential and nursing care homes, per 100,000 population<br>***Outcome measures***<br>**Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs**<br>**Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services**<br>2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services*<br>2D The outcomes of short-term services: sequel to service<br>*Placeholder 2E The effectiveness of reablement services*<br>**When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence**<br>2C Delayed transfers of care from hospital, and those which are attributable to adult social care |

| | |
|---|---|
| 3 Ensuring that people have a positive experience of care and support | ***Overarching measure***<br>**People who use social care and their carers are satisfied with their experience of care and support services**<br>3A Overall satisfaction of people who use services with their care and support<br>3B Overall satisfaction of carers with social services<br>*Placeholder 3E The effectiveness of integrated care*<br>***Outcome measures***<br>**Carers feel that they are respected as equal partners throughout the care process**<br>3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for<br>**People know what choices are available to them locally, what they are entitled to, and who to contact when they need help**<br>3D The proportion of people who use services and carers who find it easy to find information about support<br>**People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual**<br>This information can be taken from the Adult Social Care Survey and used for analysis at the local level. |
| 4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm | ***Overarching measure***<br>4A The proportion of people who use services who feel safe**<br>***Outcome measures***<br>**Everyone enjoys physical safety and feels secure**<br>**People are free from physical and emotional abuse, harassment, neglect and self-harm**<br>**People are protected as far as possible from avoidable harm, disease and injuries**<br>**People are supported to plan ahead and have the freedom to manage risks the way that they wish**<br>4B The proportion of people who use services who say that those services have made them feel safe and secure |
| **Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework**<br>* Indicator is shared<br>** Indicator is complementary<br>Indicators in italics in development | |

**Table 2 NHS Outcomes Framework 2015–16**

| Domain | Overarching indicators and improvement areas |
|---|---|
| 1 Preventing people from dying prematurely | ***Overarching indicators***<br>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare<br>i Adults<br>1b Life expectancy at 75<br>i Males ii Females |
| 2 Enhancing quality of life for people with long-term conditions | ***Overarching indicator***<br>2 Health-related quality of life for people with long-term conditions**<br>***Improvement areas***<br>**Reducing time spent in hospital by people with long-term conditions**<br>2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions<br>**Enhancing quality of life for carers**<br>2.4 Health-related quality of life for carers**<br>**Enhancing quality of life for people with dementia**<br>2.6 i Estimated diagnosis rate for people with dementia*<br>*ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life****<br>**Improving quality of life for people with multiple long-term conditions**<br>*2.7 Health-related quality of life for people with three or more long-term conditions*** |
| 3 Helping people to recover from episodes of ill health or following injury | ***Overarching indicators***<br>3a Emergency admissions for acute conditions that should not usually require hospital admission<br>3b Emergency readmissions within 30 days of discharge from hospital*<br>***Improvement areas***<br>**Improving recovery from stroke**<br>*3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*<br>**Improving recovery from fragility fractures**<br>3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days<br>**Helping older people to recover their independence after illness or injury**<br>3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service*<br>ii Proportion offered rehabilitation following discharge from acute or community hospital* |

<table>
<tr><td>4 Ensuring that people have a positive experience of care</td><td>Overarching indicators<br>4a Patient experience of primary care<br>i GP services<br>ii GP Out-of-hours services<br>4b Patient experience of hospital care<br>4c Friends and family test<br>4d Patient experience characterised as poor or worse<br>I Primary care<br>ii Hospital care<br>Improvement areas<br>Improving hospitals’ responsiveness to personal needs<br>4.2 Responsiveness to inpatients’ personal needs<br>Improving people’s experience of accident and emergency services<br>4.3 Patient experience of A&E services<br>Improving the experience of care for people at the end of their lives<br>4.6 Bereaved carers’ views on the quality of care in the last 3 months of life<br>Improving people’s experience of integrated care<br>4.9 People’s experience of integrated care**</td></tr>
<tr><td>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</td><td>Overarching indicators<br>5a Deaths attributable to problems in healthcare<br>5b Severe harm attributable to problems in healthcare</td></tr>
<tr><td colspan="2">Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework<br>* Indicator is shared<br>** Indicator is complementary<br>Indicators in italics in development</td></tr>
</table>

**Table 3 Public health outcomes framework for England, 2013–2016**

| Domain | Objectives and indicators |
|---|---|
| 4 Healthcare public health and preventing premature mortality | ***Objective***<br>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities<br>***Indicators***<br>4.11 Emergency readmissions within 30 days of discharge from hospital*<br>4.13 Health-related quality of life for older people<br>4.15 Excess winter deaths<br>4.16 Estimated diagnosis rate for people with dementia |
| ***Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework***<br>* Indicator is shared | |

# 3 Summary of suggestions

## *3.1 Responses*

In total 8 stakeholders responded to the 2-week engagement exercise (07/12/15-21/12/15).

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

NHS England's patient safety division submitted a full patient safety report for this topic, which is presented alongside this document and can be found in full in appendix 2.

Full details of all the suggestions provided are given in appendix 3 for information.

**Table 4 Summary of suggested quality improvement areas**

| Suggested area for improvement | Stakeholders |
|---|---|
| **Admission**<br>• Information on admission<br>• Assessment on admission | AS, SCM2, AGILE, SCM1 |
| **During hospital stay**<br>• Normal routines | SCM1 |
| **Discharge**<br>• Information sharing<br>• Coordinating discharge<br>• Timing of discharge<br>• Follow-up after discharge | RCN, AGILE, SfC, RPS, SCM2, CHPCIC, AS, SCM3, SCM1 |
| **Supporting infrastructure**<br>• Access to community services<br>• Short-term interventions<br>• Suitability of housing | RCN, SCM3, CRE, AGILE, SfC |
| **Involving carers**<br>• Supporting involvement of carers | CHPCIC, SCM1 |
| **Other**<br>• Fire risk<br>• Medicines-related information sharing<br>• Shared decision-making in medicines<br>• Services for end of life care<br>• Willingness to take more risks | RCN, RPS, AS, LFB, CHPCIC |
| AGILE, Physiotherapy professional network for older people (Chartered Society of Physiotherapy)<br>AS, Alzheimer's Society<br>CRE, Care and Repair England<br>CHPCIC, City Health Care Partnership CIC<br>LFB, London Fire Brigade<br>RCN, Royal College of Nursing<br>RPS, Royal Pharmaceutical Society<br>SfC, Skills for Care | |

## *3.2 Identification of current practice evidence*

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 959 studies were identified for transition between inpatient hospital settings and community or care home settings. In addition, current practice examples were suggested by stakeholders at topic engagement (46 studies) and internally at project scoping (57 studies).

Of these studies, 7 were assessed as having potential relevance to this topic and the suggested areas for quality improvement identified by stakeholders (see appendix

3). A summary of relevant studies is included in the current practice sections for each suggested area of improvement.

# 4 Suggested improvement areas

## *4.1 Admission*

### 4.1.1 Summary of suggestions

**Information on admission**

Stakeholders highlighted the need for all relevant information about an adult to be available to the admitting team to enable care in hospital to be more individualised and to facilitate discharge planning. For example, adults with social care needs who are at risk of hospitalisation should have a contingency plan developed by health and social care practitioners, which can be referred to if the adult is admitted to hospital.

**Assessment on admission**

Stakeholders highlighted that people's communication needs should also be assessed on admission to ensure that they are able to participate fully in decision making about their care throughout their hospital stay.

### 4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

**Table 5 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Information on admission | **Before admission to hospital**<br>NICE NG27 Recommendations 1.2.1 and 1.2.2<br>**Admission to hospital – Communication and information sharing**<br>NICE NG27 Recommendation 1.3.3 |
| Assessment on admission | **Admission to hospital – Communication and information sharing**<br>NICE NG27 Recommendation 1.3.2<br>**Assessment and care planning**<br>NICE NG27 Recommendation 1.3.9 |

**Before admission to hospital**

NICE NG27 – Recommendation 1.2.1

Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan.

NICE NG27 – Recommendation 1.2.2

If a community-based multidisciplinary team is involved in a person's care that team should give the hospital-based multidisciplinary team a contact name. Also give the named contact to the person and their family or carer.

**Admission to hospital - Communication and information sharing**

NICE NG27 - Recommendation 1.3.2

The admitting team should identify and address people's communication needs at the point of admission. For more information on communication needs see recommendation 1.1.2 in NICE's guideline on patient experience in adult NHS services.

NICE NG27 – Recommendation 1.3.3

Health and social care practitioners, including care home managers and out-of-hours GPs, responsible for transferring people into hospital should ensure that the admitting team is given all available relevant information. This may include:

- advance care plans
- behavioural issues (triggers to certain behaviours)
- care plans
- communication needs
- communication passport
- current medicines
- hospital passport
- housing status
- named carers and next of kin
- other profiles containing important information about the person's needs and wishes
- preferred places of care.

**Assessment and care planning**

NICE NG27 - Recommendation 1.3.9

As soon as people with complex needs are admitted to hospital, intermediate care or step-up facilities, all relevant practitioners should start assessing their health and social care needs. They should also start discharge planning. If assessments have already been conducted in the community, refer to the person's existing care plan.

### 4.1.3 Current UK practice

**Information on admission**

The Care Quality Commission published the results of the 2014 NHS Inpatient Survey[1] in May 2015. Of 24,412 respondents whose admission to hospital was planned in advance, 82% felt that the specialist who saw them in hospital had definitely been given all of the necessary information about their condition or illness from the person who referred them. A further 15% felt that the specialist had received information about them to some extent. However, this does not indicate that the information came from community teams, or how easy or difficult it was for the hospital team to obtain the information.

**Assessment on admission**

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

[1] Care Quality Commission (2015) NHS Inpatient Survey 2014.

## *4.2 During hospital stay*

### 4.2.1 Summary of suggestions

**Normal routines**

A stakeholder highlighted the importance of people being able to follow their normal daily routines as much as possible, to provide familiarity and reduce anxiety. This may be particularly important for some people, such as people with dementia, learning difficulties or mental health difficulties.

