Transition between inpatient hospital settings and community or care home settings for adults with social care needs

NICE quality standard

Draft for consultation

April 2016

Introduction

This quality standard covers admissions into, and discharge from, inpatient hospital settings for adults (18 and older) with social care needs. It does 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).

For more information see the transition between inpatient hospital settings and community or care home settings for adults with social care needs topic overview.

Why this quality standard is needed

Several health, social care and other services are involved when adults with care and support needs move into or out of hospital from the community or a care home. 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 (such as 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.

NHS England's Delayed transfers of care statistics for England show that, in 2014/15, every day an average of 3.7 adults per 100,000 population had their transfer of care delayed. This is equivalent to over 1,500 delayed transfers a day throughout England. This is up from 3.1 per 100,000 in 2013/14.

Healthwatch England's Safely home: what happens when people leave hospital and care settings? report (2015) highlighted that poor hospital discharge practice leads to unnecessary problems for patient and wasted resources.

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

The quality standard is expected to contribute to improvements in the following outcomes:

- health-related quality of life
- social care-related quality of life
- people's experience of care
- hospital readmissions within 30 days of discharge
- delayed transfers of care.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- Adult Social Care Outcomes Framework 2015–16
- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–16.

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*** 1A Social care-related quality of life** **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs** 1B Proportion of people who use services who have control over their daily life ***Outcome measures*** **Carers can balance their caring roles and maintain their desired quality of life** 1D Carer-reported quality of life**
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population ***Outcome measures*** **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** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* 2D The outcomes of short-term services: sequel to service *Placeholder 2E The effectiveness of reablement services* **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** 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*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services *Placeholder 3E The effectiveness of integrated care* ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **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** 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*** 4A The proportion of people who use services who feel safe** ***Outcome measures*** **Everyone enjoys physical safety and feels secure** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 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 * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** **Enhancing quality of life for people with dementia** 2.6 i Estimated diagnosis rate for people with dementia* *ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life*** **Improving quality of life for people with multiple long-term conditions** *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*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* ***Improvement areas*** **Helping older people to recover their independence after illness or injury** 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* ii Proportion offered rehabilitation following discharge from acute or community hospital*

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

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

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

Safety and people's experience of care

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to transitions between hospital and the community or a care home for adults with social care needs.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to people using services. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect people's experience of using services and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for transition between inpatient hospital settings and community or care home settings for adults with social care needs specifies that services should be commissioned from, and coordinated across, all relevant agencies. It also specifies they should encompass the whole care pathway. A person-centred,

integrated approach to providing services is fundamental to delivering high-quality care to adults with social care needs transitioning between hospital and the community or a care home.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality transition between hospital and the community or a care home are listed in related quality standards.

Legislation and policy

This quality standard has been developed in the context of important legislative changes that have a significant impact on people with care and support needs moving between hospital and the community or a care home. Implementation of the Care Act 2014 establishes new provisions as well as updating existing ones, bringing together relevant policy and guidance affecting people with care and support needs.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health, public health and social care practitioners involved in assessing, caring for and treating adults with social care needs transitioning between hospital and the community or a care home should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults with social care needs transitioning between hospital and the community or a

care home. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care. If there is doubt about the person's capacity to consent, the principles of the Mental Capacity Act must be followed.

List of quality statements

Statement 1. Adults with social care needs who are at risk of admission to hospital have a contingency plan for hospital admission.

Statement 2. Older people with complex needs have a comprehensive geriatric assessment started at the point of admission to hospital.

Statement 3. Adults with social care needs in hospital have a discharge coordinator.

Statement 4. Adults with social care needs are given a copy of their agreed discharge plan before being discharged from hospital.

Statement 5. Adults with social care needs who will be supported by family and carers after discharge from hospital have them involved in discharge planning.

Statement 6. Adults with social care needs are given a complete list of their medicines when they are discharged from hospital.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect the data for the proposed quality measures? If not, how feasible would it be for these systems and structures to be put in place?

Question 3 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to

the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Question 4 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resources that you think would be needed for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

Question 5 For draft quality statement 6: Is medicines information covered by statement 4 on discharge plans?

Quality statement 1: Planning for admission

Quality statement

Adults with social care needs who are at risk of admission to hospital have a contingency plan for hospital admission.