### 4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

**Table 6 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Normal routines | **During hospital stay**<br>NICE NG27 Recommendation 1.4.6 |

**During hospital stay**

NICE NG27 - Recommendation 1.4.6

Encourage people to follow their usual daily routines as much as possible during their hospital stay.

### 4.2.3 Current UK practice

**Normal routines**

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

## *4.3 Discharge*

### 4.3.1 Summary of suggestions

**Information sharing**

Stakeholders highlighted the need for coordinated care across health and social care services through communication and information sharing. Stakeholders suggested that this might include information provision to social services and community pharmacy, as well as providing a discharge summary to the person's GP within 24 hours of discharge. People being transferred between settings should also be given information about their own transfer.

**Coordinating discharge**

Stakeholders highlighted the importance of a coordinated discharge. Poor coordination can result in distress and reduced quality of life for people using services and their carers. It may be particularly distressing for older people who are confused or people who have dementia. Some stakeholders suggested that making a single health or social care practitioner responsible for coordinating discharge can help to make the transition smoother.

**Timing of discharge**

Stakeholders emphasised situations where early supported discharge may be beneficial. For example, early supported discharge with physiotherapist input can aid return to function, or rapid supported discharge can enable people at the end of life to die in their preferred place. However another stakeholder highlighted that discharging a person before there are clinically ready or before the necessary support is in place may lead to readmission. Another stakeholder suggested that discharge late in the day can also cause problems due to the limited availability of community support.

**Follow-up after discharge**

A stakeholder suggested that appropriate follow-up of people at high risk of readmission should occur within 24-72 hours after discharge. It can reduce early readmissions and it also encourages communication between primary and secondary care.

### 4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

**Table 7 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Information sharing | **Discharge from hospital - Communication and information sharing**<br>NICE NG27 Recommendation 1.5.5 and 1.5.6 |
| Coordinating discharge | **Discharge from hospital -**<br>**Discharge coordinator**<br>NICE NG27 Recommendation 1.5.1<br>**Discharge planning**<br>NICE NG27 Recommendations 1.5.14, 1.5.15 and 1.5.16 |
| Timing of discharge | **Discharge planning for end-of-life care needs**<br>NICE NG27 Recommendation 1.5.24<br>**Early supported discharge**<br>NICE NG27 Recommendations 1.5.25 and 1.5.26 |
| Follow-up after discharge | **After transfer from hospital**<br>NICE NG27 – Recommendation 1.5.38 |

**Discharge from hospital - Discharge coordinator**

NICE NG27 Recommendation 1.5.1

Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members of the hospital‑ or community-based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence.

**Communication and information sharing**

NICE NG27 - Recommendation 1.5.5

During discharge planning, the discharge coordinator should share assessments and updates on the person's health status, including medicines information, with both the hospital‑ and community‑based multidisciplinary teams.

NICE NG27 – Recommendation 1.5.6

The hospital‑based doctor responsible for the person's care should ensure that the discharge summary is made available to the person's GP within 24 hours of their

discharge. Also ensure that a copy is given to the person on the day they are discharged.

**Discharge planning**

NICE NG27 – Recommendation 1.5.14

The discharge coordinator should work with the hospital- and community-based multidisciplinary teams and the person receiving care to develop and agree a discharge plan.

NICE NG27 – Recommendation 1.5.15

The discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include:

- details about the person's condition
- information about the person's medicines
- contact information after discharge
- arrangements for continuing social care support
- arrangements for continuing health support
- details of other useful community and voluntary services.

NICE NG27 – Recommendation 1.5.16

The discharge coordinator should give the plan to the person and all those involved in their ongoing care and support, including families and carers (if the person agrees).

**Discharge planning for end-of-life care needs**

NICE NG27 – Recommendation 1.5.24

The discharge coordinator should ensure that people who have end‑of‑life care needs are assessed and support is in place so they can die in their preferred place.

**Early supported discharge**

NICE NG27 – Recommendation 1.5.25

Ensure that older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.

NICE NG27 – Recommendation 1.5.26

Consider early supported discharge with a home care and rehabilitation package provided by a community‑based multidisciplinary team for adults with identified social care needs.

#### After transfer from hospital

NICE NG27 – Recommendation 1.5.38

A GP or community‑based nurse should phone or visit people at risk of readmission 24–72 hours after their discharge.

### 4.3.3 Current UK practice

#### Information sharing

The National Audit of Intermediate Care 2015[2] reported that 20% of responding commissioners had a shared, electronic patient record accessed and updated by all intermediate care services, and 29% had a comprehensive, shared paper patient record accessed and updated by all intermediate care services.

The National Audit of Dementia 2012-13[3] asked participating hospitals to complete a hospital organisational checklist and a retrospective case note audit of a minimum of 40 patients with dementia. It reported that 66% of 6008 case notes had evidence that the patient or carer had received a copy of the discharge plan or summary on discharge.

A Patient Safety Alert issued by NHS England in 2014[4] highlighted that there were around 10,000 reports to the National Reporting and Learning System of patient safety incidents that were related to discharge, between October 2012 and September 2013. 33% of these concerned communication at handover. See appendix 2 for more detail.

#### Coordinating discharge

The National Audit of Dementia 2012-13 found that 83% of 210 participating hospitals reported that there was a named person who took responsibility for the discharge of people with complex needs in hospital, including people with dementia.

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[2] NHS Benchmarking (2015) National Audit of Intermediate Care.
[3] Royal College of Psychiatrists (2013). National Audit of Dementia care in general hospitals 2012-13: Second round audit report and update. Editors: Young J, Hood C, Gandesha A and Souza R. London: HQIP.
[4] NHS England (2014). Patient Safety Alert: Risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care.

### Timing of discharge

The National Audit of Dementia 2012-13 reported that 83% of 210 responding hospitals' discharge policies and 74% of hospitals' transfer policies specified that discharges and transfers should take place during the day.

### Follow-up after discharge

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

## *4.4 Supporting infrastructure*

### 4.4.1 Summary of suggestions

**Access to community services**

Stakeholders highlighted the role that community services can perform in preventing hospital admissions or to support a return home after a hospital admission. These should include local health, social care and voluntary sector services, in a coordinated approach. For example, a stakeholder suggested that discharge to assess models should involve standardised services and community team skills. Stakeholders also highlighted the need for hospital staff who are involved in the discharge process to be aware of the availability of different community services, their capacity, eligibility criteria and how to access funding, if relevant. This helps to ensure the person is discharged to the most appropriate community setting.

**Short-term interventions**

Stakeholders suggested that the provision of short-term interventions such as intermediate care, reablement and rehabilitation is inconsistent between local areas. These services can support people to remain at home and retain independence for longer, and also provide the opportunity for people to consider their future care, rather than them having to make decisions about long-term residential or nursing care while in crisis. Reablement should involve input from occupational therapists.

**Suitability of housing**

A stakeholder highlighted problems with unsuitable home conditions that can lead to hospital admissions through causing falls, or can delay hospital discharge while people wait for their homes to be made safe and secure. Practical help with adaptations or repairs can improve transitions and enhance quality of life at home. Another stakeholder suggested that occupational therapists should assess and advise on these issues.

### 4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the Committee’s discussion.

**Table 8 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Access to community services | **Discharge planning**<br>NICE NG27 Recommendation 1.5.17<br>**Early supported discharge**<br>NICE NG27 Recommendation 1.5.25<br>**Supporting infrastructure**<br>NICE NG27 Recommendations 1.6.1, 1.6.2 and 1.6.3 |
| Short-term interventions | **Discharge planning: key principles**<br>NICE NG27 Recommendation 1.5.11<br>**Supporting infrastructure**<br>NICE NG27 Recommendation 1.6.1 |
| Suitability of housing | **Discharge planning**<br>NICE NG27 Recommendation 1.5.18 |

**Discharge planning**

NICE NG27 – Recommendation 1.5.11

Ensure that people do not have to make decisions about long‑term residential or nursing care while they are in crisis.

NICE NG27 - Recommendation 1.5.17

The discharge coordinator should arrange follow‑up care. They should identify practitioners (from primary health, community health, social care, housing and the voluntary sector) and family members who will provide support when the person is discharged and record their details in the discharge plan.

NICE NG27 – Recommendation 1.5.18

The discharge coordinator should discuss the need for any specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This includes housing adaptations. Ensure that any essential specialist equipment and support is in place at the point of discharge.

**Early supported discharge**

NICE NG27 – Recommendation 1.5.25

Ensure that older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.

**Supporting infrastructure**

NICE NG27 - Recommendation 1.6.1

The hospital‑based multidisciplinary team should work with the community-based multidisciplinary team to provide coordinated support for older people, from hospital admission through to their discharge home. Ensure that a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital. This might include:

- reablement (to help people re‑learn some of the skills for daily living that they may have lost)
- other intermediate care services
- practical support for carers
- suitable temporary accommodation and support for homeless people.

NICE NG27 – Recommendation 1.6.2

Have a multi‑agency plan to address pressures on services, including bed shortages.

NICE NG27 – Recommendation 1.6.3

Ensure that all care providers, including GPs and out‑of‑hours providers, are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions.

### 4.4.3 Current UK practice

**Access to community services**

NHS England collect data on the number of patients delayed in hospital on the last Thursday of each month. Data collected in November 2015 showed that 992 patients in NHS organisations in England had a delayed transfer of care due to awaiting an assessment of their future care needs and identification of an appropriate care setting. This accounted for 17.8% of the total number of patients with delayed transfers of care on that day. At the same time, 941 patients were delayed while they waited for a care package in their own home (16.9% of all patients delayed).[5]

[5] NHS England (2016) Delayed Transfer of Care Data 2015-16.

### Short-term interventions

On the same day in November 2015, 962 patients had a delayed transfer of care from an NHS organisation in England because they were awaiting further non-acute NHS care, including intermediate care (17.2% of all patients delayed on the same day). This includes patients waiting for NHS mental health care.