Rationale

Having a plan for hospital admission can lead to a smoother transition by improving communication between community and hospital services. It can improve people's experience of hospital by helping them to know what to expect. It can also allow for other aspects of the person's life to continue as normal, such as arrangements at home.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs who are at risk of admission to hospital have a contingency plan for hospital admission.

Data source: Local data collection.

Process

The proportion of adults with social care needs and who are at risk of admission to hospital who have a contingency plan for hospital admission.

Numerator – the number in the denominator who have a contingency plan for if they are admitted to hospital.

Denominator – the number of adults with social care needs who are at risk of admission to hospital.

Data source: Local data collection.

Outcome

a) People's experience of planning for hospital admission.

Data source: Local data collection

b) Carer experience of planning for hospital admission.

Data source: Local data collection

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as GPs, community services and local authorities) ensure that systems are in place for adults with social care needs who are at risk of admission to hospital to have a contingency plan for hospital admission.

Health and social care practitioners (such as named care coordinators, GPs and social workers) ensure that adults with social care needs who are at risk of admission to hospital have a contingency plan for hospital admission.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that they commission services in which adults with social care needs who are at risk of admission to hospital have a contingency plan for hospital admission.

What the quality statement means for patients, service users and carers

Adults with social care needs who are at risk of needing to go into hospital have a written plan for their care if they do go into hospital. This plan should be available to the hospital team if they are admitted into hospital.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.2.1

Definitions of terms used in this quality statement

At risk of admission to hospital

Local areas can use existing population segmentation and risk stratification models to determine who is at high risk of admission to hospital. These may be based on

clinical knowledge, threshold modelling or predictive modelling. More information is available from NHS England:

- List of risk stratification approved organisations (2015)
- Next steps for risk stratification in the NHS (2015)
- Using case finding and risk stratification (2015)

[Adapted from NHS England (2015) Case finding and risk stratification handbook and expert opinion.]

Quality statement 2: Comprehensive geriatric assessment

Quality statement

Older people with complex needs have a comprehensive geriatric assessment started at the point of admission to hospital.

Rationale

Older people make up a significant proportion of hospital admissions, and many have complex medical, functional, psychological and social needs. Identifying these, by using a comprehensive assessment, allows practitioners to develop a long-term plan to manage their needs. This could reduce the length of hospital stay, and enable older people to regain their independence sooner and maintain it for longer. The assessment could be carried out in a specialist unit for older people.

Quality measures

Structure

Evidence of local arrangements to ensure that older people with complex needs have a comprehensive geriatric assessment started on admission to hospital.

Data source: Local data collection.

Process

Proportion of older people with complex needs who have a comprehensive geriatric assessment started at the point of admission to hospital.

Numerator – the number in the denominator who have a comprehensive geriatric assessment started at the point of admission to hospital.

Denominator – the number of older people with complex needs admitted to hospital.

Data source: Local data collection.

Outcome

a) Length of hospital stay.

Data source: Local data collection.

b) Permanent admissions to residential and nursing care homes in the 12 months after hospital admission.

Data source: Local data collection. National data on permanent admissions to residential or nursing care is collected as part of the Adult Social Care Outcomes Framework indicator 2A.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place to start comprehensive geriatric assessments when older people with complex needs are admitted to hospital.

Health and social care practitioners (such as geriatricians) ensure that they start a comprehensive geriatric assessment when older people with complex needs are admitted to hospital.

Commissioners (clinical commissioning groups) ensure that they commission services in which older people with complex needs have a comprehensive geriatric assessment started when they are admitted to hospital.

What the quality statement means for patients, service users and carers

Older people with complex needs have a thorough review of their needs when they go into hospital. This is done by healthcare professionals with specialist knowledge in caring for older people. This may be in a unit that is only for older people. The aim is to make a long-term plan for the support they need after they leave hospital.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.3.10

Definitions of terms used in this quality statement

Older people with complex needs

Older people who need a lot of support because of physical frailty, chronic conditions or multiple impairments (including dementia). Many will be affected by other factors including poverty, disadvantage, nationality, ethnicity and lifestyle. Older people generally refers to people who are 65 or older, but could include people who are younger, depending on their general health, needs and circumstances.

The presence of 1 or more of the following should trigger a comprehensive geriatric assessment, to start within 2 hours (14 hours overnight):

- falls
- immobility
- delirium and dementia
- polypharmacy
- incontinence
- end of life care.