The National Audit of Intermediate Care[6] collected organisational level data from 340 services in 2014/15 and reported waiting times for services as a key measure of accessibility. It reported that the average waiting time from referral to assessment was 6.3 days for home-based intermediate care services, 8.7 days for reablement services and 1.3 days for bed-based intermediate care services.

The Adult Social Care Outcomes Framework for England collects data on the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation/reablement services as a measure of the effectiveness of the service. In 2014-15, this was 82.1%. 3.1% of older people were offered rehabilitation/reablement services following discharge from hospital.[7]

### Suitability of housing

NHS England's data shows that on the last Thursday of November 2015, transfer was delayed for 165 patients due to awaiting the supply of items of community equipment and adaptations (3.0% of all delayed patients on that day).

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[6] NHS Benchmarking (2015) National Audit of Intermediate Care.

[7] Health & Social Care Information Centre (2015). Adult Social Care Outcomes Framework – England, 2014-15.

## *4.5 Involving carers*

### 4.5.1 Summary of suggestions

**Supporting involvement of carers**

Stakeholders highlighted the important role that is played by unpaid carers and the vital support that they can provide. They suggested that more could be done to recognise and support this role and to include carers in decision making about transitions.

### 4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

**Table 9 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Supporting involvement of carers | **Involving carers**<br>NICE NG27 Recommendations 1.5.29, 1.5.30 and 1.5.31<br>**Support and training for carers**<br>NICE NG27 Recommendation 1.5.32 |

**Involving carers**

NICE NG27 Recommendation 1.5.29

The hospital- and community-based multidisciplinary teams should recognise the value of carers and families as an important source of knowledge about the person's life and needs.

NICE NG27 Recommendation 1.5.30

With the person's agreement, include the family's and carer's views and wishes in discharge planning.

NICE NG27 Recommendation 1.5.31

If the discharge plan involves support from family or carers, the hospital-based multidisciplinary team should take account of their:

- willingness and ability to provide support

- circumstances, needs and aspirations
- relationship with the person
- need for respite.

**Support and training for carers**

NICE NG27 Recommendation 1.5.32

A member of the hospital‑based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers.

### 4.5.3 Current UK practice

The Personal Social Services Survey of Adult Carers in England is a survey conducted every two years, where questionnaires are sent out to informal, unpaid carers aged 18 or over, caring for a person aged 18 or over. The 2014-15 survey reported that[8]:

- 40% of respondents felt that they had encouragement and support
- 43% felt that they had some encouragement and support, but not enough
- 17% felt they had no encouragement or support.

When asked about the specifics of the support:

- 31% of respondents had received support from carers groups or someone to talk to in confidence to help them with their role as a carer
- 6% had received training for carers.

Of carers who were aware of discussions in the previous 12 months about support and services provided to the person they care for, 73% always or usually felt involved or consulted in these decisions, but 27% never or only sometimes felt involved or consulted.

These results cover all aspects of care and are not specific to transitions.

[8] Health & Social Care Information Centre (2015). Personal Social Services Survey of Adult Carers in England, 2014-15.

## *4.6 Additional areas*

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the Committee to establish potential for statement development.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 11th February.

#### Fire risk

A stakeholder suggested that fires, fire deaths and fire injuries for people can lead to lengthy hospital stays and that opportunities for care and support agencies to identify and address fire risk for people in receipt of care could be better identified. Preventing hospital admissions is out of scope for this quality standard.

#### Medicines-related information sharing

A stakeholder highlighted that when people move between different settings, information about their medicines is not accurately transferred. The quality standard on medicines management in care homes (QS85) contains a statement about medicines-related information sharing when people transfer to and from a care home, and there is also overlap with the quality standard on medicines optimisation, which is currently in development.

#### Shared decision-making in medicines

A stakeholder highlighted that people should be involved and engaged in decisions about their medicines. This is not considered within the source guidance and there is also an overlap with the quality standard in development on medicines optimisation.

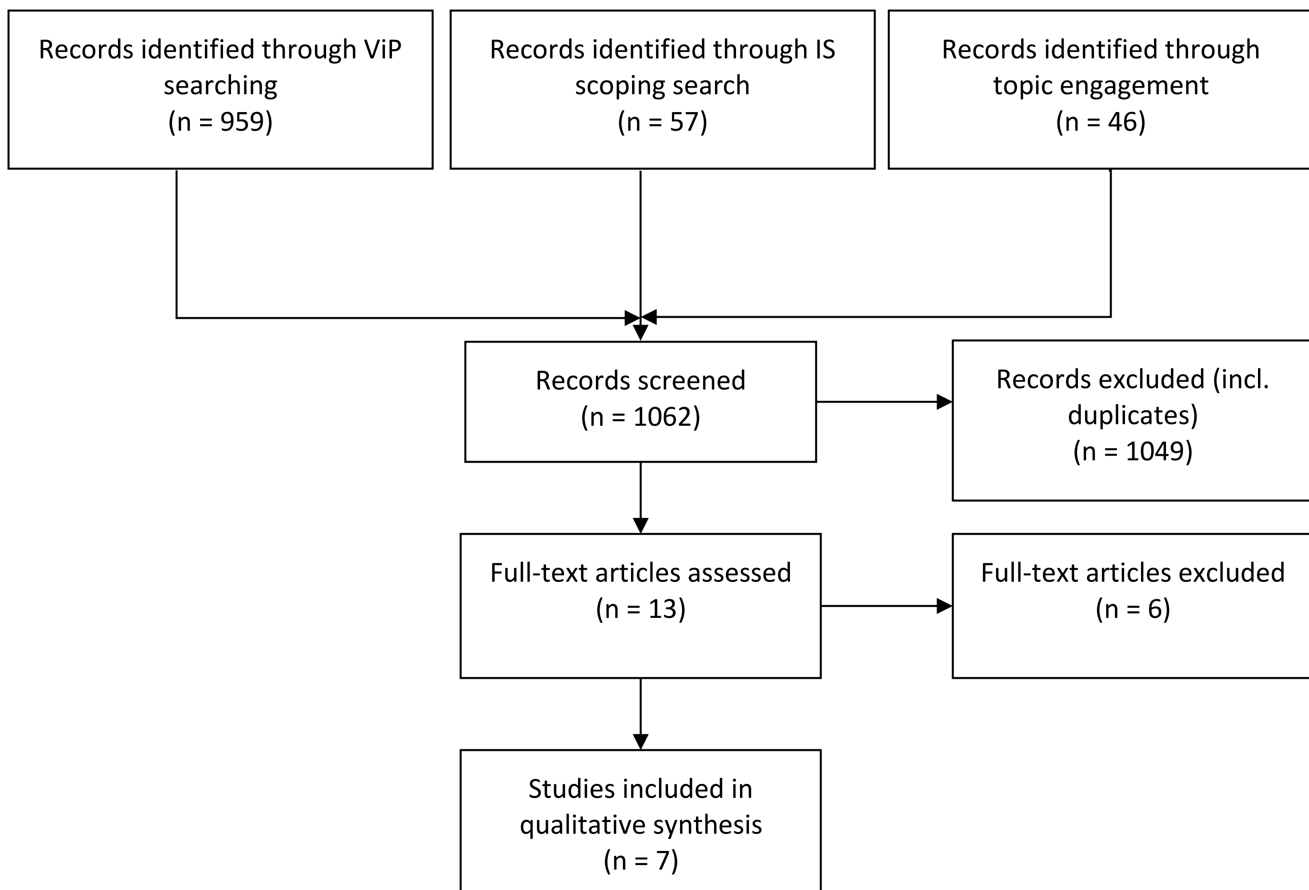
#### Services for end of life care

A stakeholder highlighted that people who need end-of-life care should be offered both general and specialist palliative care services, according to their needs. This is contained within the source guidance (NG27 Recommendation 1.5.22) but there is significant overlap in this area with the existing quality standard on end of life care (QS13), particularly with statement 10: People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.

### Willingness to take more risks

A stakeholder suggested that many people are denied the person-centred care they would choose because current services have a risk averse nature. This is not an area considered within the source guidance.

## Appendix 1: Review flowchart



## Appendix 2: NHS England patient safety report

| Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|
| Ensuring the QS development group is mindful of potential for safety risks related to communication during handover at the time of discharge and relevant work that has been or is being undertaken | For the QS to recognise the issues of safety as well as effectiveness when considering transition between inpatient hospital settings and community or care home settings. | There were around 10,000 reports to the National Reporting and Learning System (NRLS) of patient safety incidents related to discharge between October 2012 and September 2013. Communication at handover is identified as a particular area of risk and accounted for approximately 33% of the 10,000 incidents reported to the NRLS. (see link)<br><br>A Stage 1 Patient Safety Alert was issued in August 2014 'risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care' (see link) to raise awareness and provide the opportunity for organisations to share local practice. Organisations were also asked to complete a questionnaire to inform national priorities for safety improvement relating to communication during handover at time of discharge.<br><br>Analysis of questionnaires and review of literature identified the following priorities:<br>• Discharge liaison services<br>• Electronic systems and records<br>• Medicines reconciliation<br>• Policies and systems that link health and social care<br>• Systems that involve patients in their care | Please see the link to the NRLS review: https://www.england.nhs.uk/wp-content/uploads/2014/08/nrls-summary.pdf<br><br>Please see the link to the Patient Safety Alert: https://www.england.nhs.uk/wp-content/uploads/2014/08/psa-imp-saf-of-discharge.pdf |

| Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|
| | | • Systems that ensure provision of high quality information<br>• Systems to ensure information is acted on after discharge<br><br>A number of the Patient Safety Collaboratives have identified discharge from hospital as a priority and NHS Patient Safety Domain is working in partnership with the Patient Safety Collaboratives. A number of case studies of local practice have been developed and are available on the NHS England website<br><br>'Standards for the communication of patients' diagnostic test results on discharge from hospital' have also been drafted as part of this work programme and are currently being consulted on by the Academy of Medical Royal colleges. | Please see link to the website: https://www.england.nhs.uk/patientsafety/discharge/ |

## Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| **Admission** | | | | | |
| 001 | AGILE – Physiotherapy Professional network for older people (Chartered Society of Physiotherapy) | Community multidisciplinary teams (and single speciality professionals who have significant contact with adults with frailty) must provide high quality, relevant information to acute hospital settings when a patient is admitted. | There is good quality evidence that provision on information on a persons need and social situation will enable their care in hospital to be more individualised and facilitate appropriate discharge planning. | There is significant variation in quality of communication and information at the point of admission. | National Intermediate Care Audit 2015<br>BMA 2014 Hospital Discharge : the patient, carer and doctor perspective |
| 002 | SCM1 | 1.3.2<br>The admitting team should identify and address people's communication needs at the point of admission | There are numerous barriers to communication, which are often not addressed or considered at any point in a hospital stay. This not only serves as a form of disempowerment to individuals (as they are unable to make informed decisions), but it also creates additional anxiety and confusion Moreover, as the transitions guideline focuses on people who have social care needs, there is likely to be an impairment related barrier that needs consideration. The following factors can all impact significantly on an individual's level of understanding, when in a hospital environment:<br><br>Physical, learning or cognitive difficulties;<br>mental health difficulties; | The principle of Shared Decision Making is a cornerstone of both the NHS Mandate and the NHS Constitution. Indeed, there is evidence to suggest that:<br>informed individuals are much more likely to engage with and adhere to treatment and support plans (resulting in less need for costly radical or crisis intervention support);<br>informed individuals are less likely to report dissatisfaction with their healthcare provision; and<br>shared decision making is more likely to result in better and safer outcomes, as the individual shares responsibility for their own health and wellbeing.[1]<br><br>Thus, there is enormous potential to | Accessible formats of patient experience surveys are unlikely to be readily available and administered. Therefore, it may be particularly difficult for individuals with communication difficulties to participate in giving their views in this way and thus, individuals with communication difficulties may have been inadvertently excluded. I am only aware of specific initiatives (in terms of communication of information) in relation to supporting people with learning disabilities to access healthcare, in cancer support settings and with regard to dementia support. However, although there is little data with regard to the experiences of different impairments on communication within the hospital environment, |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | sensory loss (sight, speech or hearing difficulties);<br>difficulties with reading, understanding or speaking English;<br>or indeed being unable to understand all the information given, because you are so anxious about being admitted to hospital.<br><br>Thus, although an individual may nod, or remain quiet and appear to be listening, or indeed give single word responses, it is often the case that they do not have a clear understanding of what is being communicated to them. This not only results in confusion and anxiety on the part of the individual, but also affects family and informal caregivers, who may be receiving conflicting information from different professionals.<br><br>Finally, a new Kings Fund research paper into 'Making the Difference: Diversity and Inclusion in the NHS' suggests that disabled NHS staff are more likely to report higher levels of discrimination than any of the other groups of people with protected characteristics. Thus, it is highly likely that disabled individuals seeking healthcare support are likely to face similar discrimination. | be gained by ensuring that individuals are joint decision makers and that they are able to own their health and social care support plans. As a result, there are a number of initiatives and standards which are currently being developed and implemented to enable the ideology of shared decision making to become a practical reality. These include the identification and removal of current systemic and procedural barriers, which prevent people from contributing to the decision making process.<br><br>Various practical examples of difficulties caused by accessibility issues include requests for written information in electronic text format by email (for people who use screen readers) or in Easy Read (which assists many people with difficulties in understanding complex information). Indeed, as this issue is such a significant barrier (and a legal requirement under the Equalities Act, as well as other statutory documentation), it is being addressed by work on the Accessible Information Standard and its implementation. The issue of accessibility is also addressed in various NICE guidelines, including this one on transitions and both the | it can be assumed that barriers to effective communication can only be exaggerated by any additional impairment related difficulties. Thus, it may be useful to consider information from the Care Quality Commission's report on the national results of the NHS Inpatient Survey 2014 as an indicator of performance in this domain. For example, the section entitled, 'Information and support while an inpatient' states:<br><br>"One in 10 (10%) respondents said that they were not involved as much as they wanted to be in decisions about their care and treatment and 20% said that 'not enough' information about their condition or treatment was given to them.<br>14% of respondents (down from 15% in 2013) who had an operation or procedure stated that they were not told how they could expect to feel after the operation or procedure. And one in 10 respondents (10%) said that they didn't receive an explanation from a member of staff about how the operation or procedure had gone in a way |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | Homecare (NG 21) and Patient experience in adult NHS services (CG138) guidelines. However, ensuring the availability of accessible information only goes some way towards ensuring effective communication.<br><br>Difficulties in effective communication remain as there is still a perceived hierarchical relationship between the individual and the professional (which is especially evident in older people and more senior practitioners). When added to a propensity toward using every day medical jargon (e.g. raised LFTs, hypotension, etc.), as professionals are concerned with communicating information to other professionals, rather than to the individuals themselves, this only serves to exacerbate communication difficulties. This then leads to miscommunication, delays in the transfer of appropriate and relevant information which would benefit practitioners and individuals alike, as well as apprehension and unnecessary anxiety in the individual and their caregivers. Subsequently, as outcomes do not appear to be being met (due to the unnecessary delays and | they could understand.<br>Nearly one in four (24%, up from 23% in 2013) could not find a member of the hospital staff to talk to about their worries and fears, and 13% (down from 14% in 2013) did not get enough emotional support from hospital staff."<br><br>Additionally, under sections 6 and 7 (entitled doctors and nurses respectively), it is noted that more than 30% of inpatients could not always understand the answers that they were given by doctors and nurses to important questions that they had. Added to the fact that 24% of doctors and 19% of nurses talk about individuals to others, as if the individual is not there, it appears that there needs to be a massive culture change in order to facilitate effective Shared Decision Making.<br><br>Results from research evaluations of patient experience using various tools such as the Friends and Family Test (FFT), Picker Patient Experience Questionnaire (PPEQ) and research into Summary Care Records and |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | miscommunication), this also often leads to significant frustration on both the part of professionals and the individuals who are being supported.<br><br>There are also numerous professionals who do not currently have time allocated within their workload to ensure that individuals who they support have fully understood crucial information. Additionally, there are very limited resources and little planning to ensure that effective communication is given appropriate significance within commissioning and funding policy priorities (rather than being seen as of little importance in terms of other more concrete resources, such as the latest equipment or infection control). Furthermore, as has been identified in the NHS Outcomes Framework, in order to achieve effective communication with individuals who have additional communication needs, there will therefore need to be a significant shift in culture, systems and attitudes. | their utilisation should also provide further evidence to support the need for effective assessment, identification and recording of communication needs. |
| 003 | Alzheimer’s Society | Assessment on admission to hospital | People are not generally admitted to hospital for their dementia. Some | Hospitals are incentivised through CQUIN to ensure they identify 90% | CQUIN Dementia Assessment and Referral Data Collection – |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | of the most common reasons people with dementia are admitted to hospital are because of falls, broken/fractured hips or hip replacements, urinary tract infections, chest infection or from a stroke.<br><br>Memory loss, difficulties communicating, low mood, agitation, cognitive issues and frailty can make it more difficult to understand the extent of the problem and direct treatment and support appropriately for someone with dementia. However, through proper assessment on arrival which takes into account care plans, discussions with family/carers and patient passports such as 'This is Me' helps to mediate issues and ensure that care is person-centred and holistic. It is essential that staff have the necessary training in dementia to be able to support people with dementia effectively.<br><br>In line with the Mental Capacity Act people with dementia must be enabled to access an advocate if they no longer have capacity to make decisions. Advocacy services should be publicised in hospitals and to people with dementia so they | patients over 75 who may have dementia on admission to hospital. They provide these patients with a comprehensive assessment of their health wellbeing with referrals made to specialist services for follow-up as required. However, latest figures show that only 69% of hospital trusts were delivering this properly.<br><br>A CQC review in 2012/13 concluded that people with dementia have poorer outcomes than other similarly aged population groups. They found that the number of patients with dementia who died in hospital was more than a third higher (36%) than similar patients who did not have dementia.<br><br>Proper assessment on arrival in hospital is integral to ensuring care is person-centred. This will help improve outcomes and reduce health inequalities for people with dementia. | Quarter 1 2015/16, NHSE, September 2015<br><br>CQC Cracks in the Pathway, 2014<br>http://www.cqc.org.uk/sites/default/files/20141009_cracks_in_the_pathway_final_0.pdf<br><br>National Audit of Dementia Care in Hospitals 2012-13<br>http://www.rcpsych.ac.uk/pdf/NAD%20NATIONAL%20REPORT%202013%20reports%20page.pdf |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | are aware of the support they can access. | | |
| 004 | Alzheimer's Society | Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan | There are around 850,000 people in the UK living with dementia (Prince et al, 2014), with over 42,000 developing the condition before they reach 65. Nearly all people living with dementia will require care and support from both the NHS and social care system at some point as a result of dementia having features of neurological disease, mental illness and physical frailty that cross the boundaries of the health and social care system. In addition, Research indicates that around 70% of people with dementia live with co-morbidities, (Alzheimer's Society, 2015). To ensure that people with dementia are supported to live as independently and healthily as possible, they must have a comprehensive care plan that sets out of package of support that addresses health and social care needs as well as escalation plans should anything go wrong. This helps ensure people receive integrated, personal support across care settings. | A YouGov poll for Alzheimer's Society (June 2014) found that 85 per cent of people would want to stay at home for as long as possible if diagnosed with dementia, rather than go into a care or nursing home. However we know that only two thirds of people are actually able to stay in their own home. More comprehensive care planning and proper community support will enable people to stay healthier in the community for longer. | Prevalence rate:<br>Prince M, Knapp M, et al (2014). Dementia UK: Update. London: Alzheimer's Society http://www.alzheimers.org.uk/dementiauk<br><br>Most people want to stay at home if diagnosed with dementia but less than half know how.<br>ALZHEIMER'S SOCIETY WITH YOUGOV (June 2014).<br>http://www.alzheimers.org.uk/site/scripts/press_article.php?pressReleaseID=1138 |
| 005 | SCM2 | Key area for quality improvement 1<br>Ensure relevant information about a person's care is transferred with them from the | When information specific to a person and relevant to their care is known in the community (such as advanced care plans or communication needs) is not | Different types of methods for conveying information are present:<br>Hospital passports (which may or may not accompany the patient to | See full CG 27 for references around Guideline 1.3.3 |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | community to hospital. | transferred to the hospital team on admission, the risk for in-apropriate treatment increases. | the admitting team)<br>Electronic “shared care records”<br>Advanced care plans in paper format<br>Mental Health or Social Care information not available to admitting teams / OOH teams as on different electronic systems.<br>Challenge is to ensure all this information collected and accompanies person. | |
| 006 | SCM2 | Key area for quality improvement 2<br>Comprehensive Geriatric Assessment for older adults living with frailty syndromes | Older people with living with Frailty Syndromes will benefit from Comprehensive Geriatric Assessment. This is likely to be more effective when delivered by a multi-disciplinary team on a Geriatrician-led unit. | Currently there is a plethora of services for older adults presenting with frailty syndromes.<br>Some have no multi-disciplinary involvement, some have little in the way of specialist Geriatrician involvement, some have a specialist team involved on an “in-reaching” basis and others where this is in a specialist unit. The latter has better evidence as patient outcomes. | http://www.bmj.com/content/343/bmj.d6553.full.pdf+html<br>Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials<br>BMJ 2011; 343 doi: http://dx.doi.org/10.1136/bmj.d6553 |
| **During hospital stay** | | | | | |
| 007 | SCM1 | 1.4.6<br>Encourage people to follow their usual daily routines as much as possible during their stay. | Having a routine is one of the greatest aids to memory and provides familiarity, which in turn reduces feelings of anxiety. Therefore, it is crucial that individuals are able to follow their usual daily routines as much as possible, in order to aide optimal recovery and “learn to live with” the | Current systems within hospital prevent individuals from carrying out their usual routine. Routines that are established for the individual are based on healthcare interventions that need to be carried out and ward functions. For example, someone may be used to waking between 10:30 and | Information about hospital passports for people with learning disabilities and toolkits. Evidence with regard to the importance of routine and familiarity with objects and environments for people with acquired brain injury.<br>Evidence with regard to |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| | | | impacts of a new impairment on the individual's life. People with dementia, learning difficulties, mental health difficulties, acquired brain injury, epilepsy, significant fatigue and indeed some infections can have considerable issues, in relation to confusion and anxiety, when daily routines are altered. As the hospital setting is already an unfamiliar environment (which again can impact on confusion and anxiety), maintaining a person's usual daily routine is paramount in order to reduce the negative impacts of hospital admission. | 11:00am and staying up until midnight (and thus taking morning medication at 10:30am and night-time medication at midnight). However, when they are in hospital medication is given at 6:00am and the individual has to be woken up. This is likely to result in disorientation on waking, which could lead to an exacerbation of anxiety, irritability, fatigue and confusion or memory loss. Additionally, a more ludicrous example is the fact that many individuals are still being woken up by night staff, so that they can be given medication to sleep! | dementia care.<br>Evidence with regard to considerations of individual care assessment and planning. |
| **Discharge** | | | | | |
| 008 | Royal College of Nursing | Care coordination for people with complex conditions | If there is inadequate coordination there are duplications and or omissions resulting in poor discharge of avoidable admission. Families and individuals get distressed, confused and do not get the correct services | Too many people with complex needs still get too many people involved in their care without anyone bringing all the various strands together. This is inefficient, frustrating and causes system problems as well as significant levels of poor care. | NICE guideline NG22 on Older people with social care needs and multiple long-term conditions. |
| 009 | Royal College of Nursing | High quality information sharing | If the various service providers do not know who is involved in the care of an individual, what their circumstances are and who can be involved in discussing what matters to an individual then avoidable confusion, duplication and poor care occur | Poor communication and lack of information sharing is still resulting in people receiving care they neither want or need or alternatively not getting the services they require. Better IT, more information sharing in a robust and secure fashion could go a long way to | NICE guideline NG27 – Transition between inpatient hospital settings and community or care home settings for adults with social care needs |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- | --- |
| | | | | improve the current transitions. | |
| 010 | City Health Care Partnership CIC | Co-ordination | Co-ordinated & integrated appropriate resources services can reduce long-term dependency & admission to institutional care (Cochrane review 2005)<br><br>Understand and address local factors | There is no one model for co-ordinated care and the need for co-ordinated care has been recognised globally (Kings Fund 2011)<br><br>Co-ordinated, integrated care can have a significant impact upon quality of life.<br><br>Impacts upon costs and cost effectiveness<br><br>Lack of vital support leading to significant levels of readmission<br><br>If transition of care is well managed this leads to increased patient satisfaction | Mediated between social boundaries and supports integrated working . Please see article below that informs how co-ordinators can assist in understanding the occupational & organisational boundaries to safe hospital discharge<br>http://www.nhsiq.nhs.uk/media/2584351/j_health_serv_res_policy-2015-waring-35-44.pdf<br><br>https://blackboard.uic.edu/bbcswebdav/institution/SCS/270_2591/NUSC316/master/platinum/with_hands/module05/Discharging%20Patients%20earlier%20in%20the%20day.pdf |
| 011 | SCM1 | 1.5.10<br>Ensure continuity of care for people being transferred from hospital, particularly older people who may be confused or who have dementia. For more information on continuity of care see the recommendations in section 1.4 of NICE's guideline on patient experience in adult NHS services. | Many people and their carers experience significant distress and frustration with regard to the fragmented nature of health and social care services. There are difficulties with appropriate and accessible communication of relevant information, inter-agency miscommunication and delays, as well as a lack of co-ordination and communication between agencies. This is costly to both services (in | There is a significant impact upon individuals when they experience disjointed, poorly co-ordinated care. There is also a significant impact upon carers. Reports from Carers UK (2014 and 2015) highlight the fact that 50% of carers who had contact with both health and social care services experienced difficulties in the way that these services co-ordinated available support. Additionally, 41% of carers | Carers UK (2014) Quality of care and carers: How quality affects families, employers and the economy<br>Carers UK (2015) – detailed in footnote<br>http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/continuity-of-care-for-older-hospital-patients-mar-2012.pdf |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | terms of avoidable costs of duplicated services) and to individuals and their carers (as the breakdown in communication can result in mistrust). Additionally, as continuity of care is crucial to safe, efficient and personalised outcomes, there is significant benefit to providing well co-ordinated care. | listed bureaucracy as the main reason for breakdown in their ability to carry out their caring role. | |
| 012 | Royal College of Nursing | Rapid supported discharge for people who are at the end of their life | People who wish to die in their usual place of residence are not always supported to do so because of delays in arranging rapid support both health and social care to ensure that this can be facilitated. | The evidence from numerous recent reports shows that people are dying in hospital against their wishes. | Voices survey, New Ambitions for End of Life Care, NICE guidance NG31 on Care of the dying adults in last days of life |
| 013 | AGILE – Physiotherapy Professional network for older people (Chartered Society of Physiotherapy) | Early supported discharge should be offered only with high quality, daily rehabilitation, commencing within 24 hours of discharge and directed by a Physiotherapist. | Early supported discharge e can support return to function and reduce the risks associated with prolonged hospital admission however without physical rehabilitation these benefits will not be realised. | Audit evidence and local experience shows that wait times for Physiotherapy follow up on discharge can vary and can exceed that which enables patients' functional abilities to be optimised. | National hip fracture database. |
| 014 | Skills for Care | Greater communication between health and social care settings | Vital for effective / efficient care and support | Support continuity of care / quality of care for patient / service user and health and wellbeing of patient / service user.<br><br>Social care settings must receive greater and more accurate information on discharge to ensure good continuity of care | National Information Board commitment to information sharing systems.<br><br>Vanguard / Integration Pioneers sites existing protocols for information sharing agreements between NHS and community settings. |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| 015 | Skills for Care | Greater understanding of roles within health and social care settings involved in transition | Supports smooth transition to most appropriate community setting | Support continuity of care / quality of care for patient / service user and health and wellbeing of patient / service user.<br><br>Also reduces likelihood of readmission, so is cost effective and efficient. | Can be delivered in training and development of those involved in discharge |
| 016 | Royal Pharmaceutical Society | Seamless care | When patients move between primary and secondary care information about their medicines is not always transferred in a timely manner | AS above, there is a significant risk that when patients move between care settings the information about their medicines is not always transferred in a timely or accurate manner. | A number of hospitals across the country are starting to implement an initiative that enables discharge information to be transferred from hospital to community pharmacies. This then enables a professional handover between the different sectors and supports the community pharmacist to undertake Medicines Use Reviews (MURs) or New Medicines Service with the patient to ensure they understand what medicines they are on and why.<br>However, there is also an issue with MURs in that they need to be undertaken with the person in the pharmacy. Pharmacies can apply to local NHS England teams to undertake them outside of the pharmacy but the process is onerous. For housebound patients or care home residents it is not possible for them to come to the |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | pharmacy, which means there is an inequity of service to such patients. |
| 017 | City Health Care Partnership CIC | Avoiding Premature Hospital Discharges | There is evidence to indicate that discharging a patient out of hospital before they are clinical ready and/or before the necessary supportive services and resources are in place will result in the patients poor health and readmission to hospital | Estimated costs of premature hospital discharge is £2.4 billion (Health watch 'Safely Home')<br>Higher risk to the patient of post-discharge adverse events<br><br>Causes patient and carer distress<br><br>Patients and their carers lose confidence in the community service provision<br><br>Difficult to deliver planned service care – care fragmentation/discontinuation | Please see below a BMA publication that highlights the possible causes and mechanisms to avoid premature hospital discharges<br><br>file:///C:/Users/susan.pender/Downloads/PLG%20patient%20discharge%20(1).pdf |
| 018 | City Health Care Partnership CIC | Time of discharge | Returning a person home late in the day causes distress and problems to both the patient and the community based services<br><br>Follow-up / outpatient appointments should be made BEFORE discharge – to alleviate uncertainty | Supports a safe & effective transition & continuation care<br><br>Many services (including voluntary sector) finish provision between 5 – 7pm<br><br>Some care homes have a 'cut off' time for accepting admissions<br><br>Older people are the most anxious about returning home and are most likely to need supportive care when | Whole systems approach & analysis of research around delayed discharge illustrated within;<br>http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/research/delayed-hospital-discharges.pdf |