[Adapted from Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline NG27), British Geriatric Society (2012) Quality care for older people with urgent & emergency care needs: 'Silver book' and Joseph Rowntree Foundation (2013) A better life: valuing our later years.]

Comprehensive geriatric assessment

A comprehensive geriatric assessment is an interdisciplinary diagnostic process to determine the medical, psychological and functional capability of someone who is frail and old. The aim is to develop a coordinated, integrated plan for treatment and long-term support. [Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline NG27)]

Quality statement 3: Coordinating discharge

Quality statement

Adults with social care needs in hospital have a discharge coordinator.

Rationale

Poor coordination related to plans for leaving hospital can result in distress and reduced quality of life for people using services and their carers. Making a single health or social care practitioner responsible for coordinating discharge can help to make the transition smoother (for example, this person can liaise with community services to arrange follow-up care). The discharge coordinator should be involved in discharge planning from admission, and throughout the person's hospital stay.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs in hospital have a discharge coordinator.

Data source: Local data collection.

Process

Proportion of adults with social care needs in hospital who have a discharge coordinator.

Numerator – The number in the denominator where a discharge coordinator is assigned.

Denominator – The number of discharges from hospital of adults with social care needs.

Data source: Local data collection.

Outcome

a) Delayed transfers of care for adults with social care needs.

Data source: Local data collection. Delayed transfers of care data is published by NHS England.

b) People's experience of discharge process.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place so that adults with social care needs have a discharge coordinator.

Health and social care practitioners (for example, members of the hospital-based multidisciplinary team) ensure that they involve the discharge coordinator in all decisions about discharge planning for adults with social care needs.

Commissioners (clinical commissioning groups) ensure that they commission services that provide a discharge coordinator for adults with social care needs.

What the quality statement means for patients, service users and carers

Adults with social care needs in hospital should be given the name of the person who will be responsible for coordinating their discharge from hospital. This person will work with the adult, and their family or carers, to plan their move out of hospital.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.5.1

Definitions of terms used in this quality statement

Discharge coordinator

A single health or social care practitioner responsible for coordinating the person's discharge from hospital. A discharge coordinator may be a designated post or the task may be assigned to a member of the hospital- or community-based

multidisciplinary team. They should be chosen according to the person's care and support needs. A named replacement should always cover their absence. The discharge coordinator should be a central point of contact for health and social care practitioners, the person and their family during discharge planning, and should be involved in all decisions about discharge planning. They should arrange follow-up care, discuss the need for any specialist equipment and support with community services and, once assessment for discharge is complete, agree the plan for ongoing treatment and support with the community-based multidisciplinary team. [Adapted from Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline NG27) recommendations 1.5.1, 1.5.2, 1.5.17, 1.5.18 and 1.5.19.]

Equality and diversity considerations

Barriers to communication can hinder people's understanding of transitions and their involvement in making decisions. For example, learning or cognitive difficulties; physical, sight, speech or hearing difficulties; difficulties with reading, understanding or speaking English. These needs should be taken into account and adjustments made to ensure all adults with social care needs can be involved in making decisions about their care, if they have the capacity to do so.

Quality statement 4: Discharge plans

Quality statement

Adults with social care needs are given a copy of their agreed discharge plan before being discharged from hospital.

Rationale

A discharge plan is an important part of coordinating discharge. It can then be shared with everyone involved with the person's ongoing care and support. This communication can improve the success of the transfer and reduce the chance of hospital readmission. It is important that the person agrees and understands their own discharge plan to improve their own experience of the discharge process.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs are given a copy of their agreed discharge plan before being discharged from hospital.

Data source: Local data collection.

Process

Proportion of discharges from hospital for adults with social care needs in which they are given a copy of their agreed discharge plan before being discharged from hospital.

Numerator – the number in the denominator in which adults are given a copy of their agreed discharge plan before being discharged from hospital.

Denominator – the number of discharges from hospital of adults with social care needs.

Data source: Local data collection. Contained within the NHS Inpatient Survey.

Outcome

a) Readmission rates.

Data source: Local data collection. National data on emergency readmissions within 30 days of discharge from hospital are available from the Health and Social Care Information Centre as part of the NHS Outcomes Framework – indicator 3b.

b) People's experience of discharge from hospital.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place for adults with social care needs who are being discharged from hospital to be given a copy of their agreed discharge plan.