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| | | | | home (Healthwatch 2015) | |
| 019 | SCM1 | 1.7.1<br>Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates. | Unless relevant staff are appropriately and effectively trained, with access to the information that they need to facilitate a timely and co-ordinated discharge, there is little chance of either continuity of care or patient/carer satisfaction and engagement in effective discharge plans that promote an individual's health and wellbeing. Moreover, due to the complexities involved in fragmented health and social care provision, comprehensive training and information is essential to ensure that professionals are aware of ways to access funding and assess potential eligibility criteria for various services, equipment or interventions (to ensure that the resources are available to meet any necessary support needs after discharge). It is also essential to regularly update this training to ensure that the practitioner is supported to keep abreast of developments and indeed changes to criteria, eligibility or available provision. It is only in this way that effective discharge planning (and the best outcomes for individuals and their carers) can occur. | As in the response above, with regard to impact of the ineffective and delayed communication, there are significant changes required within the infrastructure of health and social care services to enable effective interdisciplinary working between hospital and community based multidisciplinary teams, individuals who are using health and social care services and their carers. Indeed, as the integration of services is crucial to improving outcomes, training is essential to support individuals and their carers to navigate through very complex and fragmented health and social care service provision. Moreover, training is essential in terms of some of the key areas of the Care Act, as although this is generally focused on the duties of local authorities, as a 'relevant partner' the NHS has a duty to meet the needs of the local population. Consideration should therefore be given to ensuring that professionals are provided with information about the rights to assessments for both individuals and their carers, along with training on the importance of the 9 wellbeing principles (which should be used to inform the practise of all hospital and | Care Act<br>National patient surveys<br>Carers UK reports. |

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| | | | | community based support services, as they are fundamental to the principles of person centred planning and holistic assessment). | |
| 020 | Alzheimer's Society | Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. | All hospitals should have a discharge policy that takes the needs of people with dementia into account. People should be assigned a discharge coordinator who ensures they have a health and social care assessment of their needs and that an appropriate support package is put in place and onward journey decided.<br><br>A Dementia Support worker provides tailored information, advice and signposting. They support people affected by dementia to navigate a complex web of health and social care services to access appropriate information and can help them to plan for the future and self-manage effectively. This array of knowledge and skills makes them perfectly placed to play the role of or support the discharge coordinator.<br><br>Plans about the date and time of discharge should be discussed with the patient and their carer. Hospital staff must ensure that transport to the person's home or care home | Badly co-ordinated discharge can lead to a variety of negative outcomes for people with dementia including extended stays in hospital, emergency readmissions and early entry to a care home.<br><br>In 2011, emergency readmissions within 30 days for people with dementia cost the NHS an estimated £109.6 million, whilst extra days spent in hospital by people with dementia was estimated to have cost the NHS at least £83.3 million.<br><br>Economic research has found that that £11,296 per person per year could be saved by delaying entry to residential care if just 5 per cent of admissions to residential care were to be delayed for one year as a result of dementia-friendly communities (Alzheimer's Society, 2013). This would deliver a net saving of £55 million per annum across England, Wales and Northern Ireland.<br><br>Better coordinated discharge would | CHKS report on NHS costs of poor discharge<br><br>http://www.chks.co.uk/userfiles/files/Dementia_an_economic_analysis.pdf |

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| | | | has been arranged. They should also take extra care when making plans to discharge someone on a Friday, or during a weekend, as it may be difficult to contact home care workers and GPs on these days. Hospital discharge policies should include details of what to do in such circumstances. Alzheimer's Society knows that some people with dementia have been discharged during the night. Under no circumstances should this happen and a discharge co-ordinator should work with hospital staff to ensure the person is discharged at an appropriate time | reduce these costs across health and social care.<br><br>A quality statement on a discharge coordinator for all people leaving hospital would encourage hospitals to adopt this role. | |
| 021 | SCM2 | Key area for quality improvement 3<br>Have a single health or social care professional responsible for co-ordinating the person's discharge and communicating with relevant team members and person and family / carers. | Discharge planning should start on admission and where multiple team members are involved where people have complex health and social care needs, all too easily can "chinese whispers" become the normal. The result: a delayed and disjointed discharge process with potential miscommunication with patient, carers and relatives to adverse sequelae with risk of readmission. | As multi-disciplinary teams become established, it is important that there is a key person identified to co-ordinate the outcomes and liaise with the relevant stake-holders.<br>This is particularly challenging in Acute Medical Units where there is a high turnover of patients and staff throughout the day. However it is particularly important even there as in excess f 50% of unplanned admissions to hospitatal can be discharged from the Acute Medical Unit or other "front facing" frailty unit. | See evidence base around NG 27 guidelines 1.5.1 |
| 022 | SCM2 | Key area for quality improvement 4 | There is large variation as to quality and timeliness of discharge | This is a key area which is eminently auditable with lends itself to Quality Improvement projects | See evidence base around NG 27 guidelines 1.5.6 |

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| | | Ensure discharge communication in the form of a discharge summary is AVAILABLE to the person's GP within 24 hours and to the person at the time of discharge | summaries.<br>Some may be electronic, some paper format, at times they may be sent onwards to the person post discharge.<br>Where the discharge process is complex, without relevant information available to community teams at the point of discharge, the risk of readmission grows. | locally.<br>The potential gain here should discharge summary quality and timeliness be reliably of a high standard could be large. | |
| 023 | SCM2 | Key area for quality improvement 5<br>Ensure appropriate follow-up of person's at high risk of readmission within 24-72 hours. | There I again a wide variety of practice. Some areas will ensure follow-up from the hospital team (phone call or other), others none at all, others asking for GP follow-up but may not be within firs 3 days where risk of re-admission is highest. | This is an area relevant to reducing early readmissions and forces through optimising channels of communication between secondary and primary care. | See evidence base around NG 27 guidelines 1.5.28 |
| 024 | SCM3 | 3. The awareness of staff supporting the discharge process of what is available and capacity therein at any given time | Also (NG27 1.6.3) the need to ensure that all care providers…are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions. | | |
| 025 | SCM (Social care of older people with long-term conditions) | 4.The integration of health and social care services to support early hospital discharge | Ensure that older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package in order to maximise function and independence. | Evidence shows that Patients who are mentally alert, medically well and mobile postoperatively are most likely to benefit from a supported discharge scheme. Supported discharge schemes have also been shown to improve patients' abilities to carry out activities of daily living. Evidence also shows that interventions that | Please see the following article; 'R Linertova, L Garcia-Perez, JR Vazquez-Diaz, A Lorenzo-Riera, and A Sarria-Santamera. (2014) Interventions to reduce hospital readmissions in the elderly: in-hospital or home care. A systematic review, University of York |

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| | | | | incorporate some component of home care were more likely to reduce hospital readmissions in elderly patients, | |
| **Supporting infrastructure** | | | | | |
| 026 | Skills for Care | Before admission /supporting infrastructure | Some local areas have integrated health and care services which can notify likelihood of admission and increase community support to prevent admission. These are excellent ways of not only saving money but providing best support for person in their own home without moving to hospital base setting. Properly resourced social are services are vital to this admission prevention work | Reduces admissions. Supports health and wellbeing of patient / service user | Vanguard / Integration Pioneers sites |

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| 027 | Royal College of Nursing | Short term interventions to support timely discharge or prevent admission | To prevent avoidable admissions to secondary care and to support timely discharge back to primary and community care | 'Intermediate Care services', re-ablement and rehabilitation are key to supporting people to remain at home or get home and need to be robust, responsive and coordinated. They are still often fragmented, provided by several organisations and are not always available depending where people live. | National Audit for Intermediate Care – NHS Benchmarking http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care.php<br><br>NICE guideline NG27 – Transition between inpatient hospital settings and community or care home settings for adults with social care needs |
| 028 | Royal College of Nursing | Additional developmental areas of emergent practice | Much more community services supporting people to remain at home, get home or remain in their care home. These need to be responsive, coordinated and from a variety of sources to ensure that the correct expertise is available | There is a lack of vision and innovation in utilising non statutory support services. There are still huge discrepancies in service provision across the country. The schisms between the statutory services are making coordinated care difficult. | NICE guideline NG27 – Transition between inpatient hospital settings and community or care home settings for adults with social care needs |
| 029 | Care and Repair England | Develop standards for tackling people's housing needs and circumstances as an essential part of hospital admissions prevention and hospital discharge planning | Most people in hospital want to go home as soon as possible, Preventing admissions due, in part, to the impact of a poor and unsuitable home environment and ensuring early discharge to a suitable, warm safe home will help | The Care Act expects local councils to ensure the integration of care and support including housing. In the Care Act guidance there is recognition that the suitability of living accommodation is a core component to enable people to live | 1. A report from Age UK (http://www.ageuk.org.uk/latest-press/archive/age-uk-show-an-escalating-social-care-crisis-in-england/)<br>identifies that from (April 2014 to March 2015), shortages in |