Health and social care practitioners (discharge coordinators and members of the hospital- and community-based multidisciplinary teams) ensure that they give a copy of the agreed discharge plan to adults with social care needs who are being discharged from hospital.

Commissioners (clinical commissioning groups) ensure that they commission services in which adults with social care needs are given a copy of their agreed discharge plan before being discharged from hospital.

What the quality statement means for patients, service users and carers

Adults with social care needs have a member of staff responsible for working with them to plan their move out of hospital. The person should be given a copy of the plan before they move out of hospital. The plan should be easy for them to read and understand, and people giving them this information should also offer to explain it to them.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.5.16

Definitions of terms used in this quality statement

Discharge plan

A document that describes the coordination of care and support for discharge from hospital. It is a working document for the multidisciplinary teams. A discharge plan should take account of the person's social and emotional wellbeing, as well as the practicalities of daily living. It should include:

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

It should be shared with the adult and all those involved in their ongoing care and support.

[Adapted from Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline NG27) glossary, recommendations 1.5.15 and 1.5.16]

Equality and diversity considerations

Barriers to communication can hinder people's understanding of transitions and their involvement in making decisions. For example, learning or cognitive difficulties; physical, sight, speech or hearing difficulties; difficulties with reading, understanding or speaking English. These needs should be taken into account and adjustments made to ensure all adults with social care needs can be involved in making decisions about their care, if they have the capacity to do so. Information should be provided in an accessible format, particularly for people with physical, sensory or learning disabilities and those who do not speak or read English.

Quality statement 5: Involving carers in discharge planning

Quality statement

Adults with social care needs who will be supported by family and carers after discharge from hospital have them involved in discharge planning.

Rationale

Families and carers play a significant role in helping adults with social care needs return home after a hospital admission, and also with ongoing support. It is therefore important that they are involved in decisions about the person's discharge plan, as they can provide information about the person's needs and circumstances beyond medical conditions or physical needs. This makes discharge planning more comprehensive and may reduce the likelihood of the person being readmitted to hospital.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs who will be supported by family and carers after discharge from hospital have them involved in discharge planning.

Data source: Local data collection.

Process

Proportion of discharges from hospital for adults with social care needs who will have support provided by family or carers after discharge whose family or carers are involved in discharge planning.

Numerator – the number in the denominator whose family and carers are involved in discharge planning.

Denominator – the number of discharges from hospital of adults with social care needs who will have support provided by family or carers after discharge.

Data source: Local data collection.

Outcome

a) Delayed transfers of care.

Data source: Local data collection. Delayed transfers of care data is published by NHS England.

b) Readmission rates.

Data source: Local data collection. National data on emergency readmissions within 30 days of discharge from hospital are available from the Health and Social Care Information Centre as part of the NHS Outcomes Framework – indicator 3b.

c) Family and carer satisfaction with involvement in discharge planning.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place to enable adults with social care needs who will be supported by family and carers after discharge from hospital to have them involved in discharge planning.

Health and social care practitioners (such as discharge coordinators and members of the hospital-based multidisciplinary team) ensure that adults with social care needs who will be supported by family and carers after discharge from hospital have them involved in discharge planning.

Commissioners (clinical commissioning groups) ensure that they commission services in which adults with social care needs who will be supported by family and carers after discharge from hospital have them involved in discharge planning.

What the quality statement means for patients, service users and carers

Adults with social care needs who will be supported by family and carers after leaving hospital have them involved in planning their move out of hospital.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.5.30

Definitions of terms used in this quality statement

Carer

A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation. Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NICE guideline NG27).

Quality statement 6: Information about medicines

Quality statement

Adults with social care needs are given a complete list of their medicines when they are discharged from hospital.

Rationale

There is a significant risk of unintended changes to medicines when people transfer between care settings. Giving people a complete list of their medicines on discharge helps them to identify any changes, and also enables sharing the information with those involved in ongoing care.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with social care needs are given a complete list of their medicines when they are discharged from hospital.

Data source: Local data collection.

Process

Proportion of adults with social care needs who are given a complete list of their medicines when they are discharged from hospital.

Numerator – the number in the denominator for which a complete list of medicines is given at the time of discharge.

Denominator – the number of discharges from hospital of adults with social care needs.

Data source: Local data collection. Contained with the NHS Inpatient Survey.