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| | | | to improve transitions.<br><br>Many older people are living in homes that do not meet the Decent Homes standard.<br><br>Cold and unsuitable home conditions can directly cause health problems (such as heart disease, stroke, respiratory, arthritis and risk of falls), and hence hospital admissions and delayed discharges. If individuals are discharged to unsafe, cold, unsuitable homes they are more likely to return to hospital. It is generally better for older peoples' health if they are discharged as soon as they no longer need hospital level medical care, hence addressing housing shortcomings can be a key element of effective hospital discharge.<br><br>Cold homes have a serious impact on older people's health. On average, over each of the last few years, there have been 27,000 excess winter deaths; more than 90% of these deaths occur in the over 60s age group and can be attributed to cold-related illnesses such as heart attacks, strokes and respiratory conditions. | independently and a recognition that getting housing right can help to prevent falls, hospital admissions and readmissions.<br><br>The NICE guidance on transitions between inpatient hospital settings and community care or care home settings for adults with social care needs has, in line with the Care Act 2014, covered health related provision (including housing) as well as health and other care and support.<br><br>Developing quality standards in this area would help to further integrate housing solutions into what is a transition home. If people are to be supported to stay home for longer (out of hospital) or get home sooner it stands to reason that where they live and the suitability of their home is a key component of that transition. Whilst some people will have no concerns about their housing many will need repairs and adaptations and advice and support to keep them safe and secure, particularly older people with long term health conditions. | community health and social care services meant the NHS has lost many hundreds of thousands of bed-days while patients wait for the right care and support in the right place with home adaptations being one of the issues identified.<br>•174,138 days waiting for a place in a residential home<br>•215,662 days waiting for a nursing home place to become available<br>•206,053 days for help from social care workers or district nurses to enable people to return to their own home<br>•41,389 days for home adaptations ranging from grab rails to ramps and stair lifts.<br><br>2. A report from BRE (Building Research Establishment funded by PHE - Homes and Ageing in England has identified that poor housing for older people costs the NHS at least £634m every year.<br>Two million older people live in homes that fail to meet the Decent Homes Standard, with 1.3m in a home with a serious hazard, resulting in high costs to the NHS, particularly due to cold |

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| | | | Each year 35% of people aged 65 and over will fall one or more times; 45% of those aged 80 years and over who live in the community fall each year http://www.slips-online.co.uk/resources/Fallsandfractures-effectiveinterventionsinhealthandsocialcare.pdf<br><br>Of those that fall between 10% and 25% will sustain a serious injury; the personal consequences of a fall for the individual can be significant.<br><br>Evidence shows falls are a major contributor to hospital admission/readmission and that home hazards contribute to falls.<br><br>Reducing the risk of falls can support safe, effective transition and home hazards are a key part of that risk reduction as evidenced by NICE guidance on falls<br><br>Given the importance of housing to health, effective transitions require links to initiatives that help people to repair and adapt their home to make sure their living environment supports their health and well-being preventing hospital admission | | related health problems and falls.<br><br>http://www.bre.co.uk/filelibrary/Briefing%20papers/86749-BRE_briefing-paper-PHE-England-A4-v3.pdf<br><br>3. A report from Care & Repair England 'If only I had known…' evaluated projects to enable older people and their carers to make informed decisions about future housing, care and support either following hospital admission or where a person had a long term health condition.<br><br>No longer being able to climb stairs, use a bath or a standard height WC are common housing difficulties that impact on older peoples' ability to leave hospital. Practical housing help to adapt or repair the home, or moving home if this is not possible, can therefore make all the difference to the hospital discharge, as well as older people's quality of life at home. Housing advisers were located within pilot area hospitals working with patients and health staff to improve the |

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| | | | and/or supporting people to go home quickly and safely.<br><br>It also requires links to information, advice and support services for older people and their carers on their housing choices whilst in hospital or where they are in touch with health professionals. | | transfer of older patients from hospital to home. They made sure that patients were returning to a suitably repaired or adapted home, or to a different home, thereby reducing the risk of readmission as well as improving older peoples' quality of life.<br><br>Evaluation reports about the programme describe the work in detail, demonstrating how housing help improved the lives of older patients as well as resulting in quantifiable savings for health and social care.<br><br>Link to summary http://careandrepair-england.org.uk/wp-content/uploads/2014/12/IOIHK-Brochure-Hospital-Housing.pdf<br><br>4. A report from EAC/First Stop - Making the Case sets out how local integrated FirstStop housing and care information and advice services help to deliver on care and health outcomes, improve the well – being of older people and make savings to the public purse. |

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| | | | | | The report is the result of an independent evaluation using data from DCLG (Department of Communities and Local Government) funded local housing and care options advice services and interviews in four local areas with service users, key local stakeholders and staff.<br><br>It identified a saving of £11.5 million to health and care services from an investment of less than £500,000 by DCLG to 16 local FirstStop services in 2015 – 16. This was due to the avoidance of falls, preventing unplanned hospital admissions and GP appointments. Local FirstStop services also identify and secure aids, adaptations and improved heating and, where appropriate, alternative housing options to support successful hospital discharge for people with complex health conditions.<br><br>http://www.housingcare.org/downloads/kbase/3432.pdf |
| 030 | Care and Repair England | Additional developmental areas of emergent practice | There are emerging examples of good practice in linking housing and health to reduce admissions and | | |

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| | | | improve discharge. Some examples are identified on our website at http://careandrepair-england.org.uk/home-from-hospital-initiatives/<br>These include housing advisers working in hospitals and with GP's and Home Improvement Agencies offering fast track repairs, adaptations and handyperson services to support people to get home from hospital. We would welcome standards that identify this good practice so that it becomes available in all areas of the country as an integral part of discharge planning. | | |
| 031 | AGILE – Physiotherapy Professional network for older people (Chartered Society of Physiotherapy) | Where 'discharge to assess' models are implemented there must be adequate care provision on discharge to fully support the patient and a strong community multidisciplinary assessment model that means the patient receives an ongoing coordinated programme of care capable of meeting the diversity and intensity of their needs. These teams must be appropriately skilled to manage frailty as evidenced by team members possessing qualifications appropriate to their grade. | Discharge to assess is gaining popularity in efforts to reduce acute length of stay and reduce four hour ED breaches. There is little standardisation of services offered post discharge or the criteria which are used to determine that patients are ready to be discharged to continue their assessment outside of hospital. | Failure to agree standards for using discharge to assess models will result in high degrees of variability and possibly in less safe care. | National audit of intermediate care 2015.<br>Nice guideline CG124 Hip Fracture Management.<br>Improving hospital discharge and intermediate care for older people. (Kings fund 2015) |
| 032 | SCM3 | Access to recuperation, rehabilitation, reablement and | NICE guidance (NG27 1.5.11) identifies as a key principle the | Nationally there are large variations in the numbers of people admitted | Adult Social Care Outcomes Framework, 2A, 2B, 2C, 2D |

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| | | other intermediate care services:<br>1. That consideration of discharge to recuperation, rehab, reablement or other intermediate care services should be the first priority for people when their hospital discharge is being planned (i.e. no one should go straight to a care home without this being considered) | need to ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis. | to long term residential and nursing care. This suggests variations in practice in relation to the hospital discharge planning process whereby people are not consistently considered for recuperation/rehab etc prior to discharge and/or there is insufficient availability of community based recuperation, rehabilitation, reablement and other intermediate care services which allow people the opportunity to maximise their independence and consider their future care and support options and/or staff supporting the discharge process do not have access to information about the availability of these services at any given time. There are also variations in the numbers of delayed transfers of care attributed to admissions to residential or nursing care. | http://www.hscic.gov.uk/article/2021/Website-Search?productid=18979&q=2B&topics=13206&infotype=13367&sort=Relevance&size=10&page=1&area=both#top |
| 033 | SCM3 | 2. The availability of the right mix and levels of recuperation, rehab, reablement and other intermediate care services in the community | Also (NG27 1.6.1) the need to ensure that a range of local health, social care and voluntary sector services is available to support people when they are discharged from hospital. | | |
| 034 | SCM (Social care of older people with long-term conditions) | 1.Provision of Reablement for older people with social care needs and multiple long term conditions on discharge from hospital | The provision of reablement is a high priority for central and local government as evidence shows that reablement has positive outcomes for people who use services, providers and commissioners. | Evidence shows that flexibility is key to the success of reablement and therefore there needs to be an outcomes focused approach to commissioning reablement | NICE guidelines NG27 ‘Transition between inpatient hospital settings and community or care home settings for adults with social care needs’ 1.6.1 NICE Dec 2015. |

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| | | | Provision or reablement is recommended by NICE guidelines. | | Please see Social Care Institute for Excellence (2012) At a Glance 56: Making the move to delivering reablement, London, Social Care Institute for Excellence, |
| 035 | SCM (Social care of older people with long-term conditions) | 2. It is crucial that people who provide reablement receive specialist training. | In order to ensure that reablement providers are trained in delivering specialised interventions as opposed to domicillary care. | Evidence shows that there needs to be a significant shift in the culture of working – which some care workers will adapt to more easily than others – for reablement to happen. | As above |
| 036 | SCM (Social care of older people with long-term conditions) | 3.The provision of occupational therapy as a critical and essential part of the reablement pathway | The occupational therapist's strengths in assessment and goal planning are integral to service users achieving personalised outcomes. Rapid access to both occupational therapy skills and equipment is essential to avoid delays in people's progress. Occupational therapists have the skills and expertise to provide training to care workers delivering reablement. Advice on rehabilitation techniques from occupational therapists can assist the continuous reablement process for people with complex conditions | Evidence from research and practice shows that occupational therapists have an important role in the delivery of reablement | Please see; Social Care Institute for Excellence (2011) At a Glance 46: Reablement; A key role for occupational therapists, London, Social Care Institute for Excellence, |
| **Involving carers** | | | | | |
| 037 | City Health Care Partnership CIC | Carers | The vital support that carers can provide should be respected and recognised by professionals.<br><br>We ned to ensure that carers are | Encourage informed choices<br><br>Respecting needs and preference | Importance of early supported discharge is highlighted in:<br>http://www.nottingham.ac.uk/clahrc-ndl-nihr/documents/stroke-rehabilitation/139026921551247 |

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| | | | supported to be able to continue to care effectively and safely.<br><br>Patients and their carers should be fully involved with decision making to foster support and collaboration. | | 4030full.pdf<br>Carers strategy<br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368478/Carers_Strategy_-_Second_National_Action_Plan_2014_-_2016.pdf |
| 038 | SCM1 | 1.5.32<br>A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers. | The NHS and social care systems are heavily dependent on the support provided by unpaid carers. Indeed, a recent report by Carers UK[2] estimates the support provided by informal caregivers to be valued in the region of £132 billion a year. As this is close to the annual cost of healthcare provision in the UK (and is expected to continue to rise as more people require care, but there is less available social care support), it is vital that carers are recognised for the contributions that they make. It is also important to ensure that carers are given appropriate information and support to enable them to carry out their caring role, without unnecessary delays and frustrations caused by a lack of co-ordinated services, which can at times prevent them for being able to provide care. | Carers are an extremely valuable resource. However, they report having significant difficulties in accessing appropriate training to meet their caring role[3], support and information with regard to navigating the fragmented and disjointed service provision provided by health and social care service providers. Additionally, as carers are more likely to have poorer health outcomes than the general population, there is a high risk that inadequate support will lead to further deterioration in wellbeing and a potential break down in their ability to carry out the caring role. This is supported by the 2015 GP patient survey, which shows:<br>Carers are far more likely than non-carers to have a long-standing health condition (51% of non-carers; 63% of carers)<br>The chances of a carer having a | Included within main body of text (e.g. National Dementia Strategy) and as footnotes. |

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| | | | However, there is a cost to providing informal, unpaid care in terms of financial, physical and emotional implications. This also needs to be recognised, acknowledged and supported in order to minimise the impact of the caring role, as well as to ensure that the in order to prevent the carer from being unable to provide care. | long-standing health problem get worse the more care they provide (70.1% of carers providing 50 or more hours a week have a long standing health problem)<br>Carers have higher levels of arthritis, high blood pressure, long-term back problems, diabetes, mobility problems than non carers, and again this increases the more care they provide.<br>Carers are often excluded from planning and decision making, particularly in relation to hospital discharge. When informal care provision breaks down, people with health and social care needs may need to be admitted to hospital. They are also more likely to experience delays in discharge from hospital and in many cases (particularly in relation to individuals with dementia), they are discharged straight from hospital to a care home (Alzheimer's Society, 2009; CSCI 2004, 2005 cited in the National Dementia Strategy – Equalities Action Plan).<br><br>Appropriate information provision, support and training is therefore vital in order that a carer feels able to provide appropriate support to the individual for whom they are caring. | |

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| **Other** | | | | | |
| 039 | London Fire Brigade | Reduction in fires, fire deaths and fire injuries for people in receipt of care and support in home and community care settings. | The prevalence of people in receipt of care and support in home and community care settings in the occurrence of fatal fires and those where injuries were serious enough to require lengthy hospitalisation. | Evidence that opportunities to identify and address fire risk for people in receipt of care have been missed by care and support agencies. | London Fire Brigade<br>Annual Review Of Accidental Dwelling Fires and Fatalities – FEP 2484<br><br>http://moderngov.london-fire.gov.uk/mgconvert2pdf.aspx?id=4384 |
| 040 | Royal Pharmaceutical Society | Medicines Optimisation | When patients move between different settings, including between different hospital wards, information about their medicines is not always accurately transferred. | There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem.<br><br>The Royal Pharmaceutical Society has produced guidance on the information that should be transferred about a person's medicines when they move between different care settings and this can be found at http://www.rpharms.com/previous-projects/getting-the-medicines-right.asp | Problems with medicines are a common reason for admissions and readmissions into hospital. In 2010 an audit across 50 acute trusts involving over 8600 patients found that when medicines were checked after admission most patients had at least one omitted drug or wrong dose. Earlier estimates suggest that between 30 and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred.<br>Many people now have more than 1 long term condition and are therefore on a number of different medicines to treat their condition(s). They are often treated for each single condition rather than a holistic approach which means that sometimes |

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| | | | | | interactions between medicines, or medicines and conditions, can be overlooked. |
| 041 | City Health Care Partnership CIC | Medication | The prescribing of medicines is perhaps the most common patient care intervention with 60% of alder people having 3 or mare changes to medications whilst in Hospital (Healthwatch 2015) | Poor compliance or unintended changes to medicine regimes an jeopardise treatment and increase the risk to re-admission | http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/discharge/index.html |
| 042 | Royal College of Nursing | A willingness to take more risks when the individual has identified what is important to them | Many people are denied what they really want to happen to them because of the risk averse nature of the current services. Data Protection, Health and Safety legislation and risks are often used as reasons to NOT do the right thing by an individual and this must be addressed. | If we really ascribe to person centred individualised care then the risks have to be accepted as long as the individual and their family are aware of them and agree to them after a proper discussion. It is the responsibility of the providers to then ensure that they are able to provide those services as long as their staff are aware of the issues and that they are protected from injury. | NICE Guidance PH17 - Physical activity for children and young people |
| 043 | Royal Pharmaceutical Society | Shared decision making | It is important to ensure that people are involved in the decisions about their medicines, that they understand the risks and benefits of taking them and that they make the ultimate informed decision based on their lifestyle and their beliefs | If patients are fully involved and engaged in the decisions about their medicines they are more likely to take them and also have a better understanding of the risks and benefits of doing so. | A body of evidence is forming that demonstrates that clinicians who have undergone health coaching training can support and empower patients in a different way that involves the patients in decisions about their care. An example of this can be found at http://www.employment-studies.co.uk/resource/case-health-coaching |

| ID | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 044 | Alzheimer's Society | Ensure that people needing end-of-life care are offered both general and specialist palliative care services, according to their needs. | All people who develop dementia will have dementia at the end of their lives, either as the condition they die from or as a factor which may complicate the care of a different condition. Diminishing capacity means that it is important for the person with dementia to plan for the end of their life at an early stage. Problems with capacity and communication can also contribute to undignified treatment and the under treatment of pain in people with dementia at the end of their lives.<br><br>Significant, co-ordinated and holistic support is needed to ensure that all people with dementia end their lives with dignity, free from pain and in the place of their choosing.<br>End-of-life care for a person with dementia requires a team approach, including hospital staff, their GP, community nurses, social worker or care home staff – among others. Palliative care staff at a local hospice or hospital should give specialist input as required. The team should keep carers and families updated as the person's condition changes and involve them in any decisions.<br><br>The person should always have an | Alzheimer's Society knows that palliative care for people with dementia is variable and by prioritising this quality standard there could be better consistency across the country. In December 2014, Marie Curie and Alzheimer's Society published a report examining the issues with people with dementia and end-of-life care. It found that there were still barriers in identification, access to palliative care and in the quality of care that was received (Marie Curie and Alzheimer's Society, 2014). The Health Select Committee inquiry into end-of-life care found that round-the-clock palliative care in the community was important, but was too often difficult to access, especially for people with dementia (House of Commons Health Committee, 2015).<br><br>A quality statement that people needing end-of-life care are offered general and specialist palliative care services in relation to their needs and aspirations will help ensure people's end of life plans are respected and that people can die with dignity. | Marie Curie and Alzheimer's Society, 2014 Living and dying with dementia in England: Barriers to care<br>http://www2.mariecurie.org.uk/Documents/policy/dementia-report.pdf<br><br>Health Select Committee Inquiry into End of Life Care<br>http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/805/805.pdf<br><br>Choice in End of-life Care Programme Board, 2015<br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407244/CHOICE_REVIEW_FINAL_for_web.pdf |

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| | | | up-to-date care plan that includes end-of-life plans and is shared with those involved in the person's care as appropriate. | | |
| **Additional evidence sources** | | | | | |
| 045 | Royal College of Nursing | Additional evidence sources for consideration | The access to Continuing Health Care is a huge barrier to supporting transition. Arguments over who pays what, needs to be simplified.<br><br>The Mental Capacity Act also needs to be updated and clarified to prevent decisions being made about people's mental capacity when they are not in their usual place of residence and so likely to present as less capable than they are. | | |
| 046 | Care and Repair England | Additional evidence sources for consideration | We would ask that two further reports are added to the list of key policy documents, reports and national audits to the Quality Standards Topic Overview to ensure that housing issues are considered in scope in the quality standard. These are<br>Memorandum of Understanding on integrating housing with health which has been developed with a range of partners such as DH, DCLG, PHE, ADASS, NHS England, LGA http://careandrepair-england.org.uk/wp- | | |

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| | | | content/uploads/2014/12/A_Memorandum_of_Understanding_MoU_to_support_joint_action_on_improving_health_through_the_home.pdf<br>Hospital2home resource pack – a very practical guide to considering older people's housing situation in hospital discharge developed with a range of partners including DH, DCLG, ADASS. LGA, RCN, Age UK http://www.housinglin.org.uk/hospital2home_pack/<br><br>We are aware that, in developing the guidance on this topic, we offered evidence on the impact of housing interventions to NICE which did not meet your criteria for inclusion. Much of this was focused on the impact of housing adaptations and repairs on health outcomes. Care and Repair England has been looking at how to stimulate fresh research on the impact of housing interventions in health and care bringing together researchers and key stakeholders to work on projects that have practical application. The project is called Catch 22 (See http://careandrepair-england.org.uk/?page_id=205)<br><br>Work already developing in this field includes the cost/ benefits of | | |

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| | | | adaptations, use of RCT in relation to adaptations, evidence on the impact of falls prevention and work on housing decision making. We would be happy to share this work with NICE.<br><br>We would also draw attention in this context to the planned programme of the Centre for Ageing Better which aims to share and apply evidence to help people age better. http://www.ageing-better.org.uk/our-work/topics In its recent topic list it has identified homes and neighbourhoods as being critical to enabling people to remain independent and has set an agenda on this area - one action being to synthesise evidence about which home design and adaptations are most cost effective. In their report they state that providing adaptations to support an older person to remain at home for just one year can save £28,000 on long-term care costs ( http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdfliver et al 2014)<br><br>Including a consideration of people's housing needs and | | |

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| | | | circumstances in the NICE quality standard would not only help to deliver better quality for people but also save on health costs. | | |
| 047 | City Health Care Partnership CIC | Additional evidence sources for consideration | Healthwatch Report 2015 http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/170715_healthwatch_special_inquiry_2015_1.pdf | | |
| 048 | British Geriatrics Society | The British Geriatrics Society's president-elect Dr Eileen Burns helped to develop this guidance so we have nothing to add to it and are happy with the content. | | | |