Outcome

Harm attributable to errors in medication following discharge from hospital.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as hospitals and care homes) ensure that systems are in place for adults with social care needs to be given a complete list of their medicines when they are discharged from hospital.

Health and social care practitioners (for example GPs, hospital- and community-based multidisciplinary teams) ensure that they give adults with social care needs a complete list of their medicines when they are discharged from hospital.

Commissioners (clinical commissioning groups) ensure that they commission services that give adults with social care needs a complete list of their medicines when they are discharged from hospital.

What the quality statement means for patients, service users and carers

Adults with social care needs are given a list of their medicines when they move out of hospital. This information should be easy to read and understand.

Source guidance

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27, recommendation 1.1.5

Equality and diversity considerations

Information should be provided in a range of formats. For example, verbally and in written format (in plain English), or in other formats that are easy for the person to understand, such as braille, Easy Read or translated material (see the Accessible Information Standard).

Question for consultation

Is medicines information covered by statement 4 on discharge plans?

Status of this quality standard

This is the draft quality standard released for consultation from 18 April to 17 May 2016. It is not NICE's final quality standard on transition between inpatient hospital settings and community or care home settings for adults with social care needs. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 17 May 2016. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from September 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's quality standard service improvement template helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources.

Diversity, equality and language

During the development of this quality standard, equality issues will be considered and equality assessments are available.

Good communication between health, public health and social care practitioners and adults with social care needs transitioning between hospital and the community or a care home is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with social care needs transitioning between hospital and the community or a care home should have an interpreter or advocate made available if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs (2015) NICE guideline NG27

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Care Quality Commission (2015) Integrated care for older people (audit in progress)
- Healthwatch England (2015) Safely home: what happens when people leave hospital and care settings?
- NHS England (2015) Delayed transfers of care statistics for England 2014/15 Annual Report
- Nuffield Trust (2015) Focus on: hospital admissions from care homes
- British Medical Association (2014) Hospital discharge: the patient, carer and doctor perspective
- Department of Health (2014) Care and support statutory guidance
- Department of Health (2013) Identifying the ordinary residence of people in need of community care services
- Royal College of Physicians (2013) Future hospital: caring for medical patients
- Age UK (2012) Right care, first time: services supporting safe hospital discharge and preventing hospital admission and readmission

- Department of Health (2012) National framework for NHS continuing healthcare and NHS funded nursing care
- Royal Pharmaceutical Society (2012) Keeping patients safe when they transfer between care providers – getting the medicines right

Definitions and data sources for the quality measures

- NHS England (2016) Delayed transfers of care.
- Health and Social Care Information Centre (2015) Adult Social Care Outcomes Framework. Indicator 2A: Permanent admissions to residential and nursing care homes, per 100,000 population.
- Health & Social Care Information Centre (2013) Indicator Portal NHS Outcomes Framework. Indicator 3b: Emergency readmissions within 30 days of discharge from hospital.
- Care Quality Commission (2014) NHS Inpatient Survey.

Related NICE quality standards

Published

- Medicines optimisation (2016) NICE quality standard 120
- Preventing excess winter deaths and illness associated with cold homes (2016) NICE quality standard 117
- Falls in older people: assessment after a fall and preventing further falls (2015) NICE quality standard 86
- Managing medicines in care homes (2015) NICE quality standard 85
- Supporting people to live well with dementia (2013) NICE quality standard 30
- Patient experience in adult NHS services (2012) NICE quality standard 15
- End of life care for adults (2011) NICE quality standard 13
- Stroke in adults (2010) NICE quality standard 2

In development

- Home care. Publication expected June 2016.
- Older people with social care needs and multiple long-term conditions. Publication expected September 2016.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Consultant review within 12 hours of admission.
- Long-term conditions, people with comorbidities, complex needs.
- Medicines management: managing the use of medicines in community settings for people receiving social care.
- Readmissions.
- Regaining independence (reablement): short term interventions to help people to regain independence.
- Transition between inpatient mental health settings and community and care home settings.

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 2. Membership of this committee is as follows:

Mr Ben Anderson
Consultant in Public Health, Public Health England

Mr Barry Attwood
Lay member

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The following specialist members joined the committee to develop this quality standard:

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on transition between inpatient hospital settings and community or care home settings for adults with social care needs.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references

to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